Health Perspectives

Undergraduate Health Studies Journal

Volume Five | March 2014

University of Toronto

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ISSN 2292-1311X

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Foreword

As the new Director of the Health Studies program at University College, it is my pleasure to introduce the fifth volume of Health Perspectives, the interdisciplinary journal of the Health Studies undergraduate program at the University of Toronto. Since 2009, students in the Health Studies program have been creating a high quality, peer-reviewed journal that gives undergraduate students in the program a place to publish their academic work. This year's edition of Health Perspectives has six original articles by student contributors, as well as a special feature on the Health Studies' "Alternative Reading Week" learning exchange that took students to the Six Nations reserve in Brantford, Ontario. The articles are equally split between international and domestic health issues, with three articles focusing on Canada and the remaining tackling important health topics in locales within the Global South. The Health Studies program focuses on developing a critical understanding of health: it is therefore exciting to me that all of the articles in this collection 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.

Since the inaugural edition of the journal, conceived and edited by Marrison Stranks, many Health Studies students have played important roles in keeping this student-run initiative alive and thriving. I want to say a special thanks to Angela Turner and Kandace Ryckman, this year's editors-in-chief (Angela was editor-in-chief for the past two years as well). Justin Struss is responsible for the journal layout. All three are graduating this year, and will be sorely missed as they move on to bigger and better things. In addition, Senior Editors Anjum Santana and Rowena Smyss, Junior Editor Liam Fox, and a number of peer- reviewers have all been integral to the publication of this journal and can't be thanked enough!

I sincerely hope you enjoy reading this volume of Health Perspectives,

SARAH WAKEFIELD
Director | Health Studies Program
University of Toronto

A Note from the Editors

It is with great pride that we present this latest volume of Health Perspectives. For its fifth year, this student-driven initiative has once again showcased the original work of undergraduate students. Each year we are always impressed with the high quality of work from all of our contributors, and this year was no exception.

Within these pages is a selection of articles focusing on a wide array of health issues from perspectives that are truly reflective of the critical nature of the Health Studies program. Each author challenges the surface definition of health as the absence or presence of disease, as they demonstrate how social, cultural, economic, and political factors shape our well-being. This volume explores the health of marginalized groups in Canada, featuring articles looking at the plight of refugees in the context of human rights, the historical and cultural impacts of the Indian Act, and various models of care for homeless individuals. International issues are also explored in articles analyzing mental health in the global South, standards of care in health research, and the concept of "voluntourism". In what is becoming a yearly tradition, this volume also features highlights from the Health Studies knowledge exchange programme to the Six Nations reserve in Ontario. It is our hope that this collection will provide critical insight on some underlying issues impacting health in Canada and around the world.

Finally, we would like to extend a warm and grateful thanks to all of the people who worked tirelessly to bring Health Perspectives, volume five, to life: our editorial team who proof-read, over and over, and who diligently verified APA formatting in all submissions -- no small task! Our layout editor, who made our haphazard notes and changes into something beautiful. And to our team of peer reviewers who were integral to the article selection process. We also wish to thank our contributing authors for their ideas and flexibility. Without you all this volume would not have been possible.

Yours in health,

K. Ryckman

Kandace Ryckman
Editor in Chief | 2014

Angela Turner
Editor in Chief | 2014

Caring for the Homeless: 'Continuum of Care' and 'Housing First' Treatment Models

EMMA BUAJITTI

The care provided by Housing First programs is more inclusive of the homeless, and leads to better housing and health outcomes. This suggests that such a program could lessen the burden of homelessness on Canadian society while providing these individuals with a greater quality of life than they currently enjoy under the continuum of care model.

Homeless people face a unique set of obstacles in attaining good health within the Canadian health care system, many of which are directly linked to their lack of shelter (Hwang et al., 2010). The current method for providing health and social services to homeless individuals is known as the continuum of care, comprised of an expansive network of emergency and transitional shelters (Hoch, 2000). However, some homeless individuals have expressed dissatisfaction with the quality of life delivered by the shelter system (Daiski, 2007). Recently, a new system for delivering care to the homeless has been developed, known as the Housing First model. Through Housing First pilot projects conducted in a number of countries worldwide, homeless people are provided with subsidized housing immediately, with no pre-conditions or obligations to complete social programming (Padgett, Gulcur, & Tsemberis, 2003; Goering et al., 2011). Since 2003, these pilots have demonstrated success in improving health incomes among the homeless, and analysis suggests that they are financially sustainable, but the continuum of care model continues to inform health service delivery to homeless individuals in Canada (Culhane, Metraux, & Hadley, 2002; Goering et al., 2011; Gulcur et al., 2003;). This paper will argue that Canadian health policymakers should adopt key principles of the Housing First model in order to provide the highest possible standard of health care to homeless individuals. The care provided by Housing First programs is more inclusive of the homeless, and leads to better housing and health outcomes. This suggests that such a program could lessen the burden of homelessness on Canadian society while providing these individuals with a greater quality of life than they currently enjoy under the continuum of care model.

In Canada, the large majority of homeless people rely heavily on the shelter system. The City of Toronto Street Needs Assessment, conducted for a second time in 2009, found that more than 80% of homeless people stayed in a shelter on the night of the survey (City of Toronto, 2009). The shelter system consists of a network of municipally and provincially operated shelters, each serving a distinct purpose (e.g. emergency shelter, family shelter, violence against women shelter, youth shelter, and so on) (City of Toronto, 2009). Health and social services provided by non-shelter drop-in centres, soup kitchens and meal programs as well (City of Toronto, 2009). Temporary or semi-permanent housing is available in some shelters, typically consisting of single rooms with shared bathroom and cooking facilities (Daiski, 2007). The shelter system is supported through subsidized housing provided by municipal governments (Goering et al., 2011). Waitlists for this housing are very long, with upwards of 40% of sheltered and street homeless waiting to qualify (City of Toronto, 2009). Additionally, retaining subsidized housing requires adherence to program mandates, including frequent monitoring of drug and alcohol use, mental health, and unit upkeep (Goering et al., 2011). This closely models the American Continuum of Care model of health service delivery, in which homeless individuals progress through emergency (in Canada, traditional emergency and violence against women) and transitional shelters (e.g. family shelters and semi-permanent housing) before accessing independent subsidized housing (Hoch, 2000). Progression requires completion of social and health programming (e.g. addiction counselling or psychiatric care) with the ultimate goal of reintegrating the individual into society as an independent adult (Hoch, 2000).

In the United States, the continuum of care model has been challenged by the Housing First model, which provides immediate subsidized housing to homeless people with no pre-conditions (Padgett et al., 2003). Under this model, comprehensive social supports are offered through a voluntary assertive community treatment (ACT) case management program (Goering et al., 2011). Often, there is no real expectation that these individuals will ever be fully financially independent, and the program is designed to prioritize stable housing over complete independence (Gulcur et al., 2003). The Housing First model is delivered in Canada by pilot initiatives such as Pathways to Housing (in Calgary and Edmonton) and Streets to Homes (in Toronto), which provide subsidized housing in conjunction with ACT or intensive case management (ICM) services (Goering et al., 2011). However, these initiatives are not widely funded and exist only on a small scale in large urban environments (Goering et al., 2011). For Housing First principles to be influential in shaping Canadian health policy, policymakers will need to support such programs to a much greater degree.

Housing First programs provide care that is more socially inclusive of homeless individuals of all backgrounds than the continuum of care model (Padgett et al., 2003). Often Housing First programs offer homeless clients a role in choosing their own place to live (Padgett et al., 2003). As Padgett and colleagues (2003) explain, this model of care gives greater agency to the homeless population served, which is a more humane, inclusive and empowering method of service delivery. This independence also extends to the behaviour of subsidy recipients, whose substance and alcohol abstinence and psychiatric treatment are often mandated by traditional continuum of care service delivery (Padgett, Stanhope, Henwood, & Stefancic, 2011). However, evidence suggests that these mandates do not typically result in alcohol and substance use reductions (Padgett et al., 2003). Since these controls therefore do not contribute to favourable health outcomes, and lead to resentment by clients due to infringement on their agency, they appear excessive within the program's context. In general, researchers studying Housing First programs agree that these programs take a more humane approach to addressing homelessness (Padgett et al., 2003; Goering et al., 2011; Collins et al., 2011). Under the continuum of care, homeless people who suffer from severe mental illness or chronic addiction are inherently disadvantaged over those who do not, and suffer severe consequences if they cannot adhere to the continuum of care process. By removing the strict regulations placed on these individuals by the continuum of care, Housing First programs play a role in reducing the stigma that surrounds mental illness and addiction within their program and supports the individual's healthy, guided recovery.

Providing barrier-free subsidized housing has the additional advantage of addressing the inherent problems within the Canadian shelter system. In a series of interviews with homeless Canadians, Isolde Daiski (2007) identified several recurring complaints about the quality of care provided by shelters. Shelter users described conditions as being 'overcrowded,' with restrictive rules and no privacy (Daiski, 2007). These cramped conditions lead to high rates of aggression, theft, and violence, including theft of personal identification documents required to access health care and receive important social services (Daiski, 2007). Several also described their difficulty in finding work using a shelter address, and even more difficulty in keeping a job without a stable living environment (Daiski, 2007). Providing subsidized housing addresses these complaints by giving homeless people a place to live that is safe, stable, and independent. Interviews with American Housing First participants revealed unanimous relief to be placed in housing after living in the shelter system (Collins et al., 2012). They were glad to have private living quarters, cooking facilities, a stable environment, and other such amenities, which the shelter system does not provide (Collins et al., 2012). Participants also reported improved feelings of social inclusion, noting a sense of community and solidarity with their fellow residents, where people "look after each other" (p. 6).

Furthermore, a large-scale Housing First program would be more accessible to the homeless population than the current continuum of care model. In the shelter system, individuals may be turned away if they demonstrate signs of extreme psychological distress, aggression, or heavy intoxication (Collins et al, 2011). This barrier makes it extremely difficult for people with severe mental illness or addiction to adhere to the continuum of care (Padgett et al, 2003). Some even report choosing to sleep on the streets because "you can't drink in a mission" (Collins et al., 2012, p.5). In general, Housing First projects take a "value-free" stance on substance use, emphasizing harm reduction programming (by minimizing consumption of surrogate/non-consumable alcohols or offering needle exchange programs), but they place no program-specific restrictions on drinking or drug use (Collins et al., 2012; Padgett et al., 2003). Similarly, case management services are provided to help clients manage their mental illness, but staying in the program is not contingent on successful psychiatric rehabilitation (Goering et al., 2011). Individuals struggling to cope with mental illness or addiction can still access these services at the same level as the rest of the homeless population, meaning that health and social services continue to be delivered to this highly vulnerable group.

When considering the Housing First model in the context of health service delivery, it is of course important to evaluate the health outcomes associated with Housing First versus continuum of care programs. Program evaluations so far suggest that Housing First programs have significant health benefits for their homeless clients over the traditional shelter system. Unsurprisingly, Housing First programs demonstrate greater success at maintaining housing for their clients than continuum of care programs (Gulcur et al., 2003). Having stable housing has important psychosocial benefits, and is associated with lower prevalence of severe mental illness and chronic addiction (Susser, Moore, & Link, 1993). The findings by Gulcur and colleagues (2003) demonstrate that continuum of care program participants spend significantly more time hospitalized and access more psychiatric services than Housing First clients. Moreover, despite the continuum of care requiring alcohol and drug abstinence, Housing First participants are significantly less likely to demonstrate substance use or abuse, and have much lower rates of addiction relapse (Padgett et al., 2011). One study found that nearly 50% of all continuum of care participants with previous drug problems relapsed into addiction within the first year of the program, highlighting its questionable efficacy (Padgett et al., 2011).

It is also important to consider attrition rates from Housing First and continuum of care treatment programs. For homeless populations with high rates of mental illness and substance abuse, leaving the program typically indicates that a participant has relapsed or returned to the streets (Padgett et al., 2011). Additionally, individuals who leave these treatment programs are often also lost to their case managers and social service providers, meaning these services are no longer delivered (Padgett et al, 2011). The potential for negative health repercussions after leaving the treatment program are therefore severe. The results of multiple studies indicate that attrition rates from Housing First programs are very low, while continuum of care attrition is relatively high (Collins et al., 2012 ; Gulcur et al., 2003; Padgett et al., 2011). Padgett et al. (2011) found that 54% of their control (continuum of care) group "went AWOL" from their treatment program in the first year after entry, while only 11% of Housing First clients did so (p.230). Individuals who stay with the program will eventually experience the many benefits of remaining stably housed, including higher potential for employment. People in subsidized housing are more likely than sheltered homeless to find voluntary or paid work, which as expressed in the Daiski interviews helps these individuals feel a sense of social inclusion and purpose (Culhane et al., 2002; Daiski, 2007). The lower attrition rates among Housing First participants also suggest that these people were happier with the program they received than the continuum of care recipients, further indicating that the Housing First program delivers better outcomes than the present system.

