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Director's Foreword

It brings me great pleasure to introduce Volume XV of Health Perspectives, the undergraduate journal of the Health Studies Program at the University of Toronto – St. George. The 15th volume is a milestone for this student driven journal and deserving of high praise. Health Perspectives has found a voice over the years as a progressive outlet where some of the best work on health and wellness produced by undergraduate students at the University of Toronto is shared, thanks in large part to the team of Health Studies community members who lead the peer-review, editorial, and publication processes. The quality of articles is stronger than ever, due to efforts by the editorial team to emphasize equity and collaboration via a less hierarchical approach to evaluating and reviewing manuscript submissions. I truly believe that the results from this approach speak for themselves.

The 15 papers in this edition of the journal shine a light on the strengths of the Health Studies Program. Two major themes have emerged in the papers that follow. First, there are a suite of articles examining how the Canadian health care system has adjusted to an evolving post-COVID world. Second, a collection of articles builds on past work in the health and wellness literature that interrogate the linkages between racism, neocolonialism, structural violence, and disparities health outcomes. Together, the papers illustrate how students in the Health Studies Program have developed into interdisciplinary thinkers who critically engage with the social sciences, public health sciences, and critical theory in a way that will make them future leaders in a range of health-related fields.

I want to thank this year's Editor-in-Chief, Anastasia Hall, for their tireless work putting this volume together. In addition, I would like to thank Senior Editors: Omnia Adam, Julianna Hill, and Helin Polat, Junior Editors: Zummana Ahsan, Tatjana Aroukatos, Zohal Aziz, Jayda Ayriss, Miles Davis, Sarah Deforest, Isabella Gouthro, Grace Lin, Isabella Liu, Chelsea McDonald-Brooks, Maria Mian, Morgan Neundorf, Zainab Shafiq, and Dilara Taflioglu, Director of Engagement: Kalsoom Shahzad, the Engagement Team: Hana Khayat, Olivia Lussow, and Hui Ling Mei, and the Layout Editor Jayden Jung.

Please enjoy Volume XV of Health Perspectives.

Sincerely,

Michael J. Widener
Director | Health Studies Program
University of Toronto – St. George

Letter from the Editors

For over a decade, Health Perspectives has provided undergraduate students the opportunity to share their research in the public health field. It has also been a center for discovering inventive solutions to the ongoing systemic issues within healthcare, both on a national and global level. While the core values of Health Perspectives remain, we as an organization made changes this year, in light of the University of Toronto community's needs following the COVID-19 pandemic. For one, our editorial team needed increased collaboration and communication between junior and senior editors to foster comprehensive discussions about the journal's direction. Second, we chose to double the size of our team. In doing so, we expanded the range of knowledge and unique skills contributing to this year's publication, allowing for an ethical, equitable, and complex lens. Finally, we significantly increased the number of papers included in this issue, to stay true to the journal's mission of emphasizing the voices of our student researchers.

What I especially take pride in is the fact that in spite of post-pandemic challenges, including those of social, academic, and emotional natures, our editorial team committed their time to the success of this project. I also applaud each and every one of our authors for giving back to their community at this time. With several structural issues being exposed in Canada's healthcare system during the pandemic, inventive research and accompanying solutions are needed now more than ever. This issue highlights many of these inequities, including those rooted in structural violence, neocolonialism, and gender-based discrimination. Our authors go further, however, to take the opportunity to put forth solutions. Best practices such as telehealth, trauma-informed care, and incorporation of mental health services into our healthcare system are gaining traction. They might be exactly what Canadian patients need to restore health–and their hope–as we look toward the future in a post-lockdown world.

Yours in health,

AHall

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Section 1

Next Generation Solutions and Trending Topics

The Impact of Poor PSW Working Conditions on LTC Residents’ Quality of Care

Please Hold: An Evaluation of Telehealth Rehabilitation Practices

Case Analysis of the Right-to-Die Movement in Canada

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The Impact of Poor PSW Working Conditions on LTC Residents' Quality of Care

Dhara Chauhan

The COVID-19 pandemic has highlighted the poor conditions in Ontario LTC facilities which resulted in hundreds of COVID-19 deaths among LTC residents. This paper discusses the impact of chronic PSW understaffing, resulting from poor PSW working conditions, on LTC residents' quality of care and health outcomes. In addition to discussing the relationship between COVID-19 mortality and PSW working conditions, this paper will discuss the relationship between PSW working conditions and Rowe and Kahn's three criteria for successful aging. This paper concludes by suggesting a policy that aims to improve PSW staffing levels by tackling their poor working conditions for the purpose of improving LTC residents' quality of care and subsequently quality of life

Introduction

The COVID-19 outbreaks in Ontario's long-term care (LTC) homes have exposed various practices that have resulted in the deaths of vulnerable elderly Ontarians. LTC facilities have been unable to meet the needs of their residents for decades. The growing privatization of Ontario's LTC industry has led to the adoption of business practices that have created poor working conditions for personal support workers (PSWs) negatively impacting the quality-of-care LTC residents receive (Berta et al., 2010). Ontario's LTC homes need to change their practices to prioritize meeting the needs of its residents, especially as Ontario's aging population grows rapidly.

Context

Ontario has the highest proportion of private for-profit LTC homes out of all Canadian provinces and territories (CIHI, 2021a). According to Daly (2010), this high proportion of private-for-profit LTC homes can be attributed to various reforms implemented by Mike Harris' Progressive Conservative Ontario government in the 1990s. As a result, many LTC homes, especially for-profits, have adopted business practices that maximize profits by cutting costs (Armstrong et al., 2020). PSWs spend the most time with residents and provide support with activities of daily life (Berta et al., 2010). However, LTC homes pay PSWs the lowest wages possible, as well as hire part-time and agency employees to cut costs of employee benefits and protections (Star Editorial Board, 2021). As a result, PSWs are forced to work multiple jobs to make ends meet (Star Editorial Board, 2021). Eventually, many experienced and skilled PSWs leave the industry for better opportunities leading to a high turnover rate (Star Editorial Board, 2021). Moreover, many people do not want to enter the profession due to these same poor working conditions (Star Editorial Board, 2021). Together, these factors have led to the decades-long chronic understaffing of PSWs in the LTC industry. The issue of chronic understaffing in the LTC industry has been ignored because it maximizes profits for private-for-profit LTC facility owners.

Chronic understaffing cannot be ignored during the pandemic because it has cost the lives of residents. The understaffing of PSWs increased COVID-19 transmission from PSWs to residents and between residents as PSWs are assigned to care for a higher number of residents as well as forced by financial circumstances to work multiple jobs (Duan et al., 2020). Chronic understaffing has hindered the province's ability to protect LTC residents from COVID-19. For example, the Ontario government restricted PSWs from working at multiple LTC facilities to curb disease transmission but exempted agency PSWs because staffing levels became too low for LTC facilities to operate (Star Editorial Board, 2021). The government stated that these restrictions significantly increased understaffing and eventually had to exempt all fully vaccinated PSWs to reduce staffing shortages (Star Editorial Board, 2021). These exemptions once again raised the risk of disease transmission among LTC homes (Star Editorial Board, 2021). To reduce the high turnover of PSWs, Ford's Provincial government temporarily increased PSW wages (McKenze-Sutter, 2022). In March of 2022, the Ford government announced that the wage increases will be made permanent, but this announcement did not include long-term solutions to retain and acquire PSWs, paid sick leave, and full-time employment at a single LTC facility among other issues (McKenze-Sutter, 2022).

During the pandemic, most of the focus on LTC homes was regarding the deadly COVID-19 outbreaks resulting from decades of poor management especially the chronic understaffing of PSWs. In comparison, concerns about the unmet holistic health needs of residents exacerbated by the pandemic receive little attention. These concerns need greater attention as the province attempts to move forward from the COVID-19 pandemic.

Problem

The pandemic exacerbated the pre-existing poor working conditions for PSWs due to which PSWs have limited time and physical, emotional, and mental capacity required to provide high-quality care to LTC residents. Due to understaffing, PSWs are assigned to many more residents than the recommended five to seven residents per PSW shift (McGregor & Harrington, 2020). As such, PSWs are forced to rush residents through their daily care routines due to which residents do not receive the minimum of four hours of daily care recommended (Bowers et al, 2000). Moreover, the lack of livable wages and juggling multiple jobs increases PSW stress levels and the rate of burnout (Bowers et al., 2000). The working conditions in LTC homes prevent PSWs from providing a high standard of care to residents.

According to both residents and PSWs, strong reciprocal relationships are integral to high-quality care, but poor working conditions do not foster these relationships (Bowers et al., 2000). A reciprocal relationship between residents and PSWs allows both parties to co-create a personalized care routine that is specific to the resident's needs yet feasible for the PSW. Given the heterogeneity of aging, personalized care is necessary to address the unique needs of residents and improve their quality of life (Sasser & Moody, 2018a). As mentioned earlier, PSWs are too busy to give the necessary time, and social and emotional energy to foster reciprocal relationships (Bowers et al., 2000). Even if a PSW and resident can bond and personalize care, residents are constantly being assigned to different PSWs, due to high turnover, disrupting care (Bowers et al., 2000). Family members and volunteers often step in to reduce this deficit, however, they are not appropriately trained to provide care which can put the volunteers, family members, and residents' health at risk (Armstrong et al., 2020). This deficit was exacerbated when visitation restrictions were implemented in LTC facilities to prevent COVID-19 outbreaks in facilities.

Poor PSW working conditions do not foster healthy relationships in LTC homes hindering successful aging. Rowe and Kahn's three criteria for successful aging are (1) freedom from disease and disability, (2) high physical and cognitive function, and (3) high social engagement (Sasser & Moody, 2018b). Poor PSW working conditions hinder the fostering of key social relationships for residents. Poor social engagement is linked to depression, cognitive decline, and behavioral symptoms of dementia among LTC residents (Bethell et al., 2021).

Furthermore, a COVID-19 study found that residents that could not interact with family were more likely to have depression than residents that did (CIHI, 2021b). During the COVID-19 pandemic, many facilities did not permit families and volunteers to enter facilities and provide social and emotional care, to prevent COVID-19 transmission. Bethell and colleagues' study (2020) provides evidence of the unmet social and emotional care needs of residents without volunteers and family members. Moreover, without reciprocal relationships with PSWs, residents have no control over their care, which leads to learned helplessness increasing the risk of depression and physical decline (Sasser & Moody, 2018b). During the pandemic, it has become apparent that LTC homes cannot protect residents from infectious diseases. According to Rowe and Kahn's theory of successful aging, Ontario's LTC homes have failed to aid its residents in successful aging (Sasser & Moody, 2018b).

Recommendation

The understaffing of PSWs needs to be addressed to improve the quality-of-care residents receive. Chronic understaffing is a result of high turnover rates and the failure to attract people into the profession (Star Editorial Board, 2021). To acquire adequate PSWs, working conditions must be improved by increasing wages and providing full-time employment at a single facility (Duan et al., 2020). These changes will make the profession financially feasible for current and aspiring PSWs. If implemented, these changes will have a downstream effect improving residents' quality of care. As the number of PSWs increases in LTC homes, PSWs will be assigned to fewer residents, which increases the time for bonding between PSWs and residents. This will increase the daily hours of care each resident receives to reach the recommended four hours (Armstrong et al., 2020). British Columbia's government has already implemented these changes by making all PSWs public employees that receive standard pay and hours of work each week at a single facility (Armstrong et al., 2020). These changes will facilitate reciprocal relationships and personalized care, which will aid the residents in successful aging. Providing full-time employment to PSWs will curb infectious disease outbreaks in LTC facilities. Adequate staffing will facilitate reciprocal relationships providing crucial social engagement to residents, which will lower rates of depression, cognitive decline, and behavioral symptoms of dementia among LTC residents (Bethell et al., 2020). Reciprocal relationships strengthen residents' locus of control by allowing residents to influence their own care routine (Sasser & Moody, 2018b). Moreover, residents have stated that are more likely to actively participate in their care which they feel valued in relationships with their PSW preventing learned helplessness associated with excess disability (Sasser & Moody, 2018b; Wilson & Davies, 2009). Thus, reciprocal relationships are a key component to achieving successful aging in LTC homes.

Increasing PSW wages and providing full-time employment at a single facility holds great potential in reducing the Ontario Ministry of Health and Long-term Care (Ministry)'s spending. The Ministry will save money spent on PSW recruitment and training and resident hospital transfers. It will also reduce medical expenses associated with disease outbreaks, excess disability, neglect, and injuries among residents. These changes will reduce the profits made by private for-profit LTC homes in Ontario which receive funding from the Ministry. As such, the private sector is likely to protest these policy changes. However, retaining experienced and knowledgeable PSWs will increase the efficiency of LTC homes and reduce costs and resident complaints in the long term. The pandemic has increased public support for these changes after witnessing the deaths of LTC residents due to poor LTC practices. Ontario's private for-profit LTC facilities need to prioritize human life over profits.

Conclusion

It is crucial that PSWs are offered full-time employment and higher wages immediately to address chronic understaffing which will improve the quality of care offered to residents. The reduction of expenses in the long term will offset the costs of these changes. The LTC COVID- 19 outbreaks have sparked public outrage against the LTC industry and its practices that value profit over human life. Addressing chronic understaffing will also help Ontario prepare to meet the needs of its growing aging population.

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Please Hold: An Evaluation of Telehealth Rehabilitation Practices

Anuijan Chandran

The World Health Organization (WHO) emphasized the need for global interdisciplinary and collaborative rehabilitation services in Rehabilitation 2030: Call for Action (Feuerstein et al., 2019). This Call for Action is a strategic initiative targeting ten priority areas to scale up rehabilitation (World Health Organization, 2017). As the efforts to prioritize rehabilitation across the globe continue, it is essential to recognize the various factors that impact healthcare and rehabilitation. Highlighting these factors can emphasize the gaps in current practices while informing future rehabilitation and policies. For example, telehealth delivers healthcare services digitally to diagnose, treat and rehabilitate patients (NEJM Catalyst, 2018). Rehabilitation delivery aims to shift care from hospital settings to patients' homes; therefore, this delivery method is becoming more popular, making it a growing trend in rehabilitation (Brennan et al., 2009; Robitaille & MacRae, 2020). This paper will discuss how the increased use of telehealth influences the practices, policies, and delivery of rehabilitation services in Canada while highlighting future considerations.

What is Telehealth Rehabilitation?

The use of digital technologies for healthcare practice and delivery has been made possible through the advancement of technology (Gogia, 2020). Telehealth dates to the early 1900s, given the use of telephones to monitor health status; however, the recent increase in smartphones and health apps has transformed telehealth into a more convenient and prevalent method of accessing rehabilitation (Gogia, 2020). In rehabilitation, telehealth practices aim to optimize therapy intensity, duration, and timing while maintaining in-person delivery effectiveness (Theodoros & Russell, 2008). For example, a meta-analysis that assessed the effectiveness of telehealth exercise-based cardiac rehabilitation found that telehealth interventions are as effective as in-person ones in improving cardiovascular risk factors and cardiac function (Rawstorn et al., 2019). Furthermore, exercise engagement and adherence were more effective amongst those in the telehealth program, demonstrating a sustainable and effective option (Rawstorn et al., 2019).

Applications of telehealth rehabilitation

Telehealth plays a crucial role in promoting rehabilitation's convenience, accessibility, and efficiency without the added challenges of cost, unavailability, and distance (Gogia, 2020). Its implementation is particularly beneficial amongst remote and rural communities, who often travel longer than their rehabilitation appointment's duration (Ellis & Russell, 2019). Reduced accessibility of rehabilitation services is associated with increased health disparities amongst rural populations, given increased rates of chronic disease, more significant risks for mental illness, and therefore reported poor health and quality of life (Harkey et al., 2020; Physiotherapy Association, 2016). For example, in 2012, only 7.9% of physiotherapy professionals worked in rural and remote regions in Canada (Canadian Physiotherapy Association, 2016). Therefore, patients needed to wait till physiotherapy appointments became available or travel long distances to urban regions to see a physiotherapist.

Another example of reduced accessibility to rehabilitation services is the lack of timely access to pediatric concussion primary and secondary care in Canadian remote and rural communities (Ellis & Russell, 2019). Telehealth was recognized as an effective tool to increase the accessibility and convenience of rehabilitative care amongst post-pediatric concussion patients by assessing the urgency of follow-up appointments and the need for additional treatment (Ellis & Russell, 2019). When evaluated from an economic perspective, telehealth rehabilitation services are more cost-effective for patients (Tousignant et al., 2015). Despite the potential installation/uninstallation costs, technical considerations, need for Wi-Fi, and other costs, expenditure on in-person visits often amounted to cost more than a telehealth visit as they require patients to take time off from work and spend money travelling back and forth from appointments (Tousignant et al., 2015; Luxton, 2013). Furthermore, a systematic review assessing patient satisfaction with telehealth rehabilitation services found that patients reported being extremely satisfied with the quality of care, audiovisual quality, privacy, convenience, and comfort (Harkey et al., 2020).

Telehealth's application has also been demonstrated to be beneficial during the recent COVID-19 pandemic. During the pandemic, the increased use of telehealth aimed to continue providing rehabilitation services while prioritizing public health safety measures (Monaghesh & Hajizadeh, 2020). When assessing its effectiveness compared to physical visits with healthcare professionals, Monaghesh & Hajizadeh found that telehealth is an effective tool (Monaghesh & Hajizadeh, 2020). Moreover, Wootton and colleagues assessed the effectiveness of delivering pulmonary rehabilitation via telehealth models amongst those who experienced lung complications due to moderate to severe COVID-19 diagnoses (Wootton et al., 2020). Despite the virtual program, participants demonstrated improvements in their exercise capacity and breathlessness, while clinicians provided individualized rehabilitation programmes for participants (Wootton et al., 2020). During the pandemic, the transition to telehealth rehabilitation practices demonstrated an effective, accessible, and safe method to deliver care (Thomas, Gallagher & Grace, 2021). Therefore, this service delivery option can be adopted and sustained in the post-pandemic world.

Limitations of telehealth rehabilitation

Although telehealth demonstrates many benefits, including increasing accessibility and effectiveness to rehabilitation services and improving the quality of life experienced by people residing in rural and remote communities, there are some limitations and barriers to telehealth. Firstly, telehealth rehabilitation methods prevent establishing relationships between the healthcare practitioner and patient (Tenforde et al., 2017). With limited interactions between clinicians and patients, there is a lack of opportunity to build a relationship and trust between both parties. Secondly, stigma against telehealth limits patients' comfort and willingness to participate in telehealth rehabilitation services (Mitchell-Gillespie et al., 2020). The perception that telehealth is of lower quality, needs more privacy and has limited patient-clinician interactions increases patient hesitation (Mitchell-Gillespie et al., 2020; Paelet et al., 2022). For example, a recent study suggests that satisfaction is often reduced among patients with chronic respiratory diseases, given the fears and suspicions of serious privacy risks (Paelet et al., 2022). Lastly, the added need to know how to use technologies (i.e., smartphones) to access care presents another barrier for older adults aiming to use telehealth rehabilitation services (Tenforde et al., 2017). With the projected increase of the Canadian older adult population (i.e., individuals aged 65 years and older) from 15.6% in 2014 to 23% by 2030, it is essential to adapt rehabilitation services and delivery to their needs. Older adults experience increased difficulties when learning new technologies (Barnard et al., 2013). Furthermore, without appropriate guidance, older adults are more likely to reject learning and using technologies (Barnard et al., 2013). Therefore, a negative experience with telehealth services can prevent future attempts at other services.

Future Considerations

Telehealth is an effective and sustainable rehabilitation service model that encourages accessibility, convenience, and equity. However, the limitations presented above call for improving the current model. Telehealth rehabilitation delivery should require healthcare professionals to phase patients into telehealth services. For example, patients should be required to begin their rehabilitation journey with in-person visits where their healthcare team can establish trust and build a relationship. Furthermore, this initial phase may be beneficial in educating the patients on how the telehealth system will be used to facilitate their recovery. Moreover, healthcare professionals can also enhance the care delivered by requesting regular feedback on the quality of care experienced by the patient and their perceived effectiveness of the session. This will help inform the healthcare team of the individualized needs of the patients while also helping improve the quality of care delivered to the patients. Moreover, the broad implementation of this model across Canada will help patients recognize this delivery method, reducing stigma and fear among patients. These steps will require additional funding and federal and provincial governments allocate healthcare personnel. However, adequate funding can improve the health status of Canadians and reduce future healthcare expenditure (i.e., hospital readmission), making it a worthwhile investment (Rogers et al., 2017). By improving these aspects of the current model, Canadians can use telehealth rehabilitation services more sustainably and effectively.

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Case Analysis of the Right-to-Die Movement in Canada

Lucy Panko

Introduction and Literature Review

This case analysis will be focused on the issue of euthanasia, medical assistance in dying and the application of palliative care in Canada. Approaches to the right-to-die movement have evolved significantly in Canada over the past fifteen to twenty years, particularly with the induction of Bill C-14 in June 2016 and Bill C-7 in March 2021 (Bill C-14, 2016; Bill C-7, 2021; Pesut et al., 2021). Currently, medical assistance in dying (MAID) is legalized in Canada for all adults living with an illness who are able to consent (Government of Canada, 2016). Note that it is not just those living with a terminal and/or fatal illness (Pesut et al., 2021).

First, I will provide a general overview of the history and current approach to these practices within Canada; I will then discuss the policy shifts and the corresponding impact of concepts such as regulation. Next, I will explore the impact of delivery and funding methods on the approach to end-of-life measures. Following that, I will define and explore the impact of ethical frameworks such as autonomy, non-maleficence, benevolence, and justice on framing the right to die. Finally, I will explore how the issue is approached in the context of mental health versus physiogenic based disorders and the resulting impact of these issues on framing.

Policy shifts

Domains of Evidence-Based Policy:

According to Brownson et al., there are three primary domains of evidence-based policy: process, content, and outcomes (2009). The key takeaway from Brownson et al's proposed model of Evidence-Based Public Health Policy is that the policy-making process is not linear; its dependence on scientific, anecdotal, and other influences is recursive (Brownson et al., 2009). This model includes Big P policies, such as formal laws and regulations, and small p initiatives, such as internal decisions, guidelines and behaviour guided by social norms (Brownson et al., 2009).

Within the first domain of evidence-based policy, process speaks to the key stakeholders and how their approaches promote policy adoption. Key players within the right-to-die movement include patients such as Gillian Bennet, a B.C. woman living with dementia, Gloria Taylor, and Sue Rodriguez, both ALS patients. Their impact on the processes occurred by bringing forth the reality of the lived experience of these terminal illnesses to encourage the development of legislation in favour of right-to-die practices (Grillo, 2019). Additional stakeholders within the process includes health professionals such as Dr. Donald Low, a microbiologist, physician Dr. Ramest Kumar Sharm, and others whom all faced consequences after engaging in physician-assisted suicide, ultimately took the legal risk to promote policy adoption (Grillo, 2019). Being well-respected professionals, they likely promoted the engagement of the issue within the Canadian political arena. Finally, there were also political figures who supported policy adoption following the efforts of patients and physicians, including Tory MP Steven Fletcher, B.C. Supreme Court Justice Lynn Smith, MP Francine Lalonde and MP Svend Robinson (Grillo, 2019).

The second domain of evidence-based policy is content; which is the recognition of policy elements which may serve as important improvements to existing policies (Brownson et al., 2009). Because Canada was not the first jurisdiction to implement Medical Assistance in Dying (MAiD) legislation, they turned to evidence-based policy in other jurisdictions, such as the Netherlands, to inform how they promoted legislature and implemented the relevant policies (Ministerie van Volksgezondheid, 2011).

The third domain of evidence-based policy is outcome which refers to the documentation of policy impact (Brownson et al., 2009). For instance, this may include efforts to record physician attitudes towards right-to-die initiatives. In addition, the impact of right-to-die measures on families of persons who engaged in end-of-life measures before the pertinent legislation was passed has been gaining growing evaluation, particularly compared to right-to-die measures that followed the implementation of Bill C-14 and C-7. For instance, right-to-die researcher Emanuel performed a review of the empirical data from the United States on euthanasia and physician-assisted suicide (2002). This can be compared with more recent work, such as Rabadi et al.'s investigation of trends in medical aid in dying in Oregon and Washington (2019).

Brownson et al. identifies several barriers to implementing effective public health policy within these three policy domains (2009). The most relevant factors that pose a barrier to passing legislature and other policy initiatives are that researchers are often isolated from the policy process and that practitioners often do not have the necessary skills to influence evidence-based policy (Brownson et al., 2009). For instance, the issue may lack communication between healthcare clinicians, researchers and policymakers, and many physicians and nurse practitioners are inadequately trained in public health in a way that appropriately informs the creation of evidence-based policy (Brownson et al., 2009).

Regulation

The organization for economic co-operation and development (OECD, 1993) defines regulation as: "the imposition of rules by the government, backed by the use of penalties that are intended to modify the economic behaviour of individuals and firms in the private sector. Various regulatory instruments or targets exist (OECD, 1993.)" Given this definition, it is understood that regulation can be directed not only to individuals or other interest groups but regulation can be imposed not only on people, but prices and activities as well. Regulation can be controversial, particularly when its goal is to constrain behaviour which puts ethical issues (discussed in the framing section of the paper) in the balance of individual versus state intervention (OECD, 1993).

There are several ways of regulating right-to-die practices to prevent impulsivity and inadequate information that informs a decision. Furthermore, it is important to address the potential lack of resources that could improve a person's quality of life in a way that would prevent their wish to end their life. Methods that promote thoughtful decision-making on an individual level includes a waiting period, input from multiple professionals, including psychological and physical evaluations, and documentation of other viable alternatives of which a patient has been informed (Government of Canada, 2016). On the broader institutional level, this includes the development of pertinent legislature and the generation of qualitative and quantitative research to inform physicians, nurse practitioners and policymakers (Pesut et al., 2020).

All these regulation mechanisms ensure that right-to-die practices will be ethically sound and protect professionals and the public. It is essential to recognize that regulation applications can be jurisdictionally dependent (OECD, 1993). For example, a regulation that was designed for an urban center such as Toronto or Vancouver may need to be adapted for an Indigenous remote fly-in community such as Igloolik, Nunavut, as they may not have the same access to qualified professionals, especially at the same frequency as someone in an urban setting. When accessible, they may not be culturally specific and, therefore, unsafe (Chakanyuka et al., 2022). As such, there is a need to move away from a one-size-fits-all regulatory model and implement and support self-regulation.

Delivery and Financing: Implications of Public versus Private

Health care delivery and financing affects how an issue, such as the right-to-die movement is framed and perceived. I will explore the delivery and financing status of how end-of-life measures are approached in the Netherlands, Switzerland, Oregon, USA and Canada. In particular I will speak to the implications of public versus private financing and delivery models.

Netherlands

The Netherlands was the first country to legalize euthanasia in April of 2001 in the "Law for the Termination of Life on Request and Assisted Suicide," and has regulation of end-of-life measures in the context of unbearable suffering (Ministerie van Volksgezondheid, 2011). Healthcare financing in the Netherlands is primarily public, while delivery is managed by the public government but supplemented through private insurance companies (Tikkanen et al., 2020a). The public nature of Dutch health care and their status as a consociational state likely contributed to their adoption of legislation favouring the right-to-die movement.

In 2015, 12,000 patients in the Netherlands requested euthanasia or assisted suicide from their physician (Evenblij et al., 2019). Notably, it is seen as an act of compassion on the physician's behalf, but professionals are not forced to provide end-of-life measures. However, there are emerging norms within the public for end-of-life measures to be integrated into Dutch physicians 'normal practice' (Evenblij et al., 2019). The evidence-based actions of process, context, and outcomes within the Netherlands concerning the right-to-die movement were largely used to inform legislation and policies in other jurisdictions.

Switzerland

While active euthanasia (the killing of a patient through active means i.e. lethal drug injection) is illegal in Switzerland, there is no law prohibiting a person from helping a patient pursue MAID (i.e., providing the means for a person to commit suicide) (Hurst & Mauron, 2003). In terms of delivery and funding, while Switzerland has universal health care, it is paid for by the individual rather than through taxes, meaning that it is publicly delivered but privately financed; it is ultimately highly decentralized (Tikkanen et al., 2020b). Notably, the difference between MAID in Switzerland versus other jurisdictions, such as Canada, is that Switzerland is the only country where assisted dying can be facilitated by someone other than a physician (Hurst & Mauron, 2003). Because of this allowance for non-physicians to aid end-of-life measures without consequence, Swiss euthanasia is often used by foreigners, which is referred to as suicide tourism (Tikkanen et al., 2020b).

Oregon, USA

Both healthcare funding and delivery are private in the United States (Tikkanen et al., 2020c). Interestingly, specifically in Oregon, since 1997, a person with a terminal illness identified as having less than six months left in life may engage in MAID (Oregon Health Authority, n.d). In this process, they would obtain a life-terminating prescription from a healthcare professional; it would then be their decision whether to take the medication to end their life (Oregon Health Authority, n.d). Notably, suppose a person's illness is such that it would prevent them from swallowing the medication. In that case, a caregiver can crush the medication, i.e. put it in a feeding tube, without legal consequence (Oregon Health Authority, n.d).

Canada

Canada's health care system is a provincial issue and is publicly financed but privately delivered (Government of Canada, 2011). MAID has been legal since 2017 and, in March 2021, was expanded so that the person receiving the end-of-life measure did not have to be considered terminally or fatally ill (D. of J. Government of Canada, 2021). To qualify for MAID in Canada, a patient must be evaluated by two independent healthcare professionals (D. of J. Government of Canada, 2021). They must be informed of alternatives to relieve suffering if their death is not reasonably foreseeable (D. of J. Government of Canada, 2021). It is essential to recognize the difference in persistence among both advocacy groups and other stakeholders and the resulting adoption of the right-to-die movement in different provinces and territories. For instance, much of the policy shifting across Canada occurred due to patients, healthcare professionals and other political actors in British Columbia (D. of J. Government of Canada, 2021). Moreover, B.C. currently has some of the highest recorded euthanasia deaths in the world (Government of Canada, 2022).