In considering the introduction of the Housing First model as a health policy issue, it is important to evaluate the cost effectiveness and financial sustainability of these programs. Cost analysis suggests that Housing First programs are more expensive to operate than the traditional shelter system, primarily due to the increase in housing subsidies awarded under this model (Culhane et al., 2002). These programs are responsible for financial gains elsewhere which help to offset the program's operating cost. These gains can mostly be attributed to reductions in social service utilizations, hospitalization, and institutionalization in psychiatric facilities or correctional facilities associated with better psychosocial health (Culhane et al., 2002; Padgett et al., 2003). Hospitalization is also reduced by stable housing independent of health, because clinics and emergency rooms will occasionally admit homeless patients overnight despite a lack of medical necessity (Messinger, 2006). These hospital stays would be greatly reduced with increased access to subsidized housing. Culhane and colleagues (2002) quantified the net savings of one New York-based Housing First program, finding that Housing First programs were more expensive to operate than continuum of care programs. However, the net extra expense represented only 5% of the cost of subsidizing housing and providing ACT case management, while 95% of operating costs were recouped through health and social service reductions (Culhane et al., 2002).

Furthermore, the financial burden the homeless individual placed on our social and health service sector was found to decrease proportionately to the length of time spent in a treatment program, whether Housing First or through the traditional shelter system (Padgett et al., 2003). This decrease in cost is brought about primarily by the service utilization reductions attributed to participation in treatment. It recalls prior findings regarding rates of attrition among the two treatment models. Since Housing First has lower rates of attrition, participants stay in the program longer, with up to 90% enrolment after 5 years (Padgett et al., 2003). This has the ability to result in cost savings for policymakers using a Housing First approach. Long-term cost savings associated with Housing First programs may be even greater than the 95% of operation costs reported.

Implementing Housing First principles into the Canadian system for providing services to homeless individuals would have demonstrated benefits for all affected groups. Most importantly, homeless people themselves would experience greater social inclusion, better health outcomes, more stable living conditions, and a generally better quality of life. The services included in the Housing First model of care would be better equipped than the current system to find meaningful work, build a community of peers, and feel safe and healthy. As implementation of Housing First principles would require massive policy change, it is also important to consider potential benefits for health and social service providers, as well as government bodies. With proper Housing First execution, health and social service providers would need to deliver fewer services to the homeless population, lessening the burden on these service providers while allowing greater access to care for those who continued to require it. Finally, government bodies would also benefit from the implementation of these principles. With more people stably housed, there would be a smaller population of street and sheltered homeless forced to rely on government support. This would come with minimal ongoing cost, though the exact financial impact implementing Housing First principles into the national care strategy would have is unknown. It is possible that in the long term, a Housing First program would actually demonstrate cost benefits.

Canadian federal and provincial governments have begun to recognize the potential benefits of a Housing First system in Canada, and preliminary efforts are underway to evaluate the effectiveness of such programs within the Canadian health system. A federal commitment to testing the Housing First model was demonstrated in 2008 when the government awarded a $110 million grant to the Mental Health Commission of Canada (MHCC) to conduct a study on mental health and homelessness (At Home/Chez Soi, 2010). The MHCC used these funds to create a 4-year evaluation of a new Housing First pilot program in five Canadian cities, named At Home/Chez Soi (At Home/Chez Soi, 2010). The research findings have not yet been published, but preliminary results indicate positive findings consistent with those of similar American studies (Goering et al., 2011). The benefits indicated by the Housing First approach have led to an extension of Canadian Institutes for Health Research (CIHR) funding, as well as a $4 million in permanent funding awarded by the Ontario government to keep At Home/Chez Soi participants housed after the trial period is complete (MHCC, 2013). This provincial response is mirrored on the federal level, with the 2013 Economic Action Plan proposing nearly $600 million over five years to renew the Homelessness Partnering Strategy (HPS) using Housing First principles (Government of Canada, 2013). The HPS provides grant funding to public and private organizations conducting health initiatives in the field of homelessness (Government of Canada, 2013). All three levels of government have demonstrated a commitment to funding evaluation of Housing First principles within Canadian communities. This is an important step towards implementing these principles within the Canadian health care system. However, direct action is required before Housing First principles will actively influence delivery of care to homeless individuals. This requires concrete policy change, which goes far beyond the pilot program evaluations currently supported by government funding.

Key Housing First principles should be incorporated into the shelter system on a national, or at least provincial, scale. This implies drastic health policy changes. For instance, pre-conditions for subsidized housing (i.e. psychiatric treatment and detoxification programs) should be waived or at least lessened, since they have no impact on decreasing substance abuse, and also lead to high program attrition rates. Acute Community Treatment or Intensive Case Management case management services should be provided to help guide psychiatric and substance abuse treatment in place of mandatory sanctions. Over time, evaluation of the impact of these policy changes will determine how best to continue providing care to Canada's homeless population, as well as any further policy changes deemed necessary. Infrastructure change will expectedly take much longer to implement. Ideally a system more congruent to a Housing First model will gradually replace the existing shelter system. As existing infrastructure ages, more appropriate facilities will emerge, including the development of a larger network of subsidized housing. Ultimately, by coupling immediate health policy change with gradual redevelopment of health infrastructure, our existing care delivery can be rebuilt to become more inclusive, effective, and supportive.

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Voluntourism: Making or Marketing a Difference?

VIKKI SCHEMBRI

> Building a school during spring break provides a physical task and a visible product after a week of dedication; it takes a lot less time, effort, and expertise than understanding why schools are not being built by locals and what societal, political, and economic barriers need to be overcome to solve the problem.

Voluntourism is an extremely popular and widely encouraged self- and global-development option for students in their gap year (either between high school and post-secondary education, or between post-secondary and employment). These students, more specifically, come from the 'Global North' to the 'Global South' in order to "volunteer in an organized way to undertake holidays that may involve the aiding or alleviating of the material poverty of some groups of society, the restoration of certain environments, or research into aspects of society or environment" (Wearing quoted by Alexander and Bakir, 2011; Lyons, et al., 2012). Volunteers (i.e. missionaries, doctors, and teachers) travelling abroad and gap year "alternative", (anti-)tourism travel (i.e. backpacking and trekking) have their roots in the nineteenth century (Benson, 2011), but the professionalization and valorization of "alternative" youth travel and "informal education" via structured voluntourism trips is a more recent phenomenon (Diprose, 2012; Lyons et al., 2012; Simpson, 2005). Voluntourism is now commonly viewed (and advertised) as a win-win-win situation: students are provided the opportunity to perform feel-good, altruistic deeds; to travel; and to develop skills for their future jobs, "all while [changing] the lives of others for the better" (Volunteer Abroad Travel, 2013). This paper will focus on the "aiding or alleviating of the material poverty" work voluntourists seek and that voluntourism agencies (seemingly) provide, and the impact this work has on the greater, global community.

Through this paper, I will investigate whether voluntourism can support its purported aim and ability to change [read: better] their world [in the Global South] or does this practice actually maintain unequal political, social, economic, and cultural global power relations and Global South under-development. Analyzing voluntourism through the lens of political economy reveals an overwhelming amount of inconsistences between the development efforts offered through voluntourism agencies and the real impacts of the trips for self-, host-, and global-development.

Limited and simplified notions of poverty and development are defined and legitimized by these projects, and complex fundamental causes of poverty are ignored in the presence of 'do-able', marketable interventions.

Increasing evidence reveals the aid provided through these trips caters more to the interests of the tourist rather than the needs of the host community. Voluntourism and voluntourists fail to recognize or acknowledge that these ventures are tailored to certain ideologies and perspectives that produce band-aid solutions in development, primarily a simplistitic view point rather than developing global citizenship and poverty eradication solutions (Lyons et al., 2012; Vrasti, 2013). This is problematic because the market-based and individualized philanthropy that ensues hampers development and underestimates the extent of Global South exploitation and global poverty. Time, money, manpower, and resources are being allocated towards trips that are not only maintaining marginalization, but that also censor and deepen marginalization of the Third World.

It is estimated that 1.6 million volunteer tourists travel yearly from all over the world and these trips are organized by a variety of institutions (private, public; state and non-state actors). It is estimated the total expenditure for volunteer tourism is between $1.66 billion and $2.6 billion (Association for Tourism and Leisure Education, 2008). Though the argument that every dollar is being wasted and contributes to under-development can be upheld no more than the argument that every dollar brings us closer to eradicating poverty, it is important to understand what this mass amount of money is actually doing for investors and investees.

Thus, this is not a cynical denouncement of volunteering abroad: it is a critical analysis of the summative effects of the practice of pursuing development and altruism (via volunteering) in the context of a money-oriented industry (such as tourism) and a competition-oriented marketplace (neoliberal capitalism). Such an analysis is crucial in order for further research into alternative means of achieving real development and how to make volunteering abroad more effective to take place. Shorter volunteer trips are more likely to be associated with self-interest values than altruistism, are less likely to result in sustainable development, and are the most popular programs (Diprose, 2012; Lyons et al., 2012). These are the main "voluntourist projects" I am referring to in this critique.

For the most part, voluntourist agencies recognize and respond to health inequalities based on issues surrounding social determinants of health. This demonstrates how voluntourism organizations have come to recognize and respond to the paradigmatic shift from biomedical to social determinant approaches to health. It is consistent with the World Health Organization's definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 2003). Certain determinants that have been identified to understand why some Canadians are healthier than others (Mikkonen & Raphael, 2009) have become the targets of the voluntourist trips in developing nations: disability, early life, education, food insecurity, health services, gender, housing, race, and social exclusion. This is exhibited by the multitudes of opportunities voluntourist agencies provide to build schools, teach children, assist in caring for infants and children, improving the quality of care for people with disabilities, and a variety of other activities. The limited scope and approach to these issues and the absence of explanations of how and why these determinants are unequally distributed, however, indicate the incompetence of these 'development' efforts.

The social determinants of health initiatives (and voluntourism) looks towards gaps in education, child care, housing, and so on to fill these gaps. However, Lofters and O'Campo (2011) argue "identification of gaps and gradients… flags the presence of a potential problem but does not explain the underlying mechanisms" (p. 93). Through the lens of political economy, the societal and structural systems that underlie the unequal access and distribution of goods and resources that determine the social determinants of health can be studied, understood, and perhaps dismantled and reconstructed. Understanding the economic, political, and socio-historical forces that all-together shape and determine the dynamics of race, class, and gender and how this manifests itself in individuals and society is the basis of this theoretical framework (Minkler, Wallace, & McDonald, 1994), and could explain how gaps were formed, why they continue to grow, and perhaps how to shrink them rather than just fill them.

Thus, voluntourism's development is actually a "particular type of 'development'… where the emphasis is on end products, such as 'teach the child' … [and] 'build the bridge' (clinic, well, library etc.)" (Simpson, 2004). Issues and gaps are recognized and filled by a stream of volunteers. Consistent with political economy theory, though, Nghia (2010) argues "targeting poverty by one or some of its symptoms cannot help break down the mechanism of interacting constraints locking poor victims deep inside" (p. 17). For example, Cross Cultural Solutions explains their approach to the "under-resourced, understaffed, and overcrowded" public education system in Guatemala City is to send over volunteers to teach English. When one "volunteer wraps up her time in Guatemala, another CCS volunteer jumps in to pick up where she left off", which they claim demonstrates the sustainability of their program (Destinations, 2011). In reality, this demonstrates the unsustainability of their solution – volunteers constantly 'need' to be sent over to fill this gap because the underlying causes of under-resourced, understaffed, and overcrowded public schools is not adequately addressed. Under this model of 'development', the political, economic, and social dynamics that cause these problems are ignored, irrelevant, and remain unfixed.

Another pertinent example relates to North American medical students bringing medical care to impoverished areas through global health projects and volunteer trips. Snyder, Dharamsi and Crooks (2011) explain this mobility of health care providers is in response to global health disparities and medical students' 'sense of social responsibility.' For example, Sub-Saharan Africa carries close to 25% of the global disease burden, but only 3% of the global healthcare workforce. Such statistics reveal a gap in health services in places such as Sub-Saharan Africa, and the response is to send over medical students and volunteers. However, this method of 'development' completely ignores and actually exacerbates the underlying mechanisms that have caused this gap – namely, 'brain drain'.