As we can see, the evolution and resulting impact of the right-to-die movement are primarily dependent and correlated with the health funding and delivery models within the country, province, and state. Significantly, the mean socioeconomic status of the country has implications on the acceptance of end-of-life measures (Yu et al., 2020). For instance, many jurisdictions where euthanasia and MAID are legal are high-income western countries (Pesut et al., 2022).

Implications of Framing on Adoption and Adherence of Policies

Framing is the use of narratives and mental structures that are selectively applied to control how a policy is presented, perceived, and evaluated (Chong & Druckman, 2007). Tversky and Kahneman posit that frames are extraordinarily powerful (Tversky & Kahneman, 1981). Frames can be altered to serve a particular interest to influence a decision, which can happen at both conscious, unconscious, and subjective levels (Tversky & Kahneman, 1981). Framing is the foundation of many political efforts and often informs which stakeholders are involved (Tversky & Kahneman, 1981). Concerning framing, I will speak to the impact of policy communities, the precautionary principle, slippery slope, ethical frameworks, and the impact of private versus public financing and delivery.

Slippery slope

One key concept and approach to framing within the right-to-die movement is the slippery slope idea. This asserts that setting a legal precedent that allows euthanasia as a morally and ethically permissible act creates the potential for applying the accepted framing to other issues in a morally and ethically harmful fashion. For example, Grodin et al., provides the example of the German involuntary euthanasia program and the slippery slope that followed that ultimately resulted in the evolution of concentration camps during the Holocaust (2018). This application of the slippery slope ultimately supports framing on behalf of opponents of end-of-life measures such as euthanasia. It suggests that the legalization of euthanasia will create the impetus for marginalized populations to be abused and forced to use end-of-life measures (Grodin et al., 2018). Dr. Naheed Dosani, a palliative care physician whose primary patient population is vulnerably housed individuals advocates against the blanket application of end-of-life measures based on this slippery slope principle. He argues that if we permit the use of MAID and euthanasia marginalized populations, such as those who are unhoused, may turn to these end of life measures not because they wish to die but because they do not have the resources to live with a reasonable quality of life (Stajduhar et al., 2019).

The same argument within the context of the slippery slope and the right-to-die movement could be made concerning the issue of life insurance compensation and the emotional burden that may compel family members to manipulate a patient into choosing end-of-life measures (Givens & Mitchell, 2009). Given these examples, it is evident that there are both benefits and drawbacks to the slippery slope argument. A benefit is that they can encourage listeners and bystanders to examine the underlying rationale and framing of an issue (Chong & Druckman, 2007). However, Walton posits that slippery slope arguments, when effective, tend to result in sub-optimal policy decisions as the issue becomes framed in a potential outcome rather than one that is accurate (2015).

Ethical Frameworks

Autonomy

Autonomy is “the capacity of an agent to act in accordance with objective morality rather than under the influence of desires” (Johnson & Cureton, 2022). In other words, a person is acting autonomously if they have the freedom to decide about a personal goal. Gómez-Vírseda et al. introduce an essential concept concerning autonomy in their 2019 systematic review, which challenges the common approach to autonomy primarily centred on individualism (2019). They cite four critical weaknesses and subsequent ways to address the traditional approach to individually based autonomy: autonomy should speak to more than a person’s cognitive capacity, patients who exist in a social and cultural vacuum do not exercise autonomy, it is not a binary issue, and it needs to be addressed in the context of other issues rather than within an “isolated discrete discussion” (Gómez-Vírseda et al., 2019). They refer to this new conceptualization as ‘relational autonomy’ (Gómez-Vírseda et al., 2019).

Relational autonomy is relevant to the right-to-die movement as it recognizes the effect of the dominating political ideologies and cultural and social norms. For example, there is more resistance towards applying MAID for persons with severe and persistent mental illness than physiogenic diseases. This reflects the stigma toward persons living with mental illnesses (Trachsel et al., 2019). Furthermore, relational autonomy speaks to the support or lack thereof on behalf of a patient’s relationships with family and friends and how these dynamics affect a patient’s perceived autonomy and final decision (Gómez-Vírseda et al., 2019). Gott also recognizes the impact of gender on the ability of a patient to act autonomously in the context of end-of-life measures (2020). For instance, women are at greater risk of coercion, mainly due to the role of paternalism within the medical care (Gott et al., 2020). As such, additional analysis may be needed to ensure that a woman’s decision is genuinely autonomous when forming a decision around end-of-life measures (Gott et al., 2020).

It is vital to address the state’s role and how these interest groups must balance their predominating ideologies and corresponding initiatives regarding their impact on an individual and a broader societal level. Acknowledging the effects on the different levels will inform the extent to which it seems acceptable for the government to interfere on the level of the individual. A lens of autonomy emphasizes the implications of protecting individual versus state rights (Arrieta Valero, 2019). It is essential to recognize that members of an interest group, such as patients, will not always have the capacity to prioritize and attend to their needs (Arrieta Valero, 2019).

The dominating framing concerning autonomy within the right-to-die movement is centred around the issue of a dignified death. Dignity means different things to various individuals and interest groups. Researchers found that respect for a patient's autonomy was integral to a physician's decision to provide end-of-life measures within active euthanasia and MAID (Schüklenk et al., 2011). Fried et al. cited that physicians who were against end-of-life measures respected the need for autonomy but that other factors, including potential legal implications, were a concern (1993). It is crucial to recognize that the issue of autonomy is relevant not only to patients but also to health professionals. MAID may be preferred to respect autonomy as it involves the patient performing the final act as opposed to a health professional (Fried et al., 1993). Furthermore, in some jurisdictions, such as the Netherlands and Belgium, legislation is such that healthcare professionals can opt not to perform end-of-life measures and instead refer to another clinician to preserve their autonomy (Marijnissen et al., 2022). Whereas in Canada, regulatory authorities encourage but do not require referral of patients if a health care professional is unwilling or unable to provide end-of-life practices (S. C. Government of Canada, 2022).

Nonmaleficence

Nonmaleficence refers to the protection of a person, in this case, on behalf of a health professional or political actor, to act in a way that does not inflict harm on others (Jahn, 2011). The precautionary principle applies to the ethical issue of nonmaleficence as it speaks to the obligation to protect persons against threats, even if the uncertainty of outcome is present (Martuzzi & Weltgesundheitsorganisation, 2004). In the context of the right-to-die movement, MAID may be preferred to active and even passive euthanasia as it does not involve direct action on behalf of the clinician to end a patient's life. It is difficult to ascertain and form clear boundaries regarding a health professional's role and responsibility in aiding a patient to end their life. The identified role and responsibility are ultimately informed by framing. For instance, a religious-orientated interest group, such as the Roman Catholic Church, strongly opposes right-to-die issues such as MAID and euthanasia and may frame both these issues as an act of harm to the patient and their family (PEW Research, 2013). Simultaneously, modern palliative care medical technology may also be seen as a prolongation of death (PEW Research, 2013). These beliefs contrast the framing of the issue by a group such as Dying with Dignity (Dying With Dignity Canada, n.d).

A critical ethical topic that fits into the discussion of nonmaleficence is the issue of futility. According to Schneiderman, futile treatment is defined as "any treatment that has no realistic chance of providing an effect that the patient would ever have the capacity to appreciate as a benefit… or has no realistic chance of achieving the medical goal of returning the patient to a level of health that permits survival outside the acute care setting of the medical center" (2011). When the initial Bill C-14 was established, further treatment efforts needed to be considered futile as the patient had to have a terminal and fatal illness with no reasonably foreseeable potential to improve (Government of Canada, 2016). However, the expansion of this legislation which included the passing of Bill

C-7 meant that regulating professionals no longer needed to ensure that further treatment would be futile legally (Government of Canada, 2021). However, to uphold the value of nonmaleficence, it may be necessary to address the futility issue when deciding if the end-of-life measures are an act of harm.

Benevolence

Benevolence complements the above discussion of nonmaleficence; rather than avoiding harming others, benevolence focuses on promoting the well-being of others (Jahn, 2011). There are different perspectives on how benevolence interacts with the right-to-die movement. Some healthcare professionals believe that benevolence implies preserving life regardless of the cost and impact on the patient's quality of life (Schüklenk et al., 2011). However, others, such as many palliative care physicians, frame the issue in a way that asserts that prolonging a person's life when they are in pain is perpetuating a patient's suffering and therefore does not promote their well-being and, as such, is a violation of benevolence (Schüklenk et al., 2011). This benevolence issue is also relevant when political actors design the legislation. Furthermore, benevolence also speaks to when and how healthcare professionals decide what form of end-of-life action promotes a patient's well-being and minimizes suffering the most. For example, they may be tasked with deciding between active and passive euthanasia. They may consider whether withholding treatment in the context of passive euthanasia will create more suffering and if performing active euthanasia or providing patients with the means to engage in MAID will protect and even better promote the welfare of the patient (Schüklenk et al., 2011).

Justice

Within health care, justice refers to the equitable and fair distribution of health resources (Jahn, 2011). Within the right-to-die movement, justice may be framed in a way that supports end-of-life measures because it is viewed as unjust to maintain and ever exacerbate a patient's suffering by denying them a dignified death (Schüklenk et al., 2011). The emotional and financial consequences on the patient and their family and friends may also support the framing that end-of-life measures are an act of justice. In contrast, end-of-life measures could be framed as unjust as they cause whoever is providing the means for a person to end their life to carry out an action they may feel conflicted about, particularly if there are legal repercussions (Schüklenk et al., 2011).

Application of MAID for Mental Illness

The current political landscape and resulting discussion of MAID in Canada surround its applicability to Mental Illness. Currently, if a person's sole underlying medical issue is mental illness, they are not eligible for MAID (Government of Canada, 2022). However, this exclusion will be repealed on March 17th, 2023, when they analyze the relevant protocols and safeguards for persons with mental illness (Government of Canada, 2022). It is important to recognize that when mental illness is addressed, it will not include persons with neurocognitive and neurodevelopmental disorders (Government of Canada, 2022). Outside of a Swiss paper by Trachsel et al., there is limited empirical evidence for attitudes toward end-of-life and even palliative care for persons with mental illness (2019). Psychiatric illnesses bring unique complications to ethical issues, including autonomy, beneficence, nonmaleficence and justice, mainly because psychiatric patients can be uniquely vulnerable as they are sometimes unable to understand and consent for or against treatment.

Conclusion

The right-to-die movement is relatively new, with severe considerations of its integration into current legislation only occurring over the past twenty to twenty-five years. As discussed, the policy frameworks, funding, delivery models, and framing have impacted the acceptance of end-of-life measures such as euthanasia and MAID. These components will continue to inform Canadian approaches to the right-to-die movement, including the upcoming analysis of the application of MAID for mental illness.

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Need for Increased Accessibility to Mental Health Services: Political Economy Paradigm

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To address the issue of poor access to adequate mental health services, I propose a political economy-focused intervention strategy targeted at the Ontario Healthcare System. This intervention calls for the Government of Canada to incorporate various mental health services under the publicly funded and government-run Ontario Health Insurance Plan. This plan works to include all forms of mental health services; employing psychologists, psychotherapists, counselors, and other mental healthcare professionals. The approach intends to ensure mental health services for all Ontario residents, with a focus on providing access to disadvantaged and vulnerable individuals where services are facilitated through referrals from primary care physicians and focused mental health clinics. Groups that are most vulnerable to the development of mental illnesses consist of "people with disabilities, people with dementia, immigrants and refugees, workers in low-wage or precarious employment and people who reside in crowded or communal housing, such as shelters" (Centre for Addiction and Mental Health [CAMH], 2020). The main goal of the intervention is to decrease both the number of those struggling with mental illness and suicide rates by creating a healthcare system that supports the wellbeing of all its people.

Background Information, Context:

Poverty and marginalization are closely linked to a lower level of mental wellbeing and increased prevalence of mental illness (JRF, 2016, p.4) due to poor conditions such as substandard housing, food insecurity, "discrimination, economic insecurity, and political exclusion," as well as a lack of access to adequate healthcare services (Jacob, 512). Private health insurance may grant those who are of greater economic status with the necessary mental services, but oftentimes this care is inaccessible for those engaged in lower socioeconomic forms of work. For example, those who are unemployed, self-employed or employed by a small business may not have access to a comprehensive private health insurance plan. Additionally, mental health services are often unaffordable for those having to pay for the care as an out-of-pocket expense. For instance, mental health therapy costs approximately $50 to $240 CAD per session (Collie, 2019) with multiple and subsequent sessions required for health improvement (Scharf & Oinonen, 2020). Poor mental health among marginalized individuals is not a new problem, but it has been greatly exasperated as a result of the COVID-19 pandemic. Although there has shown to be an overall increased trend in reported mental illness as a result of the pandemic (Scharf & Oinonen, 2020), impoverished individuals are among the most vulnerable to the greatest burden of "fear, grief, social isolation, and financial and occupational losses" (Scharf & Oinonen, 2020) linked to COVID-19. To illustrate the magnitude of the issue, CAMH, the Centre for Addiction and Mental Health, reports that "recent projections are that COVID-19-related unemployment could result in 418 to 2114 excess deaths due to suicide in Canada during 2020-2021" (CAMH, 2020). Yet, despite this spike in poor mental health, no adequate change in mental health care services has been made (Scharf & Oinonen, 2020); therefore, the pandemic must act as a wake-up call for the urgent need for structural change in the Canadian Healthcare system.

Supporting Evidence

To illustrate the drastic need for mental health services to be incorporated in OHIP, I present evidence of the downfalls in the Ontario Government's COVID-19 mental health crisis response alongside the evaluation of the social democratic healthcare system in Sweden (Lombardo, 2022a). Next, I put forward CAMH's Policy Advice on accessibility to mental health resources in Toronto, coupled with the highlighted recommendations made by Scharf and Oinonen on the integration of the Provincial Public Health Insurance System.

Critique of Ontario's Response to Covid-19 Related Mental Illness:

In Scharf and Oinonen's Ontario's response to COVID-19 shows that mental health providers must be integrated into Provincial Public Health Insurance Systems, they describe the various downfalls to Ontario's "physician-only public healthcare system" in its limitations to the access of mental health services during the Covid-19 pandemic (Scharf & Oinonen, 2020). In order to compensate for the drastic surge in the need for mental health services, the government response "has focused on Ontario Health Insurance Plan (OHIP)-covered primary medical providers to increase the intensity and scope of available mental healthcare" (Scharf & Oinonen, 2020). Although this response may help to increase access to these services, there arise many problems with directing mental health care to primary physicians in the quality of care and

burden of care. The authors emphasize the potential health dangers in "telephonic trauma counseling and patient self-serve online tools" facilitated by underqualified primary physicians (Scharf & Oinonen, 2020. These primary physicians are "typically not trained to provide evidence-based psychotherapies" and their expertise could be better utilized in a different area of care during the pandemic (Scharf & Oinonen, 2020). Additionally, they describe how when the government directs patients to undertrained providers for this type of care, it devalues the professionals trained in this specialized work. In the case of front line workers, "psychologists and other registered mental health provider services have been largely left out of the provincial response" (Scharf & Oinonen, 2020) as these professionals are often employed by a private company whose services are not covered under OHIP. As a result of this insufficient government response and high level of suffering endured due to the mental health fallout, many mental health practitioners have themselves decided to provide free services to front line workers (Scharf & Oinonen, 2020). Although this is a compassionate effort, it is unstable and does not work at a sufficient scale to satisfy the services needed. This volunteer work only poses as a short term and low scale solution. These efforts may also hinder long term structural change as the full extent for the need for policy change is clouded by volunteer assistance (Scharf & Oinonen, 2020). These responses are ones that arise from an inadequate mental health system that fails to prioritize the needs of vulnerable populations (Scharf & Oinonen, 2020). This is a result of the absence of an increase in access to other mental health providers not covered by OHIP that would be able to provide accessible and suitable services.

Mental Health Inclusive Universal Health Care System, Sweden:

In order to demonstrate the distinct positive consequences that the COVID-19 pandemic has had on mental health within a system that includes mental health services in its publicly

funded health insurance, I present Sweden's response. In Sweden, "universal health system is nationally regulated and locally administered" and "enrollment is automatic" (Tikkanen et al., 2020). Mental health services are covered within this plan as the system demonstrates its value for "Human dignity: All human beings have an equal entitlement to dignity and have the same rights regardless of their status in the community" (Tikkanen et al., 2020). Although mental illness and distress still rose as a result of COVID-19 in Sweden, negative effects were mitigated on account of the Country's adequate accessibility to mental health services (Chen et al., 2022). "Swedish adolescents exposed to COVID-19 during most of 2020 showed no differences in longitudinal changes in mental health, relationships with parents and peers, and health behaviours compared to those not exposed to COVID-19" (Chen et al., 2022); thus mitigating the long-term effects and magnitude of devastation on the population.

Feedback Conjunction:

I propose to combine the advice from both CAMH and Scharf & Oinonen for future action. In their analysis of Ontario's COVID-19 response, Scharf & Oinonen call for government measures to "identify critical service gaps and inform meaningful mental health system budgeting and future workforce planning" (Scharf & Oinonen, 2020). They use Denmark and Norway as examples of how it is plausible to integrate providers that were once privately run into a public health system where the physician holds a central role (Scharf & Oinonen, 2020). Additionally, CAMH demands a focus on granting care for marginalized individuals. More specifically, they call for a focus on mental health services provided for front-line and essential workers, COVID-19 survivors and those with pre-existing mental illness who have suffered some of the highest negative effects on their mental health during the COVID-19 pandemic (CAMH, 2020). Hence, I propose an intervention strategy where mental health services are covered under OHIP, and where this coverage is extended with utmost priority to targeting areas of greatest risk.

Discussion and Implications

Political Economy Lens:

In order to address the issue of access to mental health services, an intervention that works through the political economy lens such as the one that I propose is best. The suggested intervention is defined as one in the political economy paradigm as its efforts focus on the production and distributions of resources (Bryant et al., 2019, p.62) as the determinants of health for the population (Lombardo, 2022a). The key issue that the proposal aims to solve is one of "availability of social and health services" (Lombardo, 2022a) through the implementation of "policies to protect the most vulnerable" (Lombardo, 2022a). By imposing change through this lens and investing in human capital, widespread positive changes to accessibility and consequently, the overall well being of a society will prevail.

Health Promotion:

Additionally, the intervention proposal aims to achieve health promotion by working to ensure prerequisites for health (Lombardo, 2022b). The main prerequisites for health that the intervention focuses on are that of equity and social justice, which then has trickle-down effects on various other factors such as income (Lombardo, 2022b). The emphasis on justice and equity works to reduce "inequalities for direct and indirect

influences on health" (Lombardo, 2022b) by enhancing one's ability to gain control over their own health (Lombardo, 2022b). In further detail, as mental illness and poverty are closely intertwined and greatly influence one another, "the cyclic nature

of mental illness can make job retention a challenge" (Canadian Mental Health Association [CMHA], 2022); thus, improving mental wellbeing through access to mental health services is likely to improve one's capacity for bettering their work opportunities. This intervention also aims to work in health promotion to decrease stigma around the use of mental health services through widespread accessibility and normalized use in order to maximize its positive effects.

Potential Weaknesses, Conflict of Interest:

Although the encompassment of mental health services strives to ensure greater access to the required care, there arise various challenges and weaknesses. To begin, the mental health inclusive OHIP proposal focuses on the mitigation of harms associated with mental illness by providing the accessible health resources, but it is not an intervention that centers its efforts in the prevention of mental illness. The intervention aims to decrease the prevalence of mental illness and stress related to the accessibility of helpful services, thus enhancing overall community well being. Nevertheless, there are still numerous other prerequisites of health that are not of the plan's main target. For example, unaddressed prerequisites for health include food, shelter, and income (Lombardo, 2022b). Although the intervention works to decrease the harmful mental health effects of marginalization, without meeting all of the prerequisites of health, poverty will still prevail. If the issue of poverty is left unsolved, mental illness will continue to be an issue as the two factors impact one another; mental illness influences poverty, while poverty contributes to mental health struggles. An additional potential hindrance to this intervention's success is that of the disparity of interests between the rich and poor; as well as among healthcare professionals (Lombardo, 2022a). As these public health

services are funded by taxes under the program of OHIP, there persists a conflict of interest among required payments. For instance, individuals who will not utilize these mental health services may feel opposed to paying for services that are not of direct benefit to them. A similar issue arises among persons who already have access to these services as covered by a private insurer or are able to afford private care if needed, thus feeling opposed to paying taxes towards services that are mainly beneficial to others. Government spending and budgeting is also a debate in question for the allocation of resources. Some may argue as to whether or not mental health services are appropriately deserving of this funding over other areas in which government resources and funding are also needed. Lastly, there may arise a conflict of interest between healthcare service providers as "many psychologists and other RMHPs might not want their services integrated into the public healthcare system because it could mean less pay and more government oversight and dictation of services" (Scharf & Oinonen, 2020), thereby posing the threat of a shortage of willing professional participation in OHIP providing mental health services.

Conclusion, Next Steps

Health Investment, Cost Efficiency:

To address some of the aforementioned challenges, I propose solutions in my proposed intervention plan. In order to address the conflict of interest between tax-payers for mental health inclusive OHIP intervention as well as the debate on proper targets for tax-payer and government budget spending, it is essential to put forth investment returns. With the inclusion of mental health services under OHIP, this intervention is likely to provide "a return on government

investment by reducing health system costs associated with related health complications" (Moroz et al., 2020). Through early investment, there persists the potential for long-term economic benefit by means of preventing future high-cost and invasive medical services such as procedures for brain injury from drug overdose. Additionally, preventative and accessible mental health services work to foster a community of higher productivity; thus, empowering the prevalence of a high functioning society and generating economic growth.

Compensation and Training:

Incentives must be given in order to gain the voluntary participation of mental health professionals in OHIP care. As stated in Scharf and Oinonen's work, to ensure that healthcare providers remain compelled to continue with their difficult practices, they must be paid fairly for their level of expertise in their practice and in congruence with private providers (2020). This economic motivation is combined with an ethical motivation to positively impact the health of members of marginalized communities by increasing access to services. If there still persists a shortage of mental health professionals, government funding to train additional mental healthcare workers is required. This intervention then demands for specialized mental health training for healthcare workers and other healers that focus on providing the appropriate care for marginalized communities. An additional benefit of this training program includes cultural sensitivity and knowledge on religious values in healthcare practice; thus, creating a sense of trust in the healthcare system and its providers where there may have otherwise been tension felt by the patient. For example, training an Indigenous member in providing mental health care welcomes inclusivity and encourages the use of available services as their expertise consists of not only westernized mental healthcare procedures, but also the understanding and knowledge of traditional Indigenous healing techniques. Indigenous members leading this type of care would allow for adequate practice of culturally-specific techniques and allow for a higher level of trust between patient and provider. Techniques may include trading herbal healing practices, prayer and rituals to accompany other procedures, and working as support personnel for Indigenous patients. Moreover, this wide-spread training program would help to overcome geographic barriers to access and would also work to improve income inequality and marginalization through the creation of stable job opportunities.

Takeaway Message:

To reiterate, I propose a mental health inclusive OHIP plan that focuses on providing accessibility of its services to marginalized and impoverished communities. This program thus fosters equity in accessibility to services that help to decrease mental illness and mitigate the accompanying symptoms. This proposal takes a political economy standpoint and works to protect the most vulnerable through equity-based initiatives, helping to ensure the prerequisite of health for equity and social justice in resource accessibility through the creation of a healthy public policy (Government of Canada, 2017). Although the intervention works to make positive changes in mental wellbeing and in overall quality of life for all parties, additional initiatives must take place alongside the mental health service inclusive OHIP strategy in order to ensure satisfaction in all prerequisites for health (Lombardo, 2022; Lecture 2, Slide 16).

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SECTION 2

Analyzing Vulnerability in Community-Focused Research

The Black Maternal Health Data Gap: A Growing Canadian Public Health Concern

Samuel Garcia-Feliz

Canada lacks national race-based data on maternal health, particularly Black maternal health. Therefore, within this paper, I argue that critical Canadian stakeholders (i.e., the Canadian federal government and Canadian health and healthcare institutions and agencies [e.g., hospitals and the Public Health Agency of Canada]) must begin to collect Black maternal health data. To supplement my argument, I will do the following: examine the health of Black women in the Canadian context; explore the U.S. Black maternal health crisis; discuss the implications of collecting Black maternal health data and the consequences of not collecting this data; and, lastly, provide tangible recommendations on how Canada can better collect data on Black maternal health. Black maternal health data collection will be critical in effectively improving Black Canadian maternal health and health care practices for Black Canadian mothers. Black population health in Canada profoundly depends on this data collection.

The Black Maternal Health Data Gap: A Growing Canadian Public Health Concern

In recent years, the United States of America (U.S.) and the United Kingdom (U.K.) have begun developing and implementing policies and strategies to address Black maternal health inequities (Mpinga, 2022), or the preventable, unjust, and socially produced maternal health differences between sociodemographic groups (PHAC, 2019; PHAC, 2018; Scott et al., 2019). However, Canada is far behind in these efforts (Dayo et al., 2023; Mpinga, 2022). The reason for this is that Canada lacks national race-based data on maternal health (a woman's health during pregnancy, childbirth, and postpartum [Taylor, 2020]), maternal morbidity (the short- and long-term health issues resulting from pregnancy, childbirth, or both [Giurgescu & Misra, 2021]), and maternal mortality (the death of a woman during pregnancy, childbirth, or postpartum [CDC, 2022a.; Oribhabor et al., 2020]) (Dayo et al., 2023; Mpinga, 2022).

The data gap in Black maternal health poses potential harm to Black Canadian women because Canadian medical and public health institutions may not be able to identify, address, and confront factors possibly impacting the health of Black women before, during, and after childbirth (Mpinga, 2022). Therefore, I argue that critical Canadian stakeholders (e.g., Canadian health and healthcare institutions and agencies) must begin to collect Black maternal health data (Dayo et al., 2023). To supplement my argument, I will do the following: first, I will examine the health of Black women in the Canadian context; then, I will explore the U.S. Black maternal health crisis; subsequently, I will discuss the implications in collecting Black maternal health data and the repercussions of not collecting this data; and, lastly, I will provide tangible recommendations on how Canada can better collect data on Black maternal health.

The Health of Black Women in the Canadian Context

In Canada, Black women are at a higher risk of suffering from hypertension, HIV/AIDS, diabetes, asthma, sexually transmitted diseases, uterine fibroids, sickle cell anemia, breast and cervical cancer, and an overall poorer state of health compared to the general population (Flynn & Taylor, 2009; McGibbon & McPherson, 2011; Nnorom et al., 2019; Veenstra, 2019; Veenstra & Patterson, 2016). One of the few Canadian studies on race-based maternal health outcomes found that Black Canadian women were more likely to give birth to preterm babies than White Canadian women (McKinnon et al., 2016). Furthermore, Black Canadian women are at a higher risk of experiencing mistreatment and discrimination during interactions with health care providers (Joshi, 2021). However, it is essential to note that there is a growing concern within academic literature and Black Canadian health professionals about the lack of data and knowledge on the overall health of Black Canadian women and the potential health inequities this population endures (Nnorom et al., 2019).

Black Women's Health & The Social Determinants of Health

Why are Black Canadian women susceptible to poor health outcomes and health care? To answer this question, I will explore the various explicit and nuanced factors that impact the health of Black Canadian women. These factors are called the social determinants of health (SDoH) or the social, economic, political, and environmental conditions "in which people are born, grow, live, work, and age" (Crear-Perry et al., 2021, p. 230) that mould and impact an individual's health (Clark et al., 2022; Oribhabor et al., 2020; PHAC, 2019; PHAC, 2018; Scott et al., 2019). In Canadian society, several negative intra/interpersonal, institutional, and structural SDoH (e.g., poverty, health care provider mistreatment, unsafe community environments, inadequate housing conditions, limited access to adequate health care, and food and employment insecurity) adversely impact Black Canadian women's health (McGibbon & McPherson, 2011). However, racism, specifically anti-Black racism, serves as the foundational SDoH that severely impacts the health of Black Canadian women (Bond et al., 2021; Clark et al., 2022; Crear-Perry et al., 2021; Mehra et al., 2020).

Black Women's Health, Anti-Black Racism, & Intersectionality

Anti-Black racism is the racial discrimination, abuse, prejudice, and oppression targeted explicitly at Black-identifying individuals (Dryden & Nnorom, 2021). Due to the ongoing influences of colonialism within all social structures of Canadian society (Joshi, 2021), anti-Black racism affects Black women in every facet of their lives, such as their ability to access adequate healthcare services and meaningful employment opportunities, which forms the roots of the other negative SDoH Black Canadian women endure (Bond et al., 2021; Clark et al., 2022; Crear-Perry et al., 2021; Giurgescu & Misra, 2021; Mehra et al., 2020).

Furthermore, it is critical to discuss the idea of intersectionality, which refers to the relationship between an individual's varying social identities (e.g., race and gender) that mould that individual's life experiences (Pederson & Machado, 2019). Intersectionality is critical in this discussion because Black women endure both anti-Black racism and sexism, which describes the discrimination an individual experiences due to their sex (Barlow et al., 2020).

Consequently, anti-Black racism and sexism, or gendered anti-Black racism, produce, maintain, and reinforce negative SDoH within and outside health systems that adversely impact the health of Black Canadian women (Chinn et al., 2021; Mehra et al., 2020). Given these points, Black Canadian women likely experience potential maternal health inequities; however, without explicit Black maternal health data, it is challenging to conceptualize this issue properly (Dayo et al., 2023). Therefore, I will explore the U.S. context as a critical lesson for Canada on the importance of collecting Black maternal health data.