This phenomenon refers to the emigration of health professionals from poor to rich countries (including sub-Saharan Africa) because impoverished countries lack the infrastructure and resources to provide adequate jobs to these health professionals (York, 2011). Human resources are emigrating from places like sub-Saharan Africa to already-better-off countries, such as Canada and the U.K. (Eastwood et al., 2005), which is widening global health disparities. And now, voluntourism responds to this by bringing volunteer-medical students into sub-Saharan Africa; these people are offering to provide medical care for free, and ebbs the urgenct necessity of training locals and holding onto human resources by providing adequate jobs in sub-Saharan Africa. This harm is compounded by the criticisms of inexperienced and culturally insensitive health care providers (Bishop & Litch, 2000), and that voluntourism growth is "outpacing the development of physician's social responsibilities toward communities abroad and ethical guidelines" (Snyder et al., 2011). Thus, lacking a political economy approach can cause more harm than good not only to individuals receiving care, but the greater political, economic and social systems remain underdeveloped which also contributes to the Global North's over-development in the health care sector.

Many critics of voluntourism call for guidelines (Atkins, 2012), accreditation (Fee & Mdee, 2011) and social justice pedagogy (Diprose, 2012; Simpson, 2004) to be included into voluntourism organizations to ensure development actually occurs. I argue that an investigation of and dedication to fundamental causes could decrease harm and increase effectiveness of these projects. Efforts that address education and medical inadequacies with volunteer teachers and doctors imply inequalities in education and health services are a result of lack of human resources, rather than a lack of policies and economic pressures that allow for resources to be produced, distributed, or employed. Accordingly, "labour organizing…, political leadership…, and social movement leadership… are more in line with a transformative philanthropic alternative" (Nickel & Eickenberry, 2009) than the ventures currently pursued through voluntourism. Still, it is inherently paradoxical to use short-term voluntourism trips to spur long-term systemic change, and based on my research I remain unconvinced that any amount of revamping for these (short-term) programs could spur development or reverse factors of under-development.

It is possible that voluntourism has teaching potential, however, and could structure their programs around teaching voluntourists about global inequalities and political, economic, and social mechanisms that underlie such inequalities. A political economy approach to global poverty, though, would provide less 'do-able' and less 'fun' methods of development than something like a hands-on building project. That is to say, building a school during spring break provides a physical task and a visible product after a week of dedication; it takes a lot less time, effort, and expertise than understanding why schools are not being built by locals and what societal, political, and economic barriers need to be overcome to solve the problem. This goes to show how most of these 'development' projects cater more to voluntourist needs, wants, and interests, rather than the real development needs of the host communities.

The voluntourist phenomenon demonstrates current trends in philanthropy – more specifically, market-based and individualized philanthropy. These trends reveal how neoliberalism has permeated philanthropy and how capitalism has curbed humanitarian actions towards meeting neoliberal marketplace needs. In the same way that political, economic, and socio-historical factors underlie the health inequalities experienced in the Global South, investigation of these same factors in the West can reveal why voluntourism and specific types of "development" are so widely accepted and pursued by gap year students. Market trends (rather than legitimate needs) are being used to define poverty issues and solutions. Ironically, these trips appear to be rooted in altruism and opposed to "the violent orderings of modernity" (Wearing & Grabowski, 2011), but these very values are being exploited by neoliberal market and capitalist system of the West to produce citizens that actually adhere to neoliberal, capitalist values.

The acculturation of conscious consumerism, a practice that has facilitated the growth and professionalization of voluntourism, is a market response to changing global relations. With the rise of globalization, the internet, and global mobility, consumers are becoming aware told that everyday activities (e.g. buying a T-Shirt) and leisure activities (such as tourism) are actually global activities and carry global impacts, especially on the Global South. If done wrong, they can intensify inequality and harm (i.e. buying a shirt made in a sweat shop exhibits careless support of sweat-shops); but, if done correctly and consciously (i.e. buying a RED Gap shirt or participating in voluntourism), they can "change" or 'save the world.' While marketing and politicizing products appeals to a guilt-conscious society – guilty because they are familiar with the 'public faces' they see on World Vision commercials and because certain, dominant economic and political ideologies have ingrained in them that "today, all time [and all actions] should be productive" (Ingram, 2011) – because they provide mutual benefit solutions (Lyons et al., 2012), they simultaneously "depoliticize the relationship between the market and the negative impacts it has on human well-being" (Nickel & Eikenberry, 2009, p. 974).

Waste, defined as an avarice of the current, neoliberal and capitalist political and economic ideologies (Sears, 1999), is factored out of the consumer experience because consumers receive a product while simultaneously providing global counterparts with some sort of humanitarian aid. Voluntourism, especially, is touted for the additional benefit of developing employable skills (ex. problem-solving, teamwork) that will prepare returned voluntourists for future careers in the (Western) job market (Ingram, 2012). That is, helping the world's poor and exhibiting global citizenship is an "investment strategy designed to expand the labour power and civic spirit" of young travellers (Vrasti, 2013, p. 131). Students can enjoy their adventure holidays, feel good about helping the poor, and feel secure in their future work endeavours. There is no guilt in taking a vacation from their studies or employment because the trip isn't thought to be a vacation, but a practice of informal education, altruism, and conscious consumerism. Through such a model, consumers get pleasure from their product and the feel-good effects of consuming 'consciously', even though the actual effects and measured impact of their 'consciousness' remains unknown and under-researched. Development – the opposite of stasis and waste – has become trendy (Ingram, 2011) and has become commoditized.

This marketization of philanthropy brings the world further from development solutions and closer to market dominance since "'philanthropic products'… tell a story of the benevolence of the market…. We attempt to engage in philanthropic action but find ourselves limited to the very venue (the market) that creates the need for philanthropy in the first place" (Nickel & Eikenberry, 2009, p. 979). This type of philanthropy "feeds on genuine benevolent spirit" rather than fosters it because it produces a misguided, misunderstood concept and idealization of development and poverty (Nickel & Eikenberry, 2009). Purchasing goods and trips is understood as a responsibility of the consuming citizen and the global citizen, as they are one in the same as a neoliberal subject (Vrasti, 2013). Furthermore, purchasing goods allows consumers to purchase a benevolent identity along with it, thanks to the market. Purchasing power and conscious consumerism is purported as a means of development, when the underlying mechanisms and income inequalities that allow and prevent different groups of people from purchasing these goods (and that consequently create 'good' and 'bad' global citizens) remain ignored and irrelevant. So even though voluntourists are physically and geographically travelling to the periphery of a centralized system, they fail to escape the grips of the market. The voluntourism experience then falls victim to "the risk of speaking from the Center, to the Center, about those in the margins" (Vasas, 2005), since the Center-market continues to mitigate how Center-voluntourists respond to marginal issues.

Particularly for volunteer tourism, students fail to realize that there are certain factors predicated on inequality that allow them to have the time, money and opportunity to travel abroad and volunteer and are exhibited through this very action (Simpson, 2004). The systems underlying such factors "make the reverse process almost impossible" (Simpson, 2004, p. 690). As well, these trips offer individualized forms of cultural and corporate capital that make these students more marketable to future employers and can be exchanged for economic capital upon return home, but such 'capital' can only be collected by the students that have capital in the first place (Lyons et al., 2011; Simpson, 2005;). The very tenants of capitalism (the goal of accumulating more capital) and inequality (since initial capital is needed to produce more) are exhibited and exacerbated by the unequal access/opportunities for some people to travel and for others not to. Under this market logic, global citizenship is measured by how much and how consciously you consume. As a result, volunteer tourism masks rather than mitigates the inequalities and power relations, and reduces these complex issues to individual choices rather than systemic problems.

Hidden by development buzzwords, neoliberal market values are thus employed through philanthropic and humanitarian "aid". Market-oriented and individualized philanthropic activities facilitate a certain appreciation and legitimation for the very "competiti[ve], fear[ful] and distan[t]" market that philanthropy and altruism are opposed to as they allow people to consume guilt-free (Lyons et al., 2012). Conscious consumers actually appear to be unconscious of the very inequalities their purchasing actions exhibit and exacerbate. Voluntourists "assume that voluntourism is available to everyone because the websites… state that programmes are equally appropriate for [all travellers]" (Alexander & Bakir, 2011), but they fail to realize that this 'equal opportunity' is not distributed globally because not everyone has the opportunity and resources to travel. As Lyons et al. state, "the discourses of youth culture are already so thoroughly saturated with the ideology of consumerism that it is increasingly difficult to imagine alternatives … [to] the subsumption of… social consciousness under the logic of neoliberalism" (2012, p. 368). Far from creating global conscious citizens, actions such as voluntouring are rooted in and foster individualistic, self-conscious neoliberal citizenship.

Development, which is supposed to be "a movement away from political, economic, or social oppression" (Ingram, 2011, p. 217), is not achieved through voluntourist agencies. Most voluntourism – especially its short-term projects – lacks the capacity to produce development in the Global South since these projects currently address endpoints rather than systemic oppression. Furthermore, rather than moving away from oppression, voluntourism actually works within it because it is dictated by the neoliberal market. Myths of development are perpetuated through voluntourism when development is attributed to activities such as building schools and mobile physicians. These "solutions" are neither sustainable nor aimed at systemic change. The market actually manipulates development and philanthropy to fit them into the neoliberal market scheme – the very market founded in competition and individualization rather than social justice. Thus, these projects maintain and mask underdevelopment and function through the very political, economic, and socio-historical systems that produce inequality.

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The Indian Act: A Legacy of Limiting Aboriginal Health

Lily Yuxi Ren

Indigenous people in Canada do not have the same citizenship rights as non-Indigenous people, and the Indian Act continues to discriminate and marginalize First Nations people. By maintaining the Indian Act, the federal leadership of Canada continues to trap Aboriginal peoples in poverty while generating a large disparity between the health of Indigenous people and non-Indigenous people.

The Indian Act of 1876 continues to be a discriminatory piece of legislation. By restricting and limiting the First Nations' way of life, the Act attempts to assimilate and "civilize" First Nations to adopt European traditions (Manzano-Munguía, 2011). Although sections of the Act continue to be amended, there are still many existing issues. There are two provisions of the Act that affect the health of Aboriginal peoples on reserves. Sections 18(1) and 89(1) of the Indian Act prevents Aboriginal peoples on-reserve from obtaining title to land while forbidding the seizure of Indian lands under legal process, inhibiting legal recourse to enforce a mortgage (Canadian Real Estate Association, 2006). Entrenched in colonial practices of the 1800s, the Act strips the autonomous self-governance of Aboriginal peoples' land, and resources through the forced assimilation into the predominant European culture (Richards, 2000). This disruption in their way of life results in the deterioration of Aboriginal health, generating great disparity between non-Indigenous peoples and Indigenous peoples' health in Canada - especially for those living on-reserves (Richards, 2000).

Although the Indian Act does not fall under the Ministry of Health's jurisdiction, it directly affects the health of the Aboriginal population. Proper health care demands a multidisciplinary approach involving all aspects of public and government affairs. It has been noted that Aboriginal peoples, overall, show significantly greater incidence of a range of afflictions and premature death from various causes (Bryant, Raphael, & Rioux, 2010). These issues result from several social determinants of health - such as housing, income, food security, employment and working conditions, social exclusion, and so on, reflecting a history of neglect from Canadian society (Bryant et al., 2010).

An underlying issue for Aboriginal health is on-reserve housing conditions that impact impacts the health and well being of individuals and communities (Durbin, 2009). Under the Indian Act, on-reserve housing is the responsibility of the Canadian federal government (Durbin, 2009). The standard of living on Indian reserves in Canada reveals a poor response to improve the health of Aboriginal peoples on-reserves. The Department of Indian Affairs and Northern Development (DIAND) states that of the 91,652 housing units on-reserve, 55.9% (50,220) need piped water, 39.1% (35,152) pipes need sewage service, 23.1% (21,050) need minor renovations, 16.3% (14,224) need major renovations, 5.3% (5,051) need indoor plumbing, and 5.2% (4,715) need overall replacement (Alcantara, 2005). In addition, the inability to meet the increased housing demand is exacerbated by the higher birth rate. The Aboriginal population in Canada exhibited an increased growth rate of 45%, compared to the 8% seen in non-Aboriginal populations from 1996 to 2006 (Durbin, 2009).