The American Black Maternal Health Crisis: Lessons From the U.S. Context

The U.S. currently has the highest maternal mortality rate among high-income countries (Clark et al., 2022). Between 2007 to 2016, approximately 700 mothers died, with two-thirds of these tragic deaths being preventable, during pregnancy, childbirth, or within one year of the postpartum period; additionally, this number increased to about 861 maternal deaths in 2020 during the coronavirus (COVID-19) pandemic (CDC, 2022a; CDC, 2022b; Clark et al., 2022; Stephenson, 2022). More importantly, African American women are three to four times more likely to die due to pregnancy-related complications than their White counterparts (CDC, 2022b; Clark et al., 2022; Chinn et al., 2021; Stephenson, 2022). Additionally, African American women are more likely to experience adverse physical (e.g., pregestational diabetes, chronic hypertension, gestational diabetes, preterm birth, and cesarean deliveries) and mental health conditions (e.g., postpartum depression and anxiety) during pregnancy, childbirth, and after birth (Bond et al., 2021; Matthews et al., 2021; Scott et al., 2019).

In the U.S. context, African American women endure several negative SDoH resulting from historical and contemporary institutional and structural policies and practices (e.g., Jim Crow, redlining, and mass incarnation) profoundly influenced by anti-Black racism, which forms the foundation of America's Black maternal health crisis (Bond et al., 2021; Chinn et al., 2021; Clark et al., 2022; Crear-Perry et al., 2021; Giurgescu & Misra, 2021; Lemke & Brown, 2020; Matthews et al., 2021; Mehra et al., 2020; Oribhabor et al., 2020; Scott et al., 2019; Taylor, 2020).

Fortunately, in December 2021, the Biden-Harris administration issued a call to action to the private and public sectors to address the maternal health crisis affecting marginalized communities, specifically Black and Indigenous communities. The Biden-Harris administration has released several strategies to fulfill these calls to action, including a historic $3 billion investment in maternal health, which includes federal funding to improve racialized maternal health data collection (Stephenson, 2022; TWH, 2021). These efforts made by the Biden-Harris administration are significant; however, there must be more political, systemic action to address this deep-rooted crisis (Mehra et al., 2020).

The U.S. Black maternal health crisis provides an extreme yet crucial lesson for Canada on the power data has on exposing potential Black maternal health inequities, the institutional and structural cruxes of these inequities, and potential methods to effectively address these inequities. Therefore, I will examine the implications of collecting Black maternal health data and the consequences of not collecting this data on Canadian Black maternal health and Black Canadian population health.

Discussion

Implications of Collecting Black Canadian Maternal Health Data for Canadian Maternal Health & Beyond

According to Public Health Ontario (PHO, 2021), maternal health significantly impacts the physical, mental, emotional, and social health of a woman, their child, and their family. Moreover, maternal mortality and morbidity are vital markers of the health and well-being of a nation and its communities (Crear-Perry et al., 2021). Thus, Black maternal health is the cornerstone of Black women's, Black children's, and the Black population's health and wellness in Canada (Scott et al., 2019). For this reason, a lack of Black maternal health data collection can have dire consequences for this specific population.

Collecting Black maternal health data can support the development and implementation of adequate, culturally relevant, and equitable health interventions and health/public policies to address and combat the adverse SDoH that impacts Black mothers, their children, and their families (Dayo et al., 2023). Healthcare institutions can also utilize this data to improve the quality of health care practices for Black mothers (Dayo et al., 2023). Additionally, inequitable Black maternal morbidity and mortality outcomes could pose an immense economic burden for Canada's health systems, potentially resulting in millions of dollars spent annually (Crear-Perry et al., 2021).

Lastly, collecting this data can potentially catalyze the collection of more data on the overall health of Black Canadian women, which is severely limited, as previously mentioned. Therefore, Canada must begin collecting Black maternal health data to improve the health care and support of Black women within and outside health systems (Dayo et al., 2023). Ultimately, data collection can potentially have wide-reaching benefits that may ignite the process of improving Black population health in Canada at its foundation.

Conclusion

Calls to Action, Recommendations, & Potential Challenges to Address the Black Canadian Maternal Health Data Gap

As I have demonstrated in my paper, it is evident that Canada needs to begin collecting Black maternal health data. Therefore, I call on critical Canadian stakeholders, particularly the Canadian federal government and Canadian health and healthcare institutions and agencies (e.g., hospitals and the Public Health Agency of Canada), to begin collecting data on Black maternal health, mortality, and morbidity (Dayo et al., 2023). Similar to the Biden-Harris administration in the U.S., Canada's federal government must make crucial investments in improving race-based maternal health data, and especially Black maternal health data, collection in clinical and community settings (Mpinga, 2022). Furthermore, Canadian health and healthcare institutions and agencies must decolonize (i.e., active resistance against colonial social structures and practices [Narasimhan & Chandanabhumma, 2021]) their research methodologies (Dayo et al., 2023).

To effectively decolonize their research methodologies, I recommend that Canadian health and healthcare institutions and agencies partner with Black communities and community-based organizations, such as Mommy Monitor (a virtual prenatal healthcare centre that aims to provide holistic, empowering, culturally competent, and equitable maternal health care services and educational supports to Black mothers [Mommy Monitor, n.d.]), to gain deeper insights into Black maternal health and the lived experiences of Black Canadian mothers (Dayo et al., 2023; Mpinga, 2022). Partnerships with Black communities and community-based organizations must also ensure that data collection is a Black-led process that empowers Black communities and researchers to have complete control and ownership over the data and its dissemination (Dayo et al., 2023).

Lastly, I recommend that these institutions and agencies must collect data on Black mothers of varying social identities and from varying communities, including Black women from urban, rural, and marginalized communities, incarcerated Black women, Black LGBTQ2S+ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Two-Spirit)-identifying women, Black women serving in the Canadian military, and immigrant Black women to list a few (Bond et al., 2021).

One significant challenge, however, is the gendered anti-Black racism stemming from colonialism within Canada's health and non-health related institutions and health systems that severely limits the interest towards, focus on, and urgency of collecting Black maternal health data (Dayo et al., 2023; Joshi, 2021; Mpinga, 2022). Therefore, the previously mentioned Canadian stakeholders must address gendered anti-Black racism within and outside their institutions, together with decolonizing their research methodologies, so that Black maternal health data will be a significant focus in the Canadian context (Dayo et al., 2023). Overall, this data collection will be critical in effectively improving Canadian Black maternal health and health care for Black Canadian mothers (Dayo et al., 2023). We cannot continue to depend on U.S. and U.K. race-based maternal health data to inform Canadian maternal health care practices and knowledge of maternal health inequities (Mpinga, 2022). The health of Black Canadian mothers and women and the Black Canadian population profoundly depends on this data collection.

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Home Alone: The Impacts of COVID-19 Public Health Measures on Seniors

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As of December 2021, the COVID-19 pandemic has resulted in over 5 million deaths worldwide, including about 30,000 in Canada (Government of Canada, 2021). According to Statistics Canada (2021), about 80% of deaths in Canada have been among people 65 and older. Since the start of the pandemic in March 2020, preventive measures such as lockdowns and quarantines have been implemented to reduce viral spread. The implementation of these measures, while essential for risk prevention, may inadvertently lead to heightened social isolation and loneliness among older adults, as well as adverse impacts on their overall physical health.

This study aimed to assess the impact of the COVID-19 pandemic and the resulting lockdowns on older adults through interviews with four participants aged 75 or older. Transcripts of interviews were analyzed using qualitative methods to uncover four themes including: declines in mental health and well-being; impacts on physical health; reduced participation in activities; and increased workload and responsibilities for independent living. Results uncover gaps in research on the mental and physical effects on seniors of stay-at-home orders and other spread prevention measures. The results underscore the necessity of addressing the needs of older adults to sustain their well-being and independence in the current "new normal."

Introduction

The COVID-19 pandemic over the last two years has led to some of the most significant transformations in the lives of individuals and communities around the world. Much of the initial scientific research focused on understanding the virus and determining the most effective measures to curb the spread and reduce hospitalizations (Wu, 2020). This research led to various evidence-based practices implemented all globally to control contagion - such as mask wearing, stay-at-home orders, social distancing requirements, and more (Wu, 2020). Most facilities, programs, and services closed down, including healthcare settings, educational institutions, community centers, and programs that provide social support that were not deemed "essential" (Daly et al., 2021). These restrictions have been implemented with varying degrees of restrictions, depending on multiple factors, including political situation, region, setting or specific population (Daly et al., 2021).

An initially overlooked but critical area of concern, however, has been the impacts on mental health and overall well-being for particular populations. Across all age groups and strata, reports began emerging on the experiences of school-aged children, frontline workers, and in particular, seniors, whose increased vulnerability and pre-existing conditions have meant they have been disproportionately impacted by cases and deaths (Daly et al., 2021; Canadian Institute for Health Information [CIHI], 2017). Emerging research showed that lockdowns, suspensions of key services, and stay-at-home orders have led to increased cases of loneliness, anxiety, and isolation among seniors, as well as lasting physical health impacts (Wu, 2020).

This independent research study I conducted in the Fall of 2021 aims to answer the following research question: How were seniors affected by the COVID-19 public health measures in terms of their mental and physical health, and overall well-being?

A brief literature review will outline some key factors for consideration, followed by a description of research methodology used in the interviews conducted with four senior citizens. The analysis section will identify findings and themes, followed by discussion of the findings towards recommendations for future consideration.

Literature Review

The following section will summarize some information found in the literature related to seniors in Canada, including demographics, issues related to health and social factors for optimal well being, and seniors' overall experience through the pandemic.

Profile

In 2019, over 4 million Canadians were aged 75 or older, representing 15% of Canada's population. It is estimated that by 2030, seniors will represent almost a quarter of the population (CIHI, 2017). Additionally, as healthcare and technologies continue to improve, seniors are generally living much longer and healthier lives than previous generations (Jaul & Barron, 2017). Even though seniors represent such a large proportion of the population, they often experience inequities in accessing needed support, and widespread perceptions that they are non-productive and cannot contribute to society (World Health Organization [WHO], 2021). Given that this is a growing demographic, it is important to consider the well-being of the older generation to support their participation and productivity in society.

Mental and Physical Health

The research on the mental health impacts of aging is a growing field. This is due to the high levels of mental disorders in seniors, such as depression, anxiety, and substance abuse

issues (Cacioppo & Cacioppo, 2018). For older adults in particular, depression is often misconstrued as a normal part of the aging process and thus may go unrecognized and untreated. Research has also shown that a leading cause of such issues is feelings of loneliness and isolation (Centers for Disease Control and Prevention [CDC], 2021). A report from the National Academies of Sciences, Engineering, and Medicine (National Academies of Sciences, Engineering, and Medicine [NASEM], 2020) points out that more than one-third of adults aged 55 and older feel lonely, and nearly one-fourth of adults aged 75 and older are considered to be socially isolated (Mukhtar, 2020). Older adults are at increased risk for loneliness and social isolation because they are more likely to face factors such as living alone, the loss of family or friends, chronic illness, and hearing loss (Luchetti, 2020; Cacioppo & Cacioppo, 2018). Additionally, the effects of loneliness have been proven to be directly linked to cognitive declines. The CDC reports that social isolation was associated with about a 50% increase of risk of dementia (Public Health Agency of Canada, 2021).

In addition to mental health issues, seniors experience higher levels of chronic physical issues (Jaul & Barron, 2017). A 2019 study conducted by the Public Health Agency of Canada (PHAC) on seniors living in Canada found that about 65% of seniors were living with hypertension and 38% with osteoarthritis (Public Health Agency of Canada [PHAC], 2021). Additionally, estimates from the 2017–2018 Canadian Community Health Survey (CCHS) indicate that about 40% of seniors report having more than one chronic disease (Public Health Agency of Canada, 2021).

Social Services and Supports

Despite their prevalence, research has demonstrated that many common chronic diseases are preventable or manageable, and that with appropriate levels of support, senior populations can experience good quality of life and reduced impacts of poor health (Jaul & Barron, 2017). The PHAC study highlighted the importance of lifestyle adaptations, social support and preventive health care support to help mitigate the effects of different chronic illnesses (PHAC, 2020). According to a CIHI study, these types of support are critical to enable seniors to maintain good health (CIHI, 2017).

Many regions and communities are increasingly focused on building networks of services and supports which include community and recreational programs, home care therapists, personal support workers, nursing aids, and transportation and mobility support. These services and supports help seniors with basic household tasks and personal care, to attend medical appointments, and to participate in community activities (Mukhtar, 2020).

While many older people can be categorized as healthy overall, it is important to maintain health or it can decline rapidly (Daly et al., 2021). This means regularly seeing health professionals that can provide them with the necessary information and guidance they need for healthy living such as physical exercises, eating habits, and daily activities (Daly et al., 2021). Others have pre-existing conditions that require monitoring and early intervention so they do not become acute (Jaul & Barron, 2017). Additionally, monitoring and treatment of pre-existing mental health issues can help mitigate the impacts that are known to be linked directly to declines in physical health (Mukhtar, 2020). The evidence shows that decreasing mortality and morbidity rates among seniors requires an increase of infrastructure and services to be available through such various providers and interactions (Suzman et al., 2015).

COVID-19 Public Health Measures

There has been limited research conducted on the well-being of seniors during the COVID-19 pandemic (Mukhtar, 2020). This may be primarily due to the fact that most research was focused on the physical impacts of contracting the virus, given that adults 60 and older, especially those with pre-existing medical conditions, were more likely to have severe virus infection than other age groups (Daly et al., 2021). Emerging research conducted on seniors' well-being found that lockdowns had negative consequences on their mental health (Daly et al., 2021); rates of depression and anxiety among older adults rose from 10% during an initial 2018 study to 25% in 2020 (Mukhtar, 2020).

Independent Living

The pandemic exposed many health issues within facilities caring for seniors such as nursing homes and long-term care (LTC) (CIHI, 2017). In Canada, it is estimated that deaths in long-term care and nursing facilities represent two thirds of the total number of COVID-19 deaths (CIHI, 2017). Recent investigations revealed many deaths were preventable, and particularly due to the lack of infrastructure put in place to limit contagion in congregate care settings (CIHI, 2017). Additionally, many healthcare centers completely closed in order to focus just on COVID patients. This has had a large impact on many seniors who needed emergency or on-going health care (Jaarsveld, 2020).

As a result, a growing amount of attention is focusing on the provision of quality support at home, such as personal support workers and companions, nurses and occupational therapists. According to Dr. Samir Sinha, head of geriatrics at Mount Sinai and University Health Network hospitals in Toronto, this focus is "long overdue" (Ireland & Kalata, 2021). Research shows that at-home care is more cost effective, resulting in fewer hospitalizations and worsening chronic conditions (Ireland & Kalata, 2021). Dr. Sinha explains that at-home care has more direct benefits to seniors' well-being and independence - which are directly linked to their mental health (Sinha, 2012; Ireland & Kalata, 2021).

As we continue to adjust to living with mutations of COVID-19, it is important to continue to reduce seniors' risk of exposure, while at the same time prevent the impacts of disease exacerbation, loneliness, and isolation. The following qualitative research study serves to better understand the first-hand experiences faced by seniors living at home during the height of the COVID-19 pandemic.