The Indian Act serves as a legal barrier limiting the autonomous self-governance of the Aboriginal peoples of Canada. The Act allots land for reserves set aside by the federal government for occupancy by an Indian group or band (Durbin, 2009). These pieces of land are owned by the federal government, in accordance with provisions from the Indian Act, limits private home ownership opportunities for Indigenous people (Alcantara, 2005). Section 18 of the Indian Act states that on-reserve residents cannot own land nor do they own their own home; the land is held in trust by the Crown for Indigenous peoples (Optis, 2012). However, Aboriginal people living on-reserves can have private property rights but the process is not simple (Alcantara, 2005). The inability to own land leaves many on-reserve Aboriginal people in problematic situations.

For example, the lack of ownership decreases the motivation to maintain and repair their homes (Optis, 2012). This provides little incentive for a resident to maintain a home using personal financial resources. It is often left to the Band Councils to fix poor housing conditions such as mold growth. However, the limitations of Band Council funding leaves these issues unattended to and forces people to choose between building new houses to alleviate crowding or repairing old housing which are poorly maintained and constructed (Optis, 2012).

In addition to restricted land ownership, Aboriginal people face the additional challenge of obtaining mortgages in building and renovating their homes (Alcantara, 2005). Section 89 of the Indian Act prohibits lending institutions from seizing Indian assets and property in the event of a default. Consequently, third party lenders are reluctant to provide loans to status-Indians since they have no collateral without these seizure powers (Alcantara, 2005). This forces most members to rent or lease units from the band council. Members are therefore less likely to take proper care of their homes as observed by housing officials at Six Nations, Westbank First Nation, and Cowichan Tribes (Alcantara, 2005). One band member at Six Nations, Ontario, was noticed tearing off siding from his house to use for firewood (Robson, 2008). This lack or incapability of proper care on the individual basis combined with chronic flooding, poor ventilation, and overcrowding causes on-reserve housing to deteriorate quickly (Optis, 2012). Often members approach the Band Council to secure financing where they then enter into lease agreements sacrificing personal control and again lose motivation to maintain their own home (Optis, 2012).

The incidence of mold growth in on-reserve homes is a national housing crisis in Canada. Nearly half of the homes on reserves are contaminated with mold that is associated with high rates of respiratory and other illnesses (Optis, 2012). Mold growth is generated from the increased moisture levels in building envelopes and interior spaces, especially places that are damp, cool, and dark (Optis, 2012). There are several deficiencies in housing conditions that increase the moisture level in homes such as structural damage to the building envelope, overcrowding, and insufficient use of ventilation systems (Optis, 2012). For instance, amongst the Cowichan Tribes in British Columbia, almost all of the homes built in the 1960s and early 1970s are being replaced because of the presence of mold related to increased negative health among Aboriginal peoples (Alcantara, 2005). This situation emphasizes numerous issues that arise due to Sections 18 and 89 of the Indian Act.

Similarly, the issue of mold growth in on-reserve homes resulting from the combined provisions of the Indian act is demonstrated at the Long Lake reserve in Ontario. Several cases of mold infestation have led to severe health effects. As numerous homes from the same reserve reported mold infestation, the reserve declared a state of emergency. Residents were evacuated to motels, trailers, tents in bush camps and apartments off the reserve at a cost of $1.2 million (McLean & Steel, 2001).

Melissa Waboose occupied an infested home on the reserve and noted that there were slimy green molds outside the skirting of her prefabricated accompanied by a terrible smell. Her family (husband and two sons) lived in her infested home for two years during which they suffered several health problems not thought to be linked to the mold growth. This required $390 worth of asthma puffers every month throughout their stay. Melissa reported painful, open sores covering her forearms, which her doctor blamed on an allergy to the sun. She recalls, "They were gross. People stared at them so much I kept my jacket on all the time" (McLean & Steel, 2001). Soon after moving out, her rash healed leaving deep scars in its wake, while the rest of the family's allergies vanished. Authorities later informed her that there were four types of mold in her home.

Frank Onabigon, from the same reserve, lived in a 1,000 square-foot house with 11 children and grandchildren. Based on the size of his family, overcrowding is evident. He recalls, "'My grandson, less than a year old, had a very wheezy chest that [did not] clear up even with antibiotics. Two months after we moved out, it's practically all cleared up. To us, it always seemed normal because there was so much of it around.'" (McLean & Steel, 2001)

In addition to the $1.2 million for evacuation, the Department of Indian and Northern Affairs estimates that it will cost $1 million to repair 45 houses and up to $5 million to tear down and rebuild another 46 on this reserve alone (McLean & Steel, 2001). Attributing factors such as poor construction, poor maintenance, and overcrowding leads to excessive moisture in the home. However, the main contributor is overcrowding which substantially increases the moisture in homes and the tendency of mold growth. The limitation to land entitlement and mortgages generate social issues. Furthermore, few health measures are adopted to test and improve the health of these residents. Unfortunately, this is not the worse of the cases (McLean & Steel, 2001). More than half of the 633 Canadian reserves are affected by some form of mold growth (McLean & Steel, 2001).

In 2008, a large portion of the estimated 89,000 on-reserve houses in Canada reported being in poor condition due to overcrowding, unaffordable and improper service, poor site construction and inappropriate culture based shelter needs of the approximated 423,000 residents (Robson, 2008). Over 40% of all the units are considered inadequate by Canadian housing standards. Additionally, the Canada Mortgage and Housing Corporation suggests that only half of all on-reserve housing meets or exceeds the standard for suitability or adequacy (Robson, 2008). Former Grand Chief of the Grand Council Treaty 3 in Ontario and current band councilor of the Naotkamegwanning First Nation, Francis Kavanaugh reflects that "the biggest issue Aboriginal communities are facing is the lack of adequate housing … [and] severe backlogs in housing. In our territory alone, I think there are about 5,000 houses that need to be built to catch up to the needs. Present housing is in need of renovation – major renovation because of various problems such as [mold]. …Bad housing leads to social issues and social issues are…a big item for a lot of leaders" (Robson, 2008).

These "social issues" referred by Kavanaugh are intertwined with health. For example, as previously discussed, people are contracting respiratory disease because of mold infestation, shigellosis due to inadequate housing, sanitation, and water delivery systems or tuberculosis because of crowded living conditions (Robson, 2008). Beyond the explicit limitations of the provisions of the Indian Act, there are many social determinants of health such as income, social status, and education that contribute to the health risks affected by the Act. These are then manifested within the population as a range of health problems seen from psychological and physiological effects to specific diseases varying in the degree of associated morbidity (Robson, 2008). Some confronting the reserve community include eye infections, tuberculosis, meningitis, measles, intestinal, skin and middle ear infections, respiratory diseases, asthma and diarrheal diseases (Robson, 2008). Health Canada suggests that on-reserve housing is one of the most significant "non-medical determinants of health" and a measure of community well being (Robson, 2008).

In the case studies of Melissa and Frank it is clear that poor housing conditions infringe upon their human rights to health in Canada. The provisions of the Indian Act that limits ownership rights of land and homes on-reserves, and mortgage opportunities act as barriers to health for Melissa, Frank, and Aboriginal peoples. Because these limitations are reinforced by the Indian Act, Aboriginal peoples have noticeably poorer health than non-Aboriginal Canadians with increased rates of mental illness, alcoholism, family violence, injuries, diabetes, tuberculosis, obesity, lower life expectancies, higher rates of suicide, and other increased health risks (Durbin, 2009).

There are a series of historical and socioeconomic factors such as disenfranchisement from traditional territory, environmentally appropriate construction, high unemployment rates, and insufficient federal funding for on-reserve housing that produce unstable living conditions and lack of aide (Optis, 2012). These are determined by the provisions of the Indian Act, which, ultimately results in a decrease in autonomy, and self-governance makes it more challenging for Aboriginal peoples to participate in Canadian economy. This then leads to insufficient housing, overcrowding, issues of safety, and security. To make matters worse, in reference to mortgages, the chief and council decide who may receive grants. It is hard to care, let alone maintain, the supposed "homes" that they do not actually own.

Considering that Aboriginal Affairs falls under the jurisdiction of the federal government, there is an assumption that Aboriginal people would get more attention. However, there is little initiative on the government's part for the promotion and education of Aboriginal Affairs. Moreover, considering the need and demand for on-reserve maintenance, there is minimal funding set aside for these projects. In 2005, the federal government vowed to increase the number of on-reserve homes to mitigate social and health-related problems under the Kelowna Accord (Optis, 2012). The commitment to reduce housing shortages by 40% in 2010 and 80% in 2015 continue to be dishonoured (Optis, 2012). Likewise, the shift to federal leadership leads to many neglected Aboriginal concerns that jeopardize many aspects of Aboriginal health (Optis, 2012).

Proper housing is a fundamental human right as stated in the United Nations' Universal Declaration of Human Rights (1948) (Durbin, 2009). The International Covenant on Economic, Social, and Cultural Rights recognizes housing as a "constituent element of the right to an adequate standard of living" in article 11 (Durbin, 2009). The Ottawa Charter for Health Promotion (1986) states that shelter is a basic prerequisite for health. In addition, home ownership provides a means for economic prosperity and financial security over longer periods. (Durbin, 2009). The stability of housing determines how the individual will be able to obtain and maintain jobs, access required services, and develop lasting community relationships.

The Indian Act is an influential policy regarding First Nations people in Canadian history. Enacted in 1876 by the Minister of Indian Affairs and Northern Development Canada under provisions of the Constitution Act of 1867, it defines who is "Indian" and contains certain legal limitations and rights for registered Indians (Durbin, 2009). Historically, this act attempted to assimilate, civilize, and protect the Indians by deploying materialized control such as the use of reserve systems (Manzano-Munguía, 2011). It regulates reserve and band operations while depriving reserve residents of individual ownership rights. The provisions of the Act have become disincentives for businesses to move to reserves, which have negative implications for the economic success and standard of living for Aboriginal peoples on-reserves that do not support their way of life (Richards, 2000). Indigenous people in Canada do not have the same citizenship rights as non-Indigenous people, and the Indian Act continues to inadvertently discriminate and marginalize First Nations people (Durbin, 2009). By maintaining the Indian Act, the federal leadership of Canada continues to trap Aboriginal peoples in poverty while generating a large disparity between the health of Indigenous people and non-Indigenous people.

Reducing mold growth in on-reserve homes requires the government to take initiatives to educate residents on mold remediation and prevention techniques with renewed and lasting commitment to improving the socioeconomic conditions on-reserves. The mold crisis will persist and likely worsen as the disintegration of the system of health care financing and delivery to Aboriginal people leads to a growing number of Aboriginal people in need of care. A lack of funding places strain on Aboriginal health organizations that are left to mediate the situation (Lavoie, 2011) and burdens the Canadian public health care system. The health gaps between Aboriginal peoples and non-Aboriginal peoples require the efforts of the federal government, Aboriginal communities, and Canadians to reconsider the discriminatory provisions of the Indian Act in order to minimize this disparity.

Aboriginal peoples "sustain a disproportionate share of the burden of physical disease and mental illness" due to inadequate housing (Robson, 2008, p. 74). Acknowledging the causes of housing issues such as mold growth and its link to inadequate on-reserve housing is acknowledging the link between inadequate housing and poor health outcomes confronting on-reserve residents (Robson, 2008). Indigenous people are more marginalized and do not have the same rights as non-Aboriginal Canadians as materialized in the legality of the Indian Act. To decrease the gap between the health of Indigenous and non-Indigenous peoples, we must acknowledge and rectify the limitations of these provisions.

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Knowledge in Action: A Reflection on the Decolonization of Eduction Through the Exchange of Ideas

Justin Leigh Struss

> Science is one way of doing things, one attempt of the human race to understand and conceive of what is going on around us. In reality, it is no better or worse than other ways of knowing or understanding.

When I first started attending university, I assumed that science, capitalism, and Western thought were the only correct ways of understanding the world, society and life. I didn't even realize that there was another way to think. Being raised in Canada, and being the seventh generation of my family to be born here, the culture I was raised in and the education I was given revolved around science, law, and capitalism. It really was the only thing that I had experienced in my life, and it was much easier to cling to these ideas than to challenge how I think of the world, at least until I started university. In 2012 I did exactly that; I challenged my own beliefs and in doing so, began to think of the world from different perspectives. This happened because I had the opportunity to offer a knowledge exchange programme over reading week to University of Toronto students. This exchange brought Aboriginal and non-Aboriginal students together to learn from each other and from the members of the Six Nations of the Grand River Reserve community.

While on the exchange, I realized that Western thought is really only one way of conceiving of the world. Science is one way of doing things, one attempt of the human race to understand and conceive of what is going on around us. In reality, it is no better or worse than other ways of knowing or understanding. The only major fault that I have discovered within Western knowledge is that it typically discounts and discredits any knowledge or idea that is conceived outside of the Western framework. For instance, in Western thought, Aboriginal oral tradition is often automatically discredited because it was never written down. Fortunately, this is slowly starting to change, though the bias still exists. I think in understanding the world, humans would greatly benefit by drawing from the strengths of different knowledge systems. In this way, we can come to a greater understanding of ourselves, and the world around us. This is especially true when it comes to education.

Education in Canada is something that is extremely colonialist. There is no room in the education system for learning in a way that is different from the dominant method. This is especially apparent at the university level. Think, when was the last time that you were able to take a course that actually graded you based on what you are learning, not what some "expert" thinks you need to learn? Have you ever heard of a course where you can learn in your own language (if it isn't French or English) in methods that are traditional to your culture? In Canadian education, most topics are always framed from a Western colonialist perspective, one that discredits a vast amount of human experience. Through providing this cultural exchange to students, three years running now, I have attempted to decolonize the way students learn. By having exchange leaders who are not experts, but merely guides to help direct conversation, by having students from a multitude of different backgrounds, cultures, and ethnicities, and by learning directly from the Six Nations community and each other, not from a textbook written by a Canadian who is using their lens to frame Aboriginal issues, I am taking one small step in the direction of the decolonization of education. This is something that at the University of Toronto we should strive for, as we can learn a lot more than if we just try to understand something from one perspective. I hope that this opportunity can be offered to students for many more years to come, as I have learned the same amount, if not more, in the three weeks I have spent at Six Nations over the past three years. This time has challenged the way I think more than any other part of my four-year undergraduate degree. Through decolonizing education, we can truly begin to better understand each other, the world, and different cultures.

Tobacco is an integral component of Haudenoasunee cultural ceremonies, and is also used in cigarette manufacturing.

Watching a piece of pottery take shape with potter Steve Smith of Talking Earth Pottery.

The 2014 Six Nations Exchange group outside of Talking Earth Pottery with potter Steve Smith.

Global Mental Health in Southeast Asia: Challenges, Structural Difficulties, Attempted Solutions, and Policy Prescriptions

KALEEM HAWA

> Any major advances to mental health that might have proliferated in the medical community rarely reached the insular world of the asylums. This has led to obsolete systems of care that remain widely and ineffectively used. This lack of knowledge often contributed to an absence of medical supervision in the treatment process. It also led to the adoption of practices that depicted mental illness as something to be cured rather than emphasizing manners of coping and independent living.

In 2005, the World Health Organization (WHO) announced in a report from the European Ministerial Conference in Copenhagen that they believed there could be "no health without mental health" (Hunter, 2005). They were, of course, alluding to the powerful and often underestimated connection between mental health and the health of the rest of the body. This paper will first begin with an analysis of the current state of mental health affairs and highlight the nature of the problem faced by clinicians and policy makers in trying to promote significant change in the low-income regions of Southeast Asia, which includes constituent nations of Cambodia, Laos, Vietnam and Malaysia. Secondly, this paper will explore structural barriers to reform and follow this up with an unpacking of the current policy solutions that have been proposed or implemented in recent years. Special attention will be given to assess their efficacy. Finally, a case will be made for policy proposals to build capacity, reduce stigma, improve employment and augment social integration. Again, an assessment of their potential strengths and weaknesses as well as feasibility mechanisms will be provided.

First, we must assess the multi-faceted challenges faced by those with mental illness. It becomes clear upon consulting the Lancet mental health series that mental illness affects every aspect of the human condition and makes it immensely difficult for those afflicted to live with full self-actualization. Mental illness has significant ancillary health effects outside of the realm purely associated with the disease. Mental disorders are an important cause of long-term disability and dependency. The WHO's 2005 report on mental health summarized findings from the PLoS Medical Journal which attributed 31.7% of all years lived-with-disability to neuropsychiatric conditions with the five major contributors: unipolar depression (11.8%), alcohol-use disorder (3.3%), schizophrenia (2.8%), bipolar depression (2.4%), and dementia (1.6%) (Loncar & Mathers, 2006). Furthermore, mental illness has been shown to increase the onset of other non-communicable diseases such as coronary heart failure and diabetes by significant amounts (Prince, et al., 2007). High stress levels are the link established between mental illness and communicable diseases like HIV and tuberculosis. Mental illness contributes significantly to behavioural risk factors associated with HIV contraction (like needle use and indiscriminate sex) and thus has allowed for the establishment of a fairly consistent association between infection with HIV and poor mental health (Prince et al., 2007). Clearly, mental health professionals seeking to address this issue must think about building capacity that addresses a host of other health issues aside from those most commonly associated with mental illness.

Besides contributing to dependency and other physical health conditions, mental health disorders also play a significant role in social disability. Mental illness makes it significantly more challenging for individuals to access healthcare support systems or to forge lasting relationships with those around them. This often prompts onsets of social isolation in individuals, which can lead to a digression in their condition (Lowenthal, 1964). Those with mental illness also face significant economic challenges as well. An article in the Mental Health Review Journal, found that those with common mental disorders have significant difficulties finding employment due to a perceived stigma towards their employability (Boardman, 2001). These problems are further exacerbated in nations with significant cultural bases for stigma against the mentally ill. What is most worrying is how the challenges pertaining to employability reinforce this cycle and reduce the ability of the mentally ill to be meaningfully self-sufficient.

Having covered the challenges presented by mental illness on health, well-being and quality of life, it is necessary to start exploring the global health dimension of this issue and the structural difficulties embedded in the national systems of care in Southeast Asian nations. No such ‘rightful recipient of care’ has been as stigmatized in Southeast Asia as those with mental illnesses such as mood disorders, schizophrenia, personality disorders and anxiety disorders (Lauber, 2007). The roots of the problem faced by the mentally ill in Southeast Asia can be traced back to historical treatment mechanisms and societal prejudices. Meshvara (1999) explains how old colonial systems of mental-health treatment often took place in isolated asylums located far from most generalized hospitals and the rest of society. As a result, any major advances to mental health that might have proliferated in the medical community rarely reached the insular world of the asylums (Meshvara, 1999). This has led to obsolete systems of care that remain widely and ineffectively used. This lack of knowledge often contributed to an absence of medical supervision in the treatment process. It also led to the adoption of practices that depicted mental illness as something to be cured rather than emphasizing manners of coping and independent living.

Another significant structural challenge is the stigma associated with mental illness that is often prevalent in developing Southeast Asian nations. Meshvara (1999) contends that societal prejudices towards the mentally ill underscore stagnancy in mental health developments in the region. Building on this, WHO researcher Benedetto Saraceno and colleagues (2007) presents a potentially more damaging phenomenon of political infeasibility. Having surveyed multiple mental health experts, they found that respondents saw mental health's low priority on public health agendas at national and international levels as the most significant structural impediment to policy proposals. Specifically, there was concern that mental health was neither named as a Millennium Development Goal (MDG) nor as an MDG-related target, despite established links between mental disorders and MDGs. Simply put, the political systems of governance that exist in Southeast Asian nations would be unlikely to prioritize equitable healthcare for the mentally ill given the stigma associated with discussion of the topic in the public realm, as well as its lack of prioritization by organizations like the WHO.

One of the most important challenges facing mental health professionals is diagnosis. Without the appropriate training, it is often very difficult for health professionals in their native country to diagnose mental health problems due to their abstruse nature. One of the most significant factors contributing to the diagnosis problem is the lack of early-age monitoring and inspection to preempt facilitating predisposed mental illness (Murthy, 2001). In this way, mechanisms for early detection of mental illness in younger individuals allow them to be triaged and to have preventative care recommended for them.

A final significant structural barrier that needs to be addressed is the size and training of the current mental health workforce in these low-income Southeast Asian nations. In a study published by Tim Bruckner in the WHO Bulletin, the Southeast Asian region was found to have 0.07 psychosocial care providers per 100,000 people. The goal established by WHO policy is 10.06. This translates roughly into an additional 15,000 professionals needed to fill the gap (Bruckner et al., 2011). This is an almost insurmountable structural deficit and must factor into any realistic policy suggestion made in this paper.

Numerous policies with a focus on the non-health impacts of mental health (i.e. social integration, community re-entry and employment) have been implemented in Southeast Asia. For example, in a psychiatric hospital in Beijing, patients that received 36 hours of patient and family education in the hospital coupled with 2 hours per month of community counselling experienced better overall functioning and lower clinical severity scores (Patel, 2007). Furthermore, patients from a different hospital that participated in a community integration program hosted solely by Chinese natives and health professionals experienced higher rates of employment and lowered psychiatric symptoms (Patel, 2007). As a result, the Chinese Medical Administration decided to adopt aspects of these practices as institutional policy. These policies are especially effective given their ability to be implemented at the domestic level through hospitals and their lack of reliance on bureaucratic systems of global governance.

In 2008, a more global solution was developed by WHO called the Mental Health Gap Action Programme (mhGAP), which seeks to address the large treatment gap for mental, neurological, and substance-use disorders. The programme's goal is to provide health planners, policy makers, and donors with clear and coherent health policies, to commit all stakeholders to increase the allocation of financial resources for care of these disorders and to achieve higher coverage of key interventions, especially in low-income nations (Patel, 2007). One of the most effective results of the mhGAP program is its prioritization of disorders on the basis of either having a high burden (i.e. high mortality, morbidity or disability) or causing large economic costs. The programme then takes these priority disorders and develops a template intervention package to help nations plan their institutional and national health policies. A significant weakness in the mhGAP programme is its lack of local contextualization. Most of its intervention packages are uniform and general which prevents the delivery of healthcare consistent with national quirks and norms.

Another project currently underway surrounds the issue of fundraising. Too often, health professionals underestimate the importance of fundraising in helping combat health issues. The specific challenge faced by mental health is that policy makers do not perceive it as being amenable through defined, cheap and easily implemented solutions. The economic case for investment in mental health needs to be clearly made in order to generate fundraising interest. Medications, for example, are one key component in addressing mental illness, that are relatively inexpensive, affordable and effective when utilized in low-income countries. They are a facile way of attracting donations and have been effectively used in recent years (Jenkins, Baingana, & Raheelah, 2011).

This paper will make a few suggestions to produce feasible and lasting change in this area of global health. The first policy proposal is the integration of screening and core service packages into routine primary health care. This would entail screening for mental and behavioural disorders during general check-ups and, in particular, at early ages. Not only will this normalize the practice of mental health inspections but it will allow early identification of illness in young patients and their families. Early-age risk factors can be more easily identified if this policy is adopted and the information they provide can allow for more effective preemptive health services. By way of weaknesses with regards to this proposal, a substantial drawback is that it will require medical institutions and governmental ministries of health to prioritize mental health in a more significant manner. Since this is a policy of screening everyone who goes through the medical system, precedent will need to be set by the health ministries of the participant nations in order to make the policy amenable to the medical staff and general health infrastructure.

A second potential policy is the establishment of more prevalent mental health beds. Mental health beds are a form of short-term housing maintained for use by patients with mental disorders, which include those in mental hospitals or community settings. Comparative analysis done by the WHO suggests that community care has a better effect than institutional treatment on the outcome and quality of life of individuals with chronic mental disorders (Murthy, 2001). Therefore, mental health beds provided in the community can lead to improved treatment due to their more easily accessible nature and a reduction in stigma due to their prevalence. This would also address some of the identified issues with asylums and stigma and make reintegration more feasible. Unfortunately, as it stands, these beds are woefully under-provided with the median number of mental health beds in low-income countries sitting at 1.69 per 10,000 people. Almost 95% of the Southeast Asian population has access to less than one bed per 10,000 people (Jacob, Sharan, Seedat, & Mari, 2007).

It is clear from the criticism sections that there are feasibility challenges associated with both the mental health bed and primary health care screening proposals. The issue will be getting these policies to be accepted by the necessary governments and institutions. Thus, the use of economic analysis can be particularly effective. Because mental health expenditure in most low-income and middle-income countries is very low, the cost of dramatic increases to provide appropriate care or prevention to populations will be very large. In stark contrast to this, a process of gradual and stepwise increase in investment in mental health is likely to be far more economically feasible. The Lancet estimated the financial costs of "scaling-up effective interventions for mental health care in low-income and middle-income countries" in a recent report (Patel, 2007, p. 999). They first identified a basic mental health care package, which consisted of outpatient-based treatment of both schizophrenia and bipolar disorder through the utilization of first generation anti-psychotic or mood stabilizing drugs. The report pegged the estimated cost per head for each package at US$3.00-4.00 (Patel, 2007). This price point can become a substantially more effective way to relay to governments and ministries that basic mental health provisions are neither expensive nor impossible to provide under their current system and that due consideration must be provided to this health issue.