Methodology

Research Questions

While the majority of research during the pandemic focused on how to stop the spread to seniors, there was less emphasis on the isolation and neglect they experienced. This research was designed to explore first-hand experiences of seniors on the impacts that COVID-19 public health measures had on their mental and physical health and daily quality of life.

The study sought to answer the following key question: How were seniors affected by the COVID-19 public health measures in terms of their mental and physical health, and overall well-being? To answer this question, a series of open-ended questions related to different aspects of seniors' lives was compiled.

Recruitment

A total of four participants were recruited for interviews. Three participants were recruited through a posting on Facebook, which requested that they forward the posting to their friends. The posting explained the profile needed for the study and contact information for further information. Once parties confirmed their interest, they were sent an email to confirm they fit the minimum criteria (aged 75 +, living at home, living in Canada), and an explanation of the nature of the research and what would be expected of them.

Data Collection Process

Interviews were conducted in a semi-structured interview approach to engage in conversations that would elicit rich data that could be used in qualitative analysis. In order to improve the credibility of study findings, participants' experiences were explored in-depth during interviews that lasted approximately 30-45 minutes. All interviews were also recorded on a cell phone. After the interviews were conducted, recordings were transcribed and coded using the line-by-line coding technique.

Analysis and Findings

Four distinct themes emerged from the research data: Declines in Mental Health and Well-being, Physical Health Issues, Reduced Participation in Activities, and Increased Workload and Responsibilities.

Theme 1: Declines in Mental Health and Well-being

During the COVID-19 pandemic, participants reported that public health measures made it difficult for them to engage in social activities. All participants indicated that their typical social interactions were significantly reduced or impossible throughout the pandemic. For example, Elia reported that before the pandemic he would go to the gym with a few friends, and had dinners with his adult children or his grandchildren almost every week; all of which stopped because of safety measures. He explains how this greatly impacted him:

> "Yeah. I was trying hard to not lose morale and it was good to have [his wife] Roberta around. But you could say I might have depression."

Jerry also spoke of mental health declines:

> "But of course mentally I am much worse than before, it has just been so isolating even before [his wife] Lora passed away. You know I mean it was no surprise but it is still a very large adjustment."

These quotes show how the public health measures negatively impacted the participant's mental well-being. One of the main contributors to this was the loneliness felt by participants, due to being cut off from their regular activities and social circles.

Theme 2: Physical Health Issues

A second theme brought forward in the interviews was the increase in physical health problems due to reduced access to regular healthcare. For example, Elia reported that his thyroid cancer surgery was canceled due to the pandemic, which he contends will have a long-term impact on his his health;

> "I think for sure my health worsened. I'm getting along fairly well now, but I really needed the surgery…"
>
> *So you never received the surgery?*
>
> "No you see, my health worsened so much I wasn't able to get the surgery anymore, my doctor thinks I am too weak now."

Similarly, Roberta's brother and Jerry's wife both suffered from inadequate health care access during the pandemic, which led to worsening health issues and ultimately contributed to their deaths. As stated by Jerry:

> "I think it was clear that my wife was very sick and was not going to live much longer. However, many times during doctor visits they were able to detect things that were going wrong before it was too late. So it is possible that if we had been able to attend our regular appointments, she could still be here."

Some participants were also unable to continue everyday activities they performed for their physical well-being. For example, Roberta said:

> "Well one thing is, I have arthritis and leg pain so I have to do exercise to keep my blood flowing. So everyday before lockdown I went on walks to the water and around the neighborhood. Sometimes I would walk almost ten kilometers. I loved walking. But then with the lockdown I couldn't go outside anymore."

The pattern shows that older individuals with chronic health issues were left extremely vulnerable without access to their regular health promoting activities and health professionals.

The experience of participants above suggests that having chronic health issues seemed to be a main contributor to experiencing increased negative effects from the pandemic. For example, the third participant, Barb, indicated that she and her husband were both relatively healthy with no acute or chronic health concerns prior to the pandemic, and she had less negative attitudes when discussing its impact. As health measures became less strict, she and her husband were able to return to very similar lives as before the pandemic. The participants who were directly affected by prior health issues seemed to respond much more negatively to the pandemic than those who were not. They also seem to have longer-lasting impacts from the pandemic, such as worsening health conditions.

Theme 3: Reduced Participation in Activities

The loss of regular activities is notable due to its direct connection to the other themes of mental and physical health impacts. Due to COVID restrictions, many activities that seniors participated in on a daily or weekly basis were canceled (CDC, 2021). However, some of these activities were crucial to either the participant's mental or physical well-being. For example, Elia claims that his doctor instructed him to go to the gym to exercise at least three times a week. However, "Since the lockdown I wasn't able to go because it was closed" and "We couldn't even go on walks outside anymore because it was too dangerous to go outside." Roberta explained

that she usually went out for long walks. These were moments of well-being for her where she was able to meet people and have social interactions throughout the day. However, once the lockdowns were put in place she felt too scared to even go outside. She claims this experience was "quite lonely." Roberta also touched on one important activity for her, attending church:

> "Actually one thing that really changed which I should've mentioned before is that I could not go to church anymore, you know I've been attending church almost every sunday since I was a young girl. I have friends at my church and it's my time to get to myself every Sunday away from Elia. It was hard not having church anymore."

Barb had a similar experience:

> "So before lockdown, I was volunteering with the aquarium once or twice a week. That wasn't everyday, but at least it was once a week. Um, and then the other thing I was doing as I was going to aquacise. So that's being in the pool and kind of jumping around. Um, and that was, uh, at least four or five days a week. Wow. And then I would usually walk in addition to the aquacise in the morning, I would walk in the afternoon. And then that got sort of lost."

Although the loss of such activities has impacted social ties, religious traditions, and overall pastimes and hobbies, an important issue related to this is the loss of independence (Daly et al., 2021). As people age, it becomes increasingly difficult for them to remain independent. However, as noted in the literature review, it is important for seniors to continue to independently participate in their activities or passions. Doing so is tied to many positive mental and even physical health effects, as overall morale is boosted (CDC, 2021).

Theme 4 : Increased Workload & Responsibilities to Live Independently

A third common theme among participants was that strict health measures resulted in them having increased workload and responsibilities to compensate for the lack of health and social support they needed for them to continue to live on their own.

Many participants received a range of social and medical services prior to the pandemic to support their independent living. For example, Roberta mentioned that she used to have a regular helper for housekeeping and cooking for her and Elia. Almost all participants and their spouses also had regular primary care visits or home care before the pandemic. When lockdown was in place, they had to take on these responsibilities, including those previously provided by health professionals. Roberta had to take on the role of monitoring her husband's various medications, and even doing physical checks for any lumps or rashes to make sure his cancer was not worsening. Additionally, she had to take over many tasks that were previously done by hired help:

> "We had someone that would come and help us a few times a week, Katy. She would clean the whole apartment and cook us meals sometimes to give us a hand. But when we went into lockdown we couldn't risk letting her in because she helped out a lot of other families and also worked in an old-age home where there were so many cases. So I had to take over all of the work she was doing."

Similarly, Jerry explained:

> "I actually had to start tracking all her [his wife's] medications and stuff because we used to have a nurse come daily but obviously that was no longer safe."

Overall, all participants reported that due to the pandemic measures, they had to assume a heavier workload and additional responsibilities to some extent to maintain their independence.

Discussion

Limitations

This study has some limitations, the main one being the small sample size. Four participants is not a large enough sample to be able to make reliable generalizations to the broader population. Additionally, there could be an issue of volunteer response bias, since all the participants were recruited through volunteering. There was limited ethnic and cultural diversity in the participants that is not representative of the general population. Finally, the participants were all of similar middle to high socio-economic status and living independently (rather than congregate care). Despite these limitations, the study was designed to better understand the personal experiences of these participants through first-hand interviews.

Impacts on Health

Previous studies have shown that social isolation and loneliness can result in poor mental health outcomes, such as depression, anxiety, and cognitive impairments among older adults (CDC, 2021). This study found similar results, with participants experiencing a decline in their mental health and well-being due to isolating public health measures, and expressing feelings of loneliness from lack of social interaction. As previous research has shown, mental and physical health are closely connected. Reduced physical activity, as seen in this study due to being confined at home, can have negative impacts on both physical and mental well-being. It is important that in the implementation of future protocols, the larger social needs of the older adult population are taken into account to avoid potential declines in both their mental and physical health.

Chronic illnesses and at-home support

This study revealed that participants with a pre-existing chronic physical illness or those living with someone who had one, experienced substantial impacts during the COVID-19 pandemic. These participants were more likely to show signs of decreasing mental and/or physical health as a result of not accessing their regular health care or treatment. Additionally, they were overly stressed trying to care for a loved one without their regular social and medical support. The downloading of such responsibilities to senior citizens is disconcerting. In Roberta's case, it is clear that she herself is in need of medical treatment, and should not have been providing around-the-clock care for her husband. In Jerry's case, his extreme feelings of sadness and passivity can be linked to his wife's passing during the time that he was her primary caregiver.

These findings further emphasize the need for quality social and medical services for seniors. As highlighted in the literature review, provision of at-home supports help maintain mental and physical well-being and prevent health declines. The experiences of the participants with chronic health issues during the pandemic shows how lack of timely medical intervention and support they were previously receiving resulted in a decline in their health. This was evident for both Jerry and his wife; and ultimately, Jerry's wife passed away having experienced an exacerbation of her health issues for which she did not receive timely treatment. As such, this study has furthered the research showing the critical need for attention to be drawn to social and medical supports directed to senior citizens.

Passivity and internalizing treatment

Further analysis of the findings in this study revealed an unexpected common pattern in the ways that participants expressed their experiences. Participants seemed to show passivity or hopelessness toward their situation. While discussing physical and mental results of the pandemic, many of the participants tended to justify what had happened with passive resignation. For example, on discussing his wife's death, Jerry said it "would've happened anyways." Although Roberta's arthritis worsened, she asserts not to blame the doctors as they were "doing the best they could." It is important to learn more about this perspective, which may be analyzed as an internalization of the way that senior citizens are unfairly treated or ignored in many aspects of society.

Conclusion

Emerging research highlights the vital role of support in enabling seniors to lead independent, healthy and fulfilling lives. With the global population aging rapidly (WHO, 2021), ensuring optimal well-being for seniors is essential to mitigate the strain on healthcare systems. As the COVID-19 pandemic continues to mutate and public health measures change, it is crucial that policymakers and community organizations address the specific needs of seniors. This will allow them to remain self-sufficient and actively engaged in the social and economic fabrics of society as we navigate the "new normal" in the presence of the virus.

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Appendix A: Interview Questions

- Demographics: How old are you? Where do you live? Do you live alone or with a spouse?
- Before the lockdowns, how would you have described your daily life? (prompts: were you independent, involved in activities or events etc.)
- How did your daily life change when COVID-19 lockdowns took effect? (prompts: describe a typical day or week during the lockdowns)
- Before the lockdowns, what kind of social interactions did you engage in? (prompts: describe a typical day or week now. How often did you go out, or have people in, did you do to classes or volunteering or to your place of worship, or shopping, etc.)
- How did your social life change as a result of the public health measures? (prompts: did you see fewer people? Did you stop certain activities?)
- Before the lockdowns, what kinds of medical, social or personal support services were you receiving? How did these change as a result of the lockdowns? (prompts: did they end, continue or change? how did you cope with the changes?)

- Before the lockdowns, what was your overall health, physical and mental health?
- Have the COVID-19 lockdowns had physical impacts on you and if so, why?
- Have the COVID-19 lockdowns had psychological impacts on you and if so, why?
- What do you think the long-term impacts on your physical and mental health might be?
- (prompts: how do you feel that you have changed? Has your routine gone back to normal? Has your health gotten worse?

Appendix B: Facebook Advertisement

Hi there, we are looking for seniors (individuals aged 75+) to participate in a study we are conducting for my Research Methods course at the University of Toronto. The focus of the study is on the effects of the COVID-19 pandemic on the lives of senior citizens in Canada. We will be conducting a short interview of around 30 minutes, either over person or on zoom depending on what is best for you. Please get in touch if you are interested or have any questions. Thank you so much for your consideration, and please feel free to share this post with anyone who you think may be interested.

End-of-life Care for Refugee and Immigrant Populations

Archanah Kodeeswaran

Introduction

Immigrants and refugees experience differential access to healthcare services, but little is known about their perceptions of and experiences with end-of-life care. This scoping review was conducted to explore immigrants' and refugees' knowledge, attitudes and experiences regarding end-of-life and palliative care.

Methods

Using a scoping review methodology, 1881 publications were retrieved and 26 met the inclusion criteria. The empirical studies and reviews were published in English and there was no restriction on the publication dates. Descriptive and thematic analyses were used to synthesize the findings.

Findings

13 publications were based in the U.S. while 7 were focused on the Canadian context. 23 studies focused on immigrants, 1 was about undocumented immigrants and 2 were solely focused on refugees. Studies discussed the lower levels of knowledge of palliative care services, the importance of family and culture, differences in the receipt of care and psychosocial factors.

Conclusion

This scoping review highlighted significant differences in the knowledge and receipt of end-of-life care services among these populations. More research is needed on these populations, specifically research covering refugees. Culturally sensitive policies and services also need to be developed.

Keywords: Immigrants, refugees, end-of-life care, palliative care, scoping review

End-of-life Care for Refugee and Immigrant Populations

An essential part of healthcare is the receipt of culturally appropriate and patient-focused end-of-life care (Yarnell et al., 2020). Palliative care is an approach that improves the quality of life for patients with life-threatening illnesses through prevention (Abdelaal et al., 2021). It includes domains such as physical symptom management and advance care planning (ACP) and is delivered through various means such as hospices or hospital inpatient units (Abdelaal et al., 2021). Despite improving cost efficiency and one's quality of life (Gray et al., 2021), there is differential access to care (Kwak & Haley, 2005).

It is crucial to consider how immigrant and refugee status can influence the utilization of end-of-life care services. While recent immigrants are healthier than their Canadian-born counterparts, established immigrants show a deterioration in their health status over time (Vang et al., 2017). It is also important to explore the experiences of refugees and unauthorized immigrants as refugees face high rates of violence and mortality in their home countries (Madi et al., 2019), psychological distress is common (O'Connor & Meageen, 2020) and they typically have greater medical needs after resettlement (Abdelaal et al., 2021).

While the scoping review will focus on all immigrants and refugees, it is hoped that more insight will be gained into the experiences of Tamil refugees from Sri Lanka. From 1983 to 2009, there was a civil war in Sri Lanka between the Sri Lankan Security Forces and the Liberation Tigers of Tamil Eelam (Affleck et al., 2018). War can have a significant psychosocial impact on individuals, families, communities, and society at large (Somasundaram, 2010). Given the lack of literature on this subpopulation however, the research done on other refugee and immigrant groups will be used to interpret their experiences. This scoping review will explore these populations' views regarding end-of-life healthcare services and uncover how psychosocial factors and trauma intersect to influence their perceptions.