Another policy proposal that has the potential to address the deficiency of trained mental health specialists in developing nations is a psychiatric residency training elective similar to that developed by the Centre for Addiction and Mental Health in Toronto. Dr. Clare Pain is an Associate Professor at the Department of Psychiatry at the University of Toronto Medical School and Director of the Psychological Trauma Program at Mount Sinai Hospital. Dr. Pain, who was interviewed for this essay, established the Toronto Addis Ababa Psychiatry Project, which received a $2 million grant from Grand Challenges Canada for its novel approach to mental health capacity building. It proposes that resident psychiatrists perform an elective course where they teach doctors in developing nations (Ethiopia in this case) how to properly diagnose mental illness and treat it appropriately. Dr. Pain is a firm believer in the program due to its lack of dependency-building. "Aid programs and voluntourism often promote a sense of dependency that you just don't get with a training program. Our residents get to go to these nations and help develop the talent pool there, so that when they return to Canada, the effects are positive and cascading" (Pane, 2013). Essentially, the process is beneficial because it allows the transfer of skills and knowledge from more developed systems of health to those in need. The challenges associated with such a policy being implemented in Southeast Asia are significant though. Partnerships must be developed with participating medical schools at the local level and in order for this to happen, there must already be an existing group of residents and students who have an interest in psychiatric training. This is often absent in developing nations because psychiatry and counseling services are not considered prominent or relevant medical professions. Once again, it is clear that the issue of stigma becomes a very significant impediment to the reform process.

The final policy suggestion that will be put forward in this essay is the concept of a national mental health strategy. Mental health policies and plans are essential tools for coordinating all mental health services because without such coordination, mental disorders are likely to be treated in an inefficient and fragmented manner. Policies are more likely to achieve the desired effect when they reflect a clear commitment from governments, are well conceptualized, and are consistent with the existing evidence base and international standards. In Uganda, a three-step policy of drafting, consulting and then finalizing a national mental health policy was integral in setting precedents for the set of disorders and diseases and led to its successful adoption in 2007 (Ssebunnya, Kigozi, & Ndayanabangi, 2012). One of the most important statements adopted by Uganda following this drive pursued by the WHO was that they would "mobilize financial resources for program areas surrounding Mental, Neurological, and Substance Use (MNS) service delivery by ensuring equity, efficiency, transparency and accountability" (Ssebunnya, Kigozi, & Ndayanabangi, 2012, p. 4).

There exist some drawbacks to this process, of course. The most significant impediment that will be faced is the political systems in the developing nation. The passage of a national mental health strategy would require the support of numerous local politicians who would be representing constituencies, with potentially deep-seated misconceptions and intolerance towards the mentally ill. The Ugandan case study only managed to function due to a vested stakeholder interest from local Ugandan charities and the Prime Minister. This makes leveraging the same types of groups (i.e. relevant NGOs and prominent political figures) a necessity in order to establish these basic ground rules for mental health treatment and rights of the mentally ill.

In conclusion, mental illness is a significant public health issue due to high prevalence and considerable contribution to the global disease burden. It has widespread ancillary health effects, negative impacts on quality of life and often experiences minimal policy attention from governments. This essay has sought to analyze the structural barriers to developing cogent mental health policies while also presenting realistic policy proposals that complement current efforts in the field. In the end, most policy solutions are marred with difficulties centered around feasibility and stigma. However, there is an increasing sense of optimism in the mental health community that meaningful reforms can be enacted for the good of all.

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Refugees in Canada: A Human-Rights Framework for Examining Poverty

EFFIE ARGYROPOULOS

> This structural oppression ensures that refugees maintain a low-income status and subsequently compromises their health. It becomes almost ironic to note that manifestations of violations of human rights present themselves within a context of Canadian Refugees -- of which core values revolve around the idea of preserving and protecting human rights.

The world is becoming more accustomed to classifying health with respect to the social determinants, and not just through the presence or absence of disease and illness. Power inequities, economic instability and marginalization are all recurring themes when examining health status and poverty. Health is often a consequence of social factors, and we can observe this relationship in our quest to identify human rights violations, within the context of health and poverty in Canada.

In *Social Determinants of Health: Coming of Age*, Kalichman et al. (2006) highlight six societal factors that shape health. These include neighbourhood conditions, working conditions, education, income and wealth, race and racism, and the pervasive role of stress. Though this list offers a broad scope of influential social factors, it is by no means exhaustive. These underlying determinants of health are entrenched in and act in accordance with the social, cultural, and economic fabric, resulting in significant implications for health. The World Health Organization (WHO) associates poverty with undermining a range of "key human attributes, including health" (WHO, 2014). The claim is made that the poor are more vulnerable to personal and environmental health risks, and are less able to access health care than those with a higher economic status (WHO, 2014). The WHO goes on to assert the existence of poverty on a relative gradient, such that the poorer one is, the worse health they experience (WHO, 2014). Bearing this in mind, while defining health as a consequence of societal factors, and contending that poverty is inherently associated with inadequate manifestations of these social factors, the relationship between poverty and ill-health becomes distinct. Those living in poverty experience greater inequalities in health outcomes compared to the remaining members of society. No matter how strong the association between poverty and poor health, it is not to say that ill-health is a direct result of poverty, but rather that poverty facilitates the creation of socio-environmental contexts that foster ill-health.

This paper will seek to examine the association between poverty and violations of human rights, it will also demonstrate a perpetuating feedback loop between poverty resulting in violations of human rights, and subsequently demonstrate how violations of human rights feed back to poverty. Moreover, it will encompass a scope of human rights violations within the context of refugees in Canada, and examine how existing policies and conditions, along with changes to the refugee policy in 2012, infringe on the human rights of refugees. Evaluating this claim from a human rights framework involves evaluating social determinants of health with respect to certain provisions made in the Universal Declaration of Human Rights, which served as a guideline to fashioning the United Nations General Assembly's International Covenant on Economic, Social and Cultural Rights.

For someone to be conferred refugee protection in Canada, they must be deemed a 'convention refugee' (or a person in a similar circumstance) (Immigration and Refugee Protection Act, SC 2001). This indicates a person is outside of his/her country of nationality and because of a substantial fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group, is unwilling to return to said country (Immigration and Refugee Protection Act, SC 2001). Refugee protection can also be conferred when a person is in need of protection, and whose removal to their country of nationality would leave him/her vulnerable to a danger of torture (Immigration and Refugee Protection Act, SC 2001). In both of these cases, the person becomes a permanent resident under a visa application or a temporary resident under a temporary resident permit (Immigration and Refugee Protection Act, SC 2001). These provisions work in accordance with Article 3 of the Covenant Against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment, which asserts that no state party can extradite a person to another state where there is a belief that said person would be in danger of being subjected to torture (an intentional act of severe pain and suffering on physical and mental levels) (Office of the UN High Commissioner for Human Rights, 2012)

From this it becomes evident that a core value in conferring refugee status is an aim to provide security and protection against human rights violations. At the same time however, being a refugee in Canada is linked to other obstacles. Debilitating issues of poverty, and the subsequent stigma, marginalization and social factors that negatively influence health threaten their personal security and puts them at risk of having their human rights violated. Through highlighting the inherent harm imposed on refugees of colour, and asserting that societal misconceptions result in their stigmatization and marginalization, one can demonstrate the association between such harms and unfavourable consequences on psychological well-being.

Results in the most recent Canadian census have shown that recent immigrants are more vulnerable to having a low-income status than other Canadians (Statistics Canada, 2008). Furthermore, it goes on to contend that refugees are more likely to earn low-income salaries (Collin & Jensen, 2009). In 2004, refugees comprised 54.7% of all low-income earning immigrants (Collin & Jensen, 2009). While immigrants are at a higher risk for economic insecurity than non-immigrant Canadians, refugees, specifically, are the most economically vulnerable marginalized group.

With economic insecurity comes the hardship that is inherent when refugees are trying to adapt to new surroundings (Collins et. al, 2011). Many families come to Canada because of the different value system in the hopes of improving their lives. Cultural barriers may arise when refugees try to integrate into societies and lifestyles that are foreign to them. Language difficulties and racial identifiers are characteristics associated with classifying various groups as visible minorities (Bauder, 2001). While the same cannot be said for all refugees, those that are classified into visible minority groups are more likely to be targets of social marginalization (Collins et al., 2011) and are more likely to experience poverty (Ornstein, 2006). The 2006 Canadian Census determined visible minorities as those that self identify as Arab, West Asian, Black, Filipino, Chinese, Japanese, Korean, Latin American, South Asian, Southeast Asian and Pacific Islander (Statistics Canada, 2006). Furthermore, the 2010 Immigration Overview Report by Citizenship and Immigration Canada, categorized those refugees that had attained permanent resident status into five source areas, of which 45% made up the "Africa and the Middle East" group, 27% the "Asia and Pacific" group and 18% the "South and Central America" group (Citizenship and Immigration Canada, 2007, p. 21). The remaining source areas were grouped into "Europe and the United Kingdom", as well as the United States, at 5% respectively. Though this data only refers to those refugees who have attainted permanent resident status, it offers a sample to extrapolate from. Given these findings, 90% of those refugees who have attained permanent residency could all be classified under some 'visible minority' category, under the guidelines of the 2006 Census. As such, it seems reasonable to infer that a large portion of refugees fit the criteria for being deemed a visible minority. By the same token, this broad spectrum extends to such individuals being more likely to experience poverty.

Phillips (2007) asserts how poverty can also give rise to stigmatization, in that it is often seen by society that those with a lower socioeconomic status are personally responsible for their situation. This unsympathetic view of persons living in poverty can be seen in the findings of a study affiliated with the 'Refugee Resettlement Project'. It noted that the 'popular view' in

Canadian society sees refugees as being even more likely than immigrants to be a drain on the economy, and that 39% of Canadians who responded to a questionnaire strongly agreed that refugees were "using up more than their share of the country's health and social services"(Beiser, 2004, p. 54). The actual findings of the research suggested otherwise, showing that neither their [refugees'] unemployment figures, nor their usage of health services imposed an economic burden (Beiser, 2004), despite the fact that refugees are much more likely to live in poverty than non-immigrant Canadians (Beiser, 2004). This is a blatant example of stigmatizing a minority group because of their state of poverty. In turn, being a subject of stigmatization imposes multiple stresses on an individual, that negatively impact one's psychological well-being and give rise to socio-emotional maladjustments such as depression and anxiety (Phillips, 2007).

Article 12 of the UN International Covenant on Economic, Social and Cultural Rights asserts that everyone has a right to the "highest attainable standard of physical and mental health". Under this provision, poverty can be examined as giving rise to violations of human rights on two counts. First, it does so through an association with stigmatization, giving rise to psychological stresses that are not conducive to mental well-being. This impedes the provision's assertion to the "highest attainable standard of… mental health", procuring a violation of human rights. Second, poverty bears an association to discrimination, which further reinforces the notion that poverty gives rise to violations of human rights; the Covenant's statement in Article 2 claims the Covenant will be "exercised without discrimination of any kind"(Office of the UN High Commissioner for Human Rights, 2012).

When examining discrimination at a societal level, it becomes critical to investigate the integrated governance structure. From there, one is better equipped to recognize cases of structural violence and subsequent systemic racism, which violate human rights and inflict or enhance poverty. Structural violence refers to an offense where causation is not directly or clearly identifiable (Vorobej, 2008). Proceeding from the knowledge that inequalities due to discrimination against a certain race lead to harm, it then follows that systemic racism is a sub-category of structural violence. Fornwald states the notion of systemic racism, contending that Canada has a "racist immigration system" (2008, p. 3). Though this may seem like a bold statement, it is supported by the findings of the Canadian Council for Refugees' (CCR) which assert that only 19% of "predominantly white" countries require a visa to enter Canada, while 81% of countries in the Global south (which is not considered to be predominantly white) require a visa (Canadian Council for Refugees, 2009, p. 9). Having regulations that require a visa before entering the country add one more step to the process of coming to Canada, and thus could create a potential barrier to some individuals. This is not to say that imposing a requirement of a visa is a component of systemic racism. Rather, it stems from the blatant inequality that is inherent by being more lenient towards those individuals arriving from predominantly white countries. These political measures to deter or at least prolong the process of refugees (arriving from countries that are not predominantly white) from reaching Canadian borders, exemplify systemic racism. The presence of this manifestation of structural violence violates Article 2 of the Covenant for Economic, Social and Cultural Rights, which states the covenant "will be exercised without discrimination of any kind" and goes on to list certain characteristics that are not to be discriminated against, such as race and colour, among others (Office of the UN High Commissioner for Human Rights, 2012).

Again, this does not explicitly give rise to poverty, but it is in place to demonstrate its relation to structural violence within the parameters of this paper. The government is a powerful body within society and therefore has the ability to influence aspects of society's structural components, including the values that get instilled on its citizens. When government policies qualify as systemic racism, it follows that this highlights a pervasive structural violence within society and sets precedent. This is made obvious through accepted practices led by other institutions that exercise a similar level of influence, namely, the media.

Underlying negative portrayals of refugees become apparent within media discourse. Fornwald demonstrates how discussion of a "refugee crisis" or of Canada being a "haven for villains" are used dynamically and therefore instill an idea of refugees being undesirable citizens in the public eye (Fornwald, 2008). Despite the lack of evidence to support such generalized conclusions, the fact that an influential operator in society (like the media) can frame refugees in such inaccurate terms is an example of structural violence. Being perceived as an undesirable citizen suggests the absence of certain traits like loyalty, reliability, honesty, and dedication, among other moral characteristics. As such, when an individual or a group of individuals are portrayed in this manner, aspects of integration such as establishing one's place in the labour market become increasingly difficult. Lochhead (2005) draws on a point consistent with this, in that research has shown newcomers to Canada are finding it harder than ever to attain employment. It follows that struggling to secure work could lead to settling for any work, despite how poor working conditions may be. Beiser (2004) validates this idea by stating that most refugees work in menial labour positions, and goes on to say how only one out of eight refugees receive the job training required to increase their employment prospects. In this respect, the presence of structural violence in the media frames refugees in a way that leads to their discrimination by society. It contributes to the prevalence of sole availability to menial jobs, maintaining their low socioeconomic status. This is another violation of Article 2 of the Covenant of Economic, Social and Cultural Rights, facilitating poverty.

Subsequently, violations of the right to health result from the poverty that is incurred by working in menial labour conditions. A report conducted on the Health Status of Migrant Workers in Canada gave the example of migrant farm workers being a vulnerable group with issues relating to occupational injuries and exposure (Canadian Medical Association Journal, 2011). It further went on to contend that if the migrants' health statuses were to deteriorate after having arrived in Canada, it is more likely an outcome of their new menial working conditions, rather than any pre-existing conditions (Canadian Medical Association Journal, 2011). Being subjected to a working environment that causes negative health outcomes violates Article 12 of the Covenant—a refugee's right to their "highest attainable standard of physical…health" (Office of the UN High Commissioner for Human Rights, 2012).

Structural forces create contexts that limit refugees to low-income work that could subsequently give rise to negative health outcomes. This demonstrates the presence of a perpetuating cycle, whereby violations of human rights give rise to poverty, and in turn, how being bound to impoverished contexts results in further violations of human rights.

In 2012, the refugee policy was changed and the newer regulations do not allow refugees (with the exception of government-assisted refugees) access to extended health benefits, such as pharmaceuticals, dental and vision coverage, in addition to limiting other forms of coverage (Levitz, 2012). The only condition under which the refugees will have health care provided for them is if their health status posed a public health threat to other members of the population (Levitz, 2012). Because refugees are statistically more likely to live in poverty than non-immigrant Canadians, they likely will not be able to afford the medication without the government's support. Therefore, this policy change will mean that the vast majority of refugees sponsored by church groups, citizens, and other external sources will lose access to life saving medications despite its place as a human right. Article 12 of the United Nations International Covenant on Economic, Social and Cultural Rights, recognizes the "highest attainable standard of physical and mental health" (Office of the UN High Commissioner for Human Rights, 2012). With particular focus on physical health, Article 25 of the International Declaration of Human rights can further guide these standards. It attributes criteria of adequate health to factors that include access to medical care, necessary social services and sickness disability, though these are only a few of the social determinants of health mentioned in the declaration (Office of the UN High Commissioner for Human Rights, 2012). Since physical health can be interpreted within the framework of these social determinants of health, the loss of access to medical needs restricts this subgroup from achieving the highest attainable standard of physical health and therefore violates their human rights as a result of poverty. Moreover, Article 12 of the UN International Covenant on Economic, Social and Cultural Rights accounts for physical accessibility and proclaims that health "…[H]ealth facilities, goods, and services must [sic] be within safe physical reach for all sections of the population, especially the most vulnerable or marginalized sections" (Office of the UN High Commissioner for Human Rights, 2012). The spokesperson for the Immigration Minister of Canada asserted that the changes in the policy were meant to "ensure refugee claimants didn't get better health benefits than the average Canadians" (Levitz, 2012). Bearing in mind the aforementioned likelihood that refugees are living in poverty, and the association this has with refugees being an economically vulnerable subgroup, it can be inferred that implementing this policy is actively ensuring that a vulnerable subgroup has significantly less access to health benefits than the average Canadian.

Under this new policy reform, refugees no longer qualify for social assistance as well. Social assistance refers to any extended health provisions, like the benefit of money, goods or services, including food, shelter, clothing, household requirements and pharmaceuticals (Immigration and Refugee Protection Act, SC 2001). Some refugees have income levels that would make them eligible for social assistance, if they were Canadian citizens or permanent residents. What this means is that before the 2012 policy reform, refugees were eligible to receive the exact benefits that Canadians of a similar income level were receiving.

Minister Kenny's rationale for the changes to the refugee policy was to "remove the incentive for people who may be considering filing an unfounded refugee claim" (Barnes, 2012, p. 8). Steve Barnes of the Wellseley Institute acknowledged that there was no data to support this claim. The fact that refugees were once allowed to apply for support like social assistance clearly demonstrates that there was merit to having such entitlements in place. To retract nearly all social and economic support from an already economically vulnerable group based on what can only be inferred to be a hunch, further reinforces refugees into poverty and seriously jeopardizes their health outcomes. From this it seems reasonable to conclude that there was a distinct absence of applying any sort of health equity lens when reforming the refugee policy, and that the main objective of the reform is focused around a strictly monetary centre. The new policy places refugees under government hegemony. The government, being the dominant powerful force in society, fulfills its interests (namely, to save money) at the expense of the refugees, who are having their right to the "highest attainable standard of physical and mental health" violated (Office of the UN High Commissioner for Human Rights, 2012). This offers another instance of structural violence perpetuating poverty traps and violations of human rights among refugees in Canada.

This paper has addressed the vicious cycle that exists between poverty and violations of refugees' human rights, namely, the right to the "highest attainable standard of physical and mental health"and to the right of ensuring the Covenant is "exercised without discrimination of any kind", as outlined in the UN International Covenant on Economic, Social and Cultural Rights. Not only are refugees statistically more susceptible to low-income status, but a large majority of them can also be classified as visible minorities. Hence, their risk of being marginalized and subjected to poverty is heightened. This paper has also demonstrated how examining the association between poverty and violations of human rights from a more structural perspective does not indicate a unidirectional link, but instead creates a perpetuating cycle of poverty resulting in human rights violations and in turn, human rights violations giving rise to poverty. It has highlighted how the Canadian government's most recent refugee policy reform has further undermined the human rights of refugees. And finally, this paper has shown how other powerful forces, such as the media, frame refugees as undesirable citizens. This fosters contexts in which refugees will likely secure menial jobs, thereby keeping them in poverty and exposing them to potential occupational hazards. This structural oppression ensures that refugees maintain a low-income status, and subsequently compromises their health. It becomes almost ironic to note that manifestations of violations of human rights present themselves within a context of Canadian Refugees - of which core values revolve around the idea of preserving and protecting human rights. The human rights framework provides a lens through which we can see that the linkages between poverty and refugee status are further exacerbated by structural violence and systemic racism inherent in the immigration and health care policies in Canada.

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Improving Standards of Care for Health Research in the Global South

NICOLA GAILITS

Setting a global standard of care faces the problem of ethical universalism, which applies the standard used by the global North to the rest of the world, and disregards the magnitude of cultural diversity and ethno-historical specificity across countries. It is problematic to apply 'universal' moral principles that have been constructed in one cultural context and export them, without modifications, to another.

"Do the invisible poor come into view only when they become research subjects? Are all humans included under the rubric 'human'?" (Farmer and Campos, 2004, p. 248). These are important questions when researchers from the global North approach the ethics of research in the global South. Should global South research participants be guaranteed the best therapeutic treatments available across the globe or should their standard of care (SOC) be defined by what is available in their region? SOC is defined as the level of care, including standard practices and treatments that should be provided to research subjects. To clarify, a local SOC is context-specific and changes depending on the region whereas a global SOC applies one universal standard across the globe. This paper will examine global health research ethics in the context of the current SOC debate, and reflect on how the field can improve its ethical standards by forming a more respectful relationship between the global North and South.

This paper is divided into two parts. The first part will examine the present debate concerning whether a global or local SOC is more appropriate. HIV studies conducted in the global South will be used as an example for explaining both sides of the debate. The paper will fundamentally assert that a local SOC is more appropriate. However, at present, local SOCs can be taken advantage of to create extremely variable SOCs across the globe, which can lead to a slippery slope in terms of respecting the value of human life. The second part will examine how a local SOC can progress towards implementing higher ethical standards. This paper will ultimately argue that the current global health debate should focus less on whether a global or local SOC is most appropriate, and more on how to create mutually beneficial partnerships between the global North and global South. From this perspective, a local SOC would be less likely to be exploited and would more appropriately account for context-specificity and generally adhere to higher ethical standards.

Debates have arisen surrounding controversial drug testing in the global South. For example, the use of placebo controls during the testing of active drugs may be considered unethical. A placebo is a medication that looks and tastes like the active drug but does not contain the active ingredients; patients receiving the placebo serve as the control group for the study. Proponents of local SOCs justify the use of placebos in a local context because if the people do not normally have access to a treatment available elsewhere in the world, then this treatment does not need to be studied. This controversy became prominent in the late 1990s concerning research on the use of antiretrovirals in the global South to fight mother-to-child transmission of HIV. Studies in France and the U.S. had established that the '076 regimen', an intensive regimen of the antiretroviral zidovudine (AZT), reduced transmission of HIV by two-thirds (Crane, 2010). However, at a cost of $800 USD per patient, it was considered financially unfeasible to implement in low-income countries (Schuklenk, 2000). Given the epidemic of HIV in the global South, researchers wanted to test a cheaper, shorter course of AZT to determine its effectiveness, so the shorter course was tested against a placebo instead of the intensive regimen. Therapies used in the global North, like the longer course of AZT, are often considered "infeasible, too difficult, or 'cost-ineffective'" when research is conducted in the global South (Farmer and Campos, 2004). This cost-effectiveness argument is considered unethical by proponents of a global SOC because it attaches a financial value to human life, and ultimately justifies placebo use in some areas of the world but not in others.

Backlash ensued in the scientific community, with proponents of a global SOC arguing it was unethical not to implement the same SOC as in the global North. Since the long course of AZT was already proven to be effective, studies comparing the short course to a placebo could be seen as using study participants solely as a means to an end, that is, pharmaceutical research. Advocates of a global SOC strive to establish a single standard that would treat people equally, ensuring that patients in the global South are not disadvantaged. Joseph Tabula, a senior researcher at Makerere University in Uganda, contends that placebo studies in the global South are unethical because researchers knowingly put participants at a disadvantage (Crane, 2010). In the case of the HIV study, researchers were "deliberately infecting…children," since their mothers were known to have HIV and nothing was done to prevent transmission to their children (Crane, 2010, p. 857). The main issue with local SOCs is creating research protocols where respect for human life is part of the underlying framework.

In response, local SOC supporters justify placebo use with the argument that the benefits of the research outweigh the harm caused in the process. Crane refers to this as the "logic of sacrifice," whereby the deaths of a few are justified "in the name of greater public health" (Crane, 2010, p. 858). When researchers knowingly decide not to treat babies in the HIV control group, they rationalize this action by affirming that the results of this research might prevent thousands or millions more babies from becoming infected. The sacrifices of conducting research under a local SOC are seen as necessary for global health.