Methods

Scoping reviews are a research approach that involves mapping and summarizing the evidence of a field (Levac et al., 2010). They are used for four common reasons which include the following: examining the extent of research activity, determining whether a systematic review should be undertaken, disseminating research findings, and identifying research gaps (Arksey et al., 2005). It was determined that conducting a scoping review would be the most appropriate option given that there could be an exploration of the literature on this topic and the findings can be used to inform policy. The main steps involved in a scoping review are as follows: identifying the research question, finding relevant studies, conducting the study selection, charting the data, and then collating, summarizing, and reporting the results (Arksey et al., 2005). The scoping review methodology was applied, and the key features are described below.

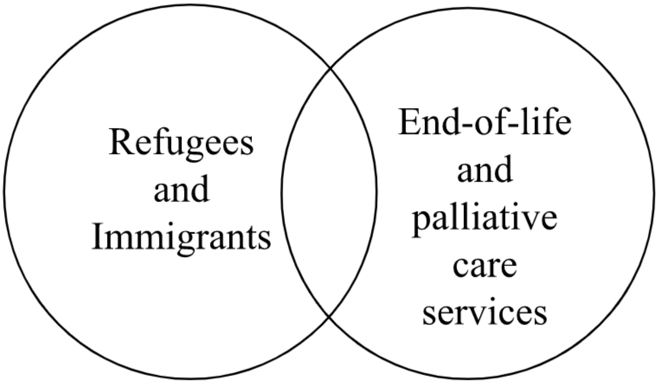
Identifying the Research Question

Originally, the research question aimed to capture the knowledge, attitudes and experiences of refugees and immigrants regarding death and dying. However, due to how broad it was, the objective was narrowed down to focus on the healthcare context. The research question then became the following: What is known about refugees' and immigrants' knowledge, attitudes, and experiences regarding end-of-life care as a healthcare service?

Finding Relevant Studies

The literature was collected from Medline, CINAHL, EMBASE, APA PsycINFO and AgeLine. MeSH terms and keywords were used to combine the population groups with concepts related to end-of-life care (Figure 1). The main search terms included the following: refugee, asylum seeker, undocumented immigrant, migrant, emigrant, immigrant, migration, immigration, death, dying, attitudes to death, palliative therapy, palliative care, hospice, terminal care, assisted suicide, and euthanasia. Additionally, the limiters of "English" and "journal articles" were applied.

Figure 1: Search Strategy



Note: This Venn diagram depicts how the publications were chosen for this scoping review. The populations included were refugees and immigrants. Then the substantive focus was their knowledge, attitudes and experiences regarding end-of-life care and palliative care services.

Conducting the Study Selection

Empirical studies and reviews that were published in English and from any date were included. The intention was to focus on those who migrated from politically unstable or developing countries, with participants over the age of 18. The Human Development Index (HDI) was used to measure the country's development so those with a score lower than 0.80 were included. While one link was used to determine the HDI of most countries ("Human development index (HDI) by country 2022", n.d.), additional websites had to be utilized as well ("Cabo Verde - United Nations Development Programme", n.d.; "Côte d'Ivoire - United Nations Development Programme", n.d.; "Taiwan", n.d.). The publications had to discuss end-of-life care or healthcare services involving terminal illnesses and needed to consider the knowledge, attitudes, and experiences of the patients.

For the title and abstract screening, the original purpose was to explore the participants' views regarding death and dying so most publication types were included in this stage. The first 20 articles in the Excel sheet were double-screened for rigour with no discrepancies being found and from there, the remaining articles were screened by one researcher. Articles that did not specify whether they were focused on immigrants or refugees, but rather on ethnic groups were flagged for the background and discussion sections. Moreover, topics such as bereavement, suicide trends, articles providing insight into end-of-life care services and those taken from the perspective of family caregivers or the parents of children receiving care were included.

The inclusion of many publications reduced the possibility of being able to do an in-depth analysis, so the inclusion and exclusion criteria were modified for the full-text review. As such, the studies had to be focused on patients using or eventually becoming the recipient of end-of-life healthcare services. Moreover, publications were excluded if they were not empirical studies or reviews, focused on grief and bereavement, and involved patients under the age of 18.

Charting the Data

The search results were de-duplicated using Zotero software and the remaining articles were exported to Excel. The charting characteristics include the following: population, country of origin, destination country, type of article, methodology, methods, research question/ objective, HDI of birth country, and knowledge, attitudes, or experiences.

Collating, Summarizing and Reporting the Data

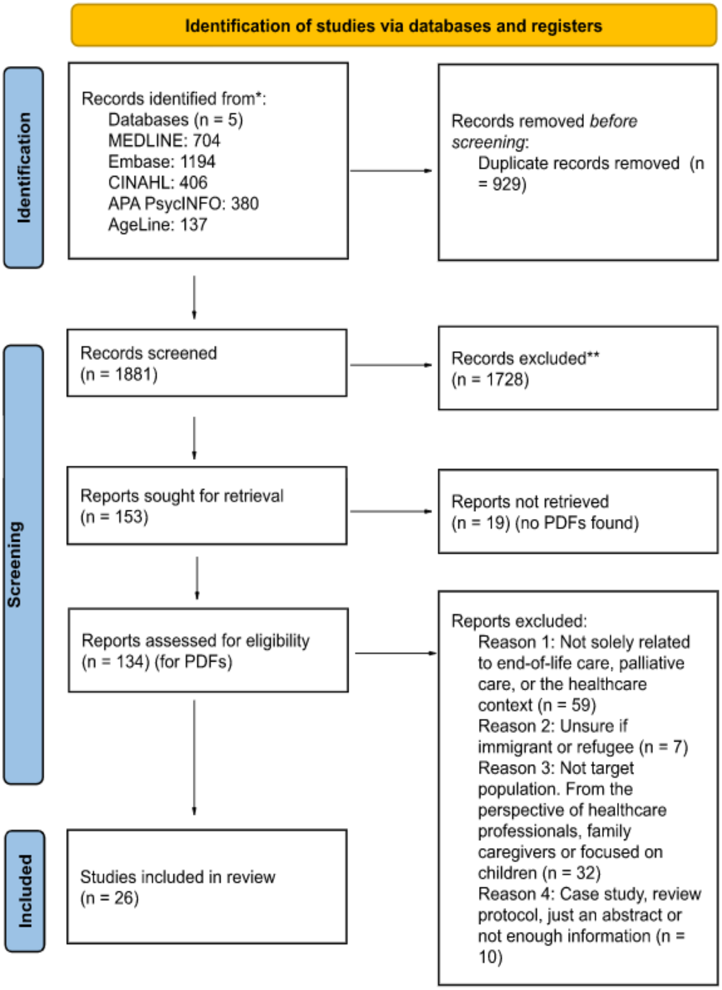
To produce the results, a table was developed with the charting characteristics, information was obtained for the descriptive analysis, and a thematic analysis took place to explore the meanings of the findings (Levac et al., 2010).

Findings

Descriptive Findings

Of the 1881 publications, 1728 were excluded after reading the abstracts and 108 were excluded after conducting the full-text review, with 26 articles being included in the scoping review. Table 1 demonstrates the number of publications that were included at each step of the screening process while Figure 2 depicts the selection process. Of the included publications, 23 were empirical studies and 3 were review studies. Most empirical studies utilized quantitative methodology with 15 articles doing so, followed by 7 using qualitative methodology and only 1 that was a mixed methods study. Moreover, 13 articles were focused on the U.S. as the destination country while 7 were focused on the Canadian context. It is important to note that while 23 publications focused on immigrants, only one focused on undocumented immigrants and two were about refugees. Table 2 highlights the charting characteristics.

Figure 2: PRISMA Model



Note: This PRISMA flow chart depicts the number of articles that were included and excluded at each step of the screening process and the reasons why they were excluded.

Thematic Findings

The findings for immigrant populations will be organized by knowledge, attitudes, and experiences followed by a review of the limited available evidence on refugee populations.

Immigrant Populations

Knowledge. Immigrants generally had lower levels of knowledge about palliative care and other processes related to end-of-life care, such as advance care directives (ACDs) (Rao et al., 2008; Dhingra et al., 2020; Doorenbos, n.d.; Shabnam et al., 2020; Kwok et al., 2020; Barwise et al., 2019). An increased stay in the destination country and acculturation led to more knowledge about these services (Doorenbos, n.d.; Barwise et al., 2019). Furthermore, the lack of culturally equivalent words for palliative care and the negative connotation of words complicated participants' understanding of these services (Shabnam et al., 2020)

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Attitudes. Many patients adhered to the family-centered model of medical decision-making and preferred being cared for by family to preserve comfort and privacy (Frank et al., 2002; Shabnam et al., 2020). Some believed that written documentation was unnecessary if family members were involved (Rao et al., 2008), and older adults did not feel the need to discuss their end-of-life preferences because of shared decision-making (Shabnam et al., 2020). Factors that influenced the discussion of end-of-life preferences include culture, religion, ethnicity, and language barriers (Shabnam et al., 2020). While the provision of palliative care is traditionally seen as the responsibility of the family (Zivkovic, 2018; Shabnam et al., 2020; Sharma et al., 2012; Kwok et al., 2020), fulfilling this filial duty was difficult (Kwok et al., 2020; Sharma et al., 2012).

There was resistance to the idea of direct disclosure as it is deemed culturally inappropriate (Frank et al., 2002; Kwok et al., 2020) but many viewed ACDs positively when given more information (Rao et al., 2008; Dhingra et al., 2020; Doorenbos, n.d.). Two studies found that participants would prefer being at home at the time of death (Doorenbos, n.d.; Shabnam et al., 2020) because they saw death as a private matter (Kwok et al., 2020; Shabnam et al., 2020). A lack of trust in staff, perceived prejudice and cultural insensitivity also discouraged them from being cared for in a hospital setting (Shabnam et al., 2020).

Experiences. Immigrants were underrepresented in hospice palliative care institutions (Henke et al., 2017) and more likely to use acute or aggressive end-of-life care (Quach et al., 2021; Möller et al., 2021; Seto Nielsen et al., 2019; Shen et al., 2019; Yarnell et al.; 2017; Chu et al., 2021; Torensma et al., 2020). They were also more likely to die in hospital settings (Quach et al., 2021; Seto Nielsen et al., 2019) and spent fewer days at home (Engelhart et al., 2021). The receipt of end-of-life care often depended on one's ethnicity and region of birth with African, South American, and Asian immigrants using more acute care than European or North American immigrants (Quach et al., 2021) and those from ethnic minorities having higher rates of surgery (Möller et al., 2021). Some preferred life-extending care however (Tergas et al., 2019) even if they were in a subjectively healthy condition (Grace Yi, 2019). Many patients were unable to communicate their preferences (Glaser et al., 2020; Rahemi, 2019; Sharma et al., 2012) due to being met with resistance (Glaser et al., 2020) or experiencing barriers such as physical distance and an unclear prognosis (Sharma et al., 2012). Overall, few had discussed end-of-life preferences (Sharma et al., 2012; Kwok et al., 2020; Pei et al., 2021) and ACP engagement among older immigrants from racial/ethnic minorities is much lower than the overall average of White immigrants (Grace Yi, 2019).

Language barriers are common (Glaser et al., 2020), impacting their ability to discuss palliative care (Shabnam et al., 2020) and although interpreters were hard to find they were preferred (Glaser et al., 2020; Shabnam et al., 2020; Kwok et al., 2020). Cultural insensitivity, discrimination, limited support, and concerns about one's immigrant status also led to a lack of trust (Seto Nielsen et al., 2019; Shabnam et al., 2020). Direct communication between the patient and healthcare providers was impacted by factors such as the gatekeeping nature of families and the gender of healthcare providers since patients were not as interactive with those of the opposite gender (Shabnam et al., 2020). Residents also felt discomfort as it was not a part of their culture to be personally cared for by someone not related to them (Nyashanu et al., 2020).

Refugee Populations

The war in the patients' home countries made treatments unavailable and the trauma they endured impacted them significantly (Guo et al., 2021). They were forced to flee from their home countries, separating them from their social network (Guo et al., 2021). Moreover, many lost their jobs and some applications for financial assistance were rejected. (Guo et al., 2021). Those with war wounds were satisfied with the acute care they received in the camps, but financial constraints and the uneven distribution of specialized healthcare services impacted the continuity of care (Pinheiro & Jaff, 2018). While there was access to primary care in clinics, those requiring tertiary care were referred to a hospital and the receipt of care was not optimal (Pinheiro & Jaff, 2018).

Refugees living outside of camps relied on various services such as charity clinics and struggled with uncertainty, loneliness, and financial difficulties (Pinheiro & Jaff, 2018). While being admitted to a hospital was difficult, the stays were valued because of the availability of food and pause from daily stressors (Pinheiro & Jaff, 2018). Patients relying on overstretched clinics and volunteer medical teams were unhappy because many believed that they had ineffective medications and there was a limited morphine supply (Pinheiro & Jaff, 2018). Overall, patients felt that the effectiveness of the service delivery was undermined by the fragmentation among charities, non-governmental organizations, and the government hospital (Pinheiro & Jaff, 2018).

Many refugees expressed feeling distressed with having to live far away from home and this was heightened by poverty (Guo et al., 2021). While many believed stress and receiving bad news worsened their condition (Pinheiro & Jaff, 2018), some experienced anxiety since healthcare providers and family avoided discussing their medical condition and treatment plan (Guo et al., 2021). Family support, a sense of community, and faith helped patients however (Guo et al., 2021; Pinheiro & Jaff, 2018). For those living in camps, being around other refugees with similar circumstances allowed them to learn about the services available and there was a sense of solidarity in their suffering (Pinheiro & Jaff, 2018). Faith was also used as a means of coping since it allowed them to endure adversity and adhere to treatment regimens (Pinheiro & Jaff, 2018).

Discussion

Some common themes that emerged were a lack of knowledge of end-of-life care, the importance of family and cultural values, differences in the receipt of care, and psychological distress. A low level of knowledge could be attributed to lower levels of acculturation, health literacy, and awareness of how the healthcare system works in their destination country (Dhingra et al., 2020). Palliative care services differ by country, thus influencing the health-seeking behaviour of patients (Kwok et al., 2020). Engagement with healthcare providers can also influence levels of knowledge since poor communication about one's diagnosis and options leads to lower awareness of the services available (Shabnam et al., 2020). Shared family decision-making and cultural values also impacted patients' engagement levels, receipt of care and knowledge of services (Rao et al., 2008). Patients often felt conflicted by the social norms of the destination country because of the differing roles of care providers (Kwok et al., 2020). Difficulties in navigating the healthcare system mean patients often find themselves in a more advanced stage of illness, leading to the increased use of aggressive or curative care (Seto Nielsen et al., 2019).