Proponents of a global SOC see this issue as "logic of exception" (Crane, 2010, p. 858). By adhering to a universal SOC, they create isolated spaces in resource poor settings where state-of-the-art medical treatment is given, thereby saving the lucky few. Crane remains skeptical of global SOCs. She accurately identifies that conducting research that demands the same SOC for Ugandan and US study participants does not necessarily make research any more equitable (Crane, 2010). In fact, it could potentially exacerbate the situation by "creating 'islands' of high level, US-funded care within an otherwise impoverished public health system" (Crane, 2010). Thus global SOCs may appear to adhere to higher ethical standards than local SOCs but may in fact produce greater inequities in the population.

A major argument in support of local SOCs is that there should not be "blanket rules" around how SOCs are applied in the global South; instead they should be context-dependent (Benatar, 2002). Setting a global SOC faces the problem of ethical universalism, which applies the standard used by the global North to the rest of the world and disregards the magnitude of cultural diversity and ethno-historical specificity across countries. Riessman (2005) claims it is problematic to "[apply] 'universal' moral principles that have been constructed…in one cultural context and [export] them, without modifications, to another." Moreover, creating a universal SOC is problematic since it is unclear what the upper limits are on this standard. Benatar (2002) encapsulates this complexity when he asks: Are we limited to providing only the best available drug treatment, and if so, "why not include the best standard medical, nursing…hospital facilities, and follow up care?" Clearly, attempting to apply a one-size-fits-all approach for global SOCs runs into numerous practical problems.

On the other hand, localizing SOCs opens up the possibility that guidelines become too lenient and allows the global North to take advantage of the global South by circumventing the laws behind research ethics. The pharmaceutical industry plays a large role in ensuring that SOCs are variable. The Declaration of Helsinki, a 1964 document that deals with "all aspects of human biomedical research and provides guidelines for research involving human subjects" (Guess et al., 2002), was updated for the sixth time following the AZT trials to include a statement declaring that placebos should not be used for treatments whose efficacy is already known (Petryna, 2007). The economic weight of this update received such pushback from the pharmaceutical field and the FDA, that in 2002, it was reversed. At present, the note of clarification essentially sanctions the legal use of placebos, since the only requirement is having "compelling and scientifically sound methodological reasons" (Crane, 2010). This demonstrates Big Pharma's ability to maneuver laws and influence the ethical standards of global health.

Given that "equivalent medication in Eastern Europe is not the same as equivalent medication in Western Europe," some go so far as to say that the Helsinki Declaration is a "workable document," bringing up concerns that the field's interest has shifted from justice to efficiency-based standards (Petryna, 2007). Ultimately, it would be "in the best interest of Western companies to keep the prices sufficiently high to prevent many people from access to drugs, because this would legitimize further research on other drugs that could not otherwise take place" (Schuklenk, 2000). Evidently, the intrinsic profit motives of multinational pharmaceutical companies clash with the need to improve the fairness and accessibility of global healthcare standards. If the field is to continue with local SOCs and aim for higher ethical standards, it needs to ensure that justice and respect are prioritized above the economic efficiency of the study.

Big Pharma is not alone in taking advantage of the global South. Scientific review boards "set their sights on compliance with the law, not pragmatic ethical engagement" and thus "endorse an unacknowledged consensus that in fact all humans are not created equal" (Farmer and Campos, 2004). Crane (2010) asserts that this can create a "slippery slope of ethical variability" leading to using "Africans as test subjects for substandard drugs." In the absence of reasonable limits, local SOCs could devalue human life. This is further exacerbated by the view of Africa being in a state of "crisis," which "not only legitimates clinical trials that might be deemed unethical in wealthy countries, but also positions this experimentation as humanitarian by bringing medicine to needy people" (Crane, 2010). In this case, standards are not just lowered but abandoned altogether, since research could be justified as "humanitarian" if it offered any sort of treatment to areas bereft of healthcare. In the extreme, a local SOC could represent a complete lack of standards, creating dangerous and limitless opportunities for exploitation of human life (Farmer and Campos, 2004). Therefore, if local SOCs are to be implemented, they need to be carefully monitored to ensure human life is respected.

Defenders of local SOCs claim that a global SOC makes research in the global South irrelevant since it does not reflect the reality of local care. Elijah Kagwa, another researcher at Makerere University in Uganda, advocates strongly for local SOCs. He contends that if you are "investigating whether something is useful, you should compare it with what is being done here rather than what is being done in the US" (Crane, 2010). He would argue in favor of using a placebo group in the study of HIV treatment. Specifically, a study comparing long and short courses of AZT will not reveal whether the short course is better than nothing. It will instead reveal how far the short course may be below the gold standard of the long course, which is irrelevant for the context in which it will be applied. Allowing such a study to use a placebo would be the only way to get "definitive answers…about the safety and value of an intervention in the setting in which the study is performed," thereby applying a local SOC in a specific context to measure a context-related outcome (Varmus and Satcher, 1997). A global SOC would never approve of using a shorter course, given that the longer course is the higher standard, and therefore using placebos or less effective control treatments is considered unethical. Conversely, failure to use them prevents doctors in the global South from conducting research that "might save or improve their patients' lives" if the higher standard were not financially realistic (Crane, 2010). Therefore, using local SOCs can be justified in terms of how necessary and feasible they are in a given local context.

Conducting locally relevant research requires the creation of context specific research protocols. For example, HIV studies in the global North normally require the use of quantitative measurements such as periodic testing of viral loads and CD4 counts, indicators of the progression of the HIV virus; however, these technologies are nowhere near close to being universally available (Crane, 2010). It therefore makes sense to develop locally relevant research protocols, and thus SOCs specific to the global South. However, given that the "locus of power in terms of access to funding and journal publication lies primarily in North America and Europe," using distinct protocols would be disadvantageous to African researchers looking for international recognition (Crane, 2010). Furthermore, the research conducted would be incompatible with the expectations of peer-reviewed journals and funding bodies in the global North (Crane, 2010). This would disadvantage research coming out of the global South, given that it would be questioned on both scientific and ethical levels (Crane, 2010). Unique research protocols applied to a local SOC is the only way global health research can appropriately take into account varying contexts; however, the emphasis on research compatibility has limited the transition towards a local SOC.

As Petryna, Professor of Anthropology at the University of Pennsylvania, states, "the baseline conditions that would make a universal ethics applicable and enforceable worldwide are highly uneven" (2007). All in all, it seems that global SOCs are unrealistic to the functioning of a deeply distinct and unequal global community. Although the abuse of local SOCs can lead to potentially unethical research, if monitored correctly, they can serve as a more appropriate choice for research protocols.

The second half of this paper will explore the ways global health research can improve its ethical standards. First, using a micro approach, I will examine how the field can advance by focusing on the communities in which the research is conducted. The context needs to be examined, the community respected, and ultimately the research should ensure a positive contribution on the local scale. I will then examine the macro conditions of the global health field and contend that the field ought to shift its attention away from disputing local versus global SOCs, and instead, emphasize the creation of mutually beneficial partnerships between the global North and South. When respectful partnerships are implemented, higher ethical standards will be adhered to under a local SOC that can account for context-specificity while respecting human life.

The first step in moving towards more ethical SOCs requires that laws and constitutions be thoughtfully interpreted. As Benatar (2002) claims, documents like the Helsinki Declaration are “not intended to cover every possible circumstance.” Context-specific issues will determine whether a particular drug regimen can be considered the appropriate standard and whether using a placebo group is ethical. For example, he looks at the “ability to extrapolate the results of drug treatment in one context to another in which the drugs may have a different profile of side effects,” and whether the drug’s use can be adequately monitored in such a different environment (2002). Arguably, each context is different, and a “cook-book application of abstract principles…obstructs deeper understanding of what can be justified through ethical reasoning” (Benatar, 2002). Thus, careful and thoughtful interpretation of context-specific research protocols can encourage the progress of local SOCs.

Another way global health ethics can progress is to look outside its field. Qualitative research in the social science field offers models that could help to create SOCs that are both ethical and local. For example, Kiragu and Warrington’s (2013) study, which involved interviewing school-aged girls in Kenya, espouses the concept of “moral imagination” in research ethics. This approach demands that ethics protocols add a social justice dimension. Research conducted in a community is first required not to cause harm to its residents and subsequently, to positively contribute to the community (Kiragu and Warrington, 2013). For instance, this study’s researchers improved the state of the washrooms in the schools where they worked, and offered girls the opportunity to receive career advice following the interviews (Kiragu and Warrington, 2013). The idea of obliging research to contribute positively to a community could similarly be applied to global health research. Nevertheless, Kiragu and Warrington (2013) stress that this approach “cannot be fully planned in advance” and therefore the best approach to research ethics may in fact be a more fluid one that assesses the local situation continuously throughout the study.

A hepatitis B vaccination study in Gambia provides one example of how this type of long-term contribution is possible within global health. The study created a "participatory process involving donors, researchers and the Gambian Ministry of Health…[ensuring] that the vaccination program could be sustained well beyond the trials" (Bhutta, 2002). This meant that participants did not suddenly have the vaccination program dismantled when the study ended. The Gambian community was intimately involved in the research, and therefore both global and local benefits of this study were considered. This is but one example; if global health research is determined to improve its ethical capacity, it ought to consider adopting Kiragu and Warrington's model as requirements.

Stepping back from a micro analysis, Edejer (1999) stresses that focusing on the research design, such as whether to use a placebo, ought not to be the primary focus of progressing global health research ethics. A more macro approach that "treats health research as a public good" is required, and as such, it should be universally accessible (Edejer, 1999). This requires global relationships. Currently, researchers in the North require the use of trial participants in the global South to lower costs. In return, the global South needs the knowledge gained by the North as well as the resulting medications. The important distinction here is between a partnership and a dependency, as this relationship is at present unbalanced.

The current relationship between the global South and North must evolve into a mutually beneficial one, rather than an exploitation of one by the other. Benatar (2002) speaks to this exploitation in a discussion of the significant profits that the global North "[gain] from clinical trials conducted efficiently and expeditiously" in the global South. Considering the immense profits accrued by pharmaceutical companies in research and drug development, Benatar (2002) suggests "the notion that it is acceptable to give a gift of minimal intrinsic [value] in exchange for extracting valuable goods should be transformed into a commitment to giving fair recompense for sharing in the development of knowledge." If the inherent problems involved with local SOCs are to be resolved, this will require a shift from an exploitative to a mutually beneficial partnership.

Emanuel et al. call for the principles of global health ethics to be updated to include a new principle, that of "collaborative partnerships." The core tenets of this principle involve the development of the community as "full and equal partners in the research enterprise," ensuring that they "receive benefits from the conduct and results of the research" and thus "share fairly financial and other rewards of the research" (Emanuel et al., 2004). Edejer (1999) gives a good example of North-South collaboration, the creation of the International Clinical Epidemiology Network, which "has succeeded in developing a sustainable network of clinical epidemiology units in the

South with technical assistance from some Northern universities." Sharing financial rewards is essential for countries of the global South who could use profits to further develop their economies. The idea of a mutually beneficial relationship involves a delicate balancing act, and ultimately means that SOCs "should neither be set at levels that are impossible to achieve, nor should research subjects be denied higher levels of care than may be available within their country if much higher standards can be achieved during the research process" (Benatar, 2002). Therefore, with a fair and equal partnership, benefits can be shared and local SOCs can be ethical where they are carefully assessed.

In conclusion, this paper aims to provide a holistic analysis of ethical concerns in global and local SOC frameworks, as well as an examination of ways global can progress its ethical standards. Applying one universal SOC across the globe seems to be unrealistic when the intricacies and complexities of each context are taken into account. Applying a local SOC appears to be the most appropriate and realistic option for the future of global health research. However, research protocols must be carefully approached to ensure that human life is respected. Currently, the field of global health research ethics can progress by moving beyond this debate to discussing the framework of forming mutually beneficial relationships, both at the community and global scale. Edejar (1999) seems to encapsulate all aspects of what the future of global health research ethics should aim for when she suggests the creation of "a sustainable, mutually beneficial working relationship that, aside from advancing science, must address inequity and put local priorities first, develop capacity with a long term perspective, and preserve the dignity of the local people by ensuring that the benefits of research will truly uplift their status."

Whereas the older field of international health worked in the global South, global health sees itself as working with the global South (Crane, 2010). This exemplifies what a true partnership ought to look like. If such changes are in fact implemented, it could pave the way for the application of local SOCs that are less ethically fraught. Additionally, ensuring that research provides a positive long-term contribution to the community, on some scale, is an equally important element for the future of global health. That said, the real problem is currently with power, and where it resides. Until the agenda for global health research is governed as equally by the South as it is by the North, ethical problems surrounding SOCs will persist.

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