In Canada, immigrants were found to make greater use of acute and aggressive care (Quach et al., 2021; Yarnell et al., 2017), more likely to die in an intensive care unit (Yarnell et al., 2017), were younger at the time of death, and were more likely to live in low-income neighbourhoods (Chu et al., 2021). The rates of care also vary according to one's region of birth or ethnic group (Yarnell et al., 2017) which can be explained by multiple factors including cultural differences, service accessibility, patient preferences, and clinician behaviour (Yarnell et al., 2017). In North American countries, immigrants reported more difficulty in accessing care which led to greater use of life-sustaining interventions (Quach et al., 2021). Language barriers and a lack of knowledge of the healthcare system can make it difficult for them to advocate for themselves (Chu et al., 2021). Community services may be a better option given that it is less costly and would align with their preferences (Quach et al., 2021). While there is universal healthcare in Canada, this does not necessarily translate to free healthcare services for undocumented immigrants (Seto Nielsen et al., 2019). Since they lack access to government-issued health insurance, they are excluded from receiving services unless they pay out-of-pocket (Seto Nielsen et al., 2019). Although their situation is similar to those in the U.S., there are clearer paths to supporting them since the U.S. encounters undocumented immigrants more often (Seto Nielsen et al., 2019).

There is a significant lack of literature on refugees, specifically in the Canadian context. In Canada, resettled refugees and refugee claimants are covered through the Interim Federal Health Program (IFHP) for medical and social services until they can obtain provincial health coverage (Abdelaal et al., 2021). They face many challenges including a lack of culturally sensitive care, unfamiliarity with the services, financial constraints, and language barriers (Abdelaal et al., 2021). Patients do not have access to comprehensive palliative care services in Ontario as it is limited to acute care settings (Abdelaal et al., 2021). Additionally, the trauma they endure predisposes them to a higher burden of physical, psychological, and socioeconomic barriers (Guo et al., 2021). This scoping review also revealed the scarcity of literature on Tamil refugees from Sri Lanka.

Limitations

In some studies, the birth countries were not specified which meant that the criterion of participants coming from countries with an HDI of less than 0.80 could not be satisfied. Additionally, the refugee populations from the included studies resided in Jordan so their experiences might not be reflective of those living in other countries. For the search strategy, only electronic publications that were empirical studies or reviews were included, meaning literature could have been missed. Finally, data was quite limited so more databases could have been used.

Conclusion

This review revealed significant differences in the receipt of end-of-life care services, lower levels of knowledge and barriers that prevent refugees and immigrants from receiving optimal care. It also uncovered how their use of these services is connected to their unique past experiences, cultural values, and psychological well-being. More research must be conducted to explore how palliative care can be used to alleviate the life-limiting illnesses they face and to incorporate culturally sensitive practices (Madi et al., 2019). There is also a gap in knowledge on Tamil refugees from Sri Lanka and while the findings on other refugee groups can be used to interpret their views, every community has unique experiences. Deepening one's understanding of patients' experiences can increase the quality of the care they receive (Najjar & Hauck, 2020) and ensure end-of-life healthcare services are inclusive.

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Tables (Only Available Online)

Table 1: Documentation of Screening and Reviewing

Table 2: Findings table

Appendices (Only Available Online)

Table A1. Search strategy and results from OVID Medline

Table A2. Search strategy and results from EMBASE.

Table A3. Search strategy and results from APA PsycINFO.

Table A5. Search strategy and results from AgeLine.

Dates Databases were Searched

Medline: June 1st, 2022

CINAHL: June 3rd, 2022

Embase: June 1st, 2022

PsycINFO: June 1st, 2022

AgeLine: June 3rd, 2022

Critical Health Perspectives: Manifestation of Structural Violence Case Analogy: Spirit to Soar

Aishah Nadeem

> Structural violence can simply be defined as the culprit of preventable suffering (Beatrice et al., 2021). Contemporary social systems and structures perpetuate inequities that disproportionately impact certain communities over others – however, these entrenched disparities are only man-made, thus making them entirely recognizable and correctable. This paper grounds the analysis of structural violence and the manifestation of this preventable phenomenon by analyzing the documentary, Mashkawi-Manidoo Bimaadiziwin Spirit to Soar (2021), which follows the aftermath of the tragic, unpursued deaths of seven young Indigenous students in Thunder Bay since the early 2000s.

What is Structural Violence?

Historically, structural violence was often confused with physical violence on a significant scale, including instances ranging from homicide to war and genocide (Gilligan, 1997). However, over time the definition of this term has been modified and adapted. With progress, the term adopted recognition of existing institutions which unjustly endorse societal barriers, the unkempt discrimination that plagues communities, or the unequal differences of opportunity. Today, we define structural violence as the root cause that attributes towards the differences between the potential a person can have and their actual lived circumstances (Galtung, 1969). This places structural violence at the root of shaping inequality and suffering through economically, politically, or culturally driven processes (Gupta, 2012) – creating marginalized factions in which certain groups of people or individuals are awarded less opportunities and more barriers due to social injustice. Structural violence does not have a single perpetrator nor a single victim, it is the product of ideologies and beliefs entrenched in different social institutions, thereby resulting in harmful impacts to multiple communities. For the sake of this paper, violence is a pattern of collective social actions that occur within institutions and structures due to adopted practises, laws, and policies that create spheres that deny communities or individuals the benefits of social progress thereby perpetuating systemic injustice (Lee, 2019).

How Structural Violence Manifests – Spirit to Soar Case Analogy

Mashkawi-Manidoo Bimaadiziwin Spirit to Soar serves as a documentary to the book written by Tanya Talaga, titled Seven Fallen Feathers. The purpose of the book and documentary was to explore the teen lives and deaths of Indigenous children in Thunder Bay, namely seven students sent over 500 kilometres away to receive a high school education due to the absence of corresponding facilities in their home communities. The absence of such educational facilities alongside staffing shortages and lack of resources has been attributable to the insufficient funding provided by the federal government, wherein Indigenous communities do not have schools to provide continuing education for the kids in the community (IAC, 2018; Porter, 2016). Thus, due to this absence of funding, influenced by a range of historical, social, political, and economic factors, children are forced to travel to unfamiliar regions to pursue further education (Harris, 2023; CBC, 2022).

To begin with, structural violence can manifest as structural genocide, or in specific cultural genocide and violence, and the lasting implications for this can carry over across generations resulting in intergenerational trauma. Indigenous communities have been the subject of structural violence since the colonization of the Americas – where about 10 million Indigenous peoples lost their lives at the hands of European violence (WHO, 2002). Families and children became separated due to the residential schooling systems, and communities were forced to forget their cultural heritage, spirituality, language, and practises. These direct forms of terror and cultural genocide epitomize structural violence, which carry across generations through intergenerational trauma and pose long-lasting implications for present-day Indigenous communities. For example, the residential schooling system – where Indigenous children were separated from families, forced to learn English, and lost their cultural heritage - was the systemic destruction and erasure of Indigenous culture and people. Despite the closure of residential schools, the present lack of secondary educational facilities and poor quality of education in Indigenous communities of Northern Ontario necessitates children to depart from home communities to pursue education in outside communities (Jackson, 2019). While the decision to leave the community is now a chosen one, it is one of the only options available to children who wish to pursue further education and continues to perpetuate the notion of separation from land, heritage, and family. As seen in Spirit to Soar, this is the lived reality for many children including Kyle Morriseau, 17, one of the students who had to pursue high school education in Thunder Bay due to the absence of a high school in his home community of Keewaywin First Nation. Today, the legacy of residential schools and colonialism manifests in the lack of equal opportunities present for Indigenous communities and the racially-based systemic discrimination that Indigenous youth experience when living in predominantly non-Indigenous communities such as Thunder Bay.

Moreover, aside from the impacts on the educational systems prevalent today, the intergenerational trauma of colonialism – in which Indigenous peoples over time were displaced and lost their connection to land, culture, and language – continues to perpetuate rippling impacts. The current day oppression has taken place indirectly and covertly – such as economic violence in the form of poverty due to minimal financial support and sustainable economic opportunities, limited access to basic goods and services including social services and persisted display of microaggressions and negative cultural stereotypes in institutions that continue to retraumatize Indigenous individuals (Kim, 2019). The underlying cause of these observable phenomenon is attributable to the enormous cultural turmoil created because of colonialism, where systems and policies in place marginalize and negate the value of Indigenous lives as less important and ultimately more expendable.

Structural violence manifests itself as systemic oppression and it can be responsible for creating narratives of divide and power exploitation, consequently leading to interpersonal violence. For the scope of this paper, the analysis is grounded in racial oppression. The birth of racial oppression is born from ideologies that include, but not limited to, colonialism and white supremacy (Matias, 2016). Colonialism and white supremacy entailed the ideology of imposition of the European values and the eradication of Indigenous ways of life. Thus, the values entrenched within systems that create an "us vs. them" mindset created racial division that are present in communities and institutions. For example, in Thunder Bay, there have been rampant racist attitudes observed within the police force – and the generalization based on race has led to the compromise of the safety and wellbeing of Indigenous peoples – often in the form of racial stereotyping, lack of police action, microaggressions, and insufficient case examinations. As seen in Spirit to Soar, the deaths of the seven Indigenous youth were questionable and sudden in nature. The documentary and book followed the stories of seven Indigenous children who died while attending high school in Thunder Bay and each of these deaths was quickly written off and classified as accidental. The lack of investigation into these deaths was a prime example of the state engaging in administrative injustice due to prejudiced notions and systemic racism. Indigenous communities in and around Thunder Bay, as seen in the documentary, have continually raised concerns about the quality of service and investigations provided by the Thunder Bay Police Service (TBPS) into the deaths of Indigenous people, with the community asserting that many of these unsolved deaths did not have thorough investigations due to differential treatment exercised by the state in legal cases involving Indigenous victims. For example, the documentary asserted that the willingness to blame an Indigenous victim was rampant in Thunder Bay – and this was an ingrained attitude that had permeated the system in the law forces of Thunder Bay. An investigation conducted by the Independent Police Review Director (OIPRD) found that systemic racism exists in Thunder Bay Police at an institutional level and runs through the ranks of the police service, resulting in discriminatory practises such as racial stereotyping (Derosier & Talaga, 2021).

The construct of structural violence also perpetuates observed epistemic injustice. Ingrained prejudices have led to hermeneutical and testimonial injustice occurring at state-levels. Spirit to Soar exemplifies these observed injustices, where due to racial oppression and prejudices, the lived experiences of Indigenous peoples are often directed or denied by the dominant discourse embedded within our administrative systems (Park et al., 2021). This has led to little recognition of the disproportionate victimization of Indigenous people, further propelling the notion of testimonial injustice, wherein the lived and recorded experiences of Indigenous peoples are continually minimized and understated (Fricker, 2007). The lack of inquiry into the sudden deaths of the seven Indigenous youth is a prime example of how police and medical records give in to stereotypical and racialized prejudices. As a result, confidence of systems set in place to serve and protect are undermined, thus eclipsing the hopes of a society which empowers by eliminating harmful stereotypes (Bumiller, 2008). For example, the seven untimely and unsolved deaths of seven Indigenous students were immediately deemed as accidental, some noted as such by the police before an official autopsy was performed by the coroner. For the deaths of the Indigenous youth in Thunder Bay, the deemed incredibility of the statements of families and refusal to carry out thorough inquests into the deaths serve as a prime example of embedded bias within the systems (Park et al., 2021). The structural violence practised by the state was shown in the documentary – where the lack of cooperation by local law forces eroded the civil right to safety and justice by excluding and silencing the lived experiences of the Indigenous communities (Johnstone & Lee, 2018).

The Role of the Community

For communities to respond and address structural violence, there must be recovery and resilience. To achieve recovery, there must be recognition of the different forms of state violence against racially marginalized people. There must be acknowledgement that there are entrenched values in institutions that positions Indigenous peoples as 'other' and exaggerates the cultural differences, thereby reinforcing racialized generalizations. Influenced by the colonial history of Canada, the years of oppressive trauma has created an anti-Indigenous sentiment that is expressed and observed in numerous ways, albeit different in the explicit manner of the past, yet it continues to disadvantage, oppress, and ultimately harm Indigenous communities. Structural violence can be observed within the policies and systems, including systems intended to serve our needs, and when policies intersect with racial stereotypes this can translate to discrimination against a group of people (Loppie et al., 2014) – and this must be acknowledged to prevent the persistence of systems that can render to be as equally harmful as those that endorse harmful ideologies explicitly.

The notion of recovery is rooted in the struggle for recognition and acknowledgement of the politics that displace and marginalized communities, and calls for the redistribution of social, political, and economic resources to address these experiences of inequality and injustice (Harper, 2012). It is only after the recognition of these unjust systems can we move to the next step, resilience, in which there must be collective approaches.

Systemic violence can be challenged through resilience, which must be achieved through radical hope and collective care. Movements that challenge the embedded violence within our institutions must be enabled and when we challenge these ideologies collectively and communally, recognizing the past trauma and present-day repercussions, we engage in collective care. This can be achieved through understanding the history of the oppressions along with the reconciliation efforts and acts of resistant that have been taken to transform these conditions, respecting, and embracing ancestral pride and cultural heritage, envisioning equitable possibilities, and creating opportunities to social justice and equality (Mosley et al., 2019). The collective care that communities must engage in must contest structures of violence and exploitation.

Conclusion

In this paper, the roots of structural violence against Indigenous communities were explored within the lens of Spirit to Soar. Colonialism and Indigenous cultural genocide result in discriminatory educational institutions, perpetual cycles of intergenerational trauma, interpersonal violence, and epistemic injustice. The vicious man-made cycle of suffering is correctable, but can only be dismantled through radical hope efforts in which resilience and collective care are integral. This entails the effort of recognizing the perpetuation of structural against Indigenous communities, engaging in accountability, and focusing on improved reconciliation efforts to truly understand the notion of collective care. Structural violence dominates the lived experiences of Indigenous communities and grounding in direct action work and community resilience are key elements to dismantling this embedded cycle of violence.

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Being Mentally Ill and Homeless in Ontario: Analyzing Health Inequities with the “3-1” Framework

Mei Timpson

The relationship between homelessness and mental health is complex, with mental illness both contributing to and an outcome of homelessness (Munn-Rivard, 2014). Canada–notably Ontario–has high rates of homelessness and mental illness, with the conditions often comorbid; compared to 8.1% of the general population, 21.2% of mentally ill Canadians in 2017 lived in inadequate housing (Statistics Canada, 2021). Moreover, the prevalence of mental illness ranges from 25% to 74% among the homeless population in Ontario, which is above the national average of 20% (Canadian Mental Health Association Ontario [CMHA, Ontario], 2014; Munn-Rivard, 2014). With homelessness increasing in prevalence, this essay will attest that attention needs to be brought to the health inequities mentally ill homeless Ontarians face, specifically discrimination, treatment barriers, and worse health outcomes (Uppal, 2022). This health priority issue will be analyzed through the “3-I” framework—which examines the interests, institutions, and ideas involved in policy development—to demonstrate that this problem places preventable burdens on the economy, healthcare system, and on struggling individuals (Gauvin, 2014).

Definitions

In this paper, homelessness refers to a person or group of people unable to attain or maintain adequate, secure housing (Canadian Observatory on Homelessness [COH], 2012). Unsheltered homelessness represents individuals who are visibly homeless—such as those living on the street or in a homeless shelter—while hidden homelessness represents individuals temporarily without a home who reside with others—like their family or friends—for shelter (Uppal, 2022). Moreover, this essay defines mental health as an individual’s cognitive and affective state that influences daily functioning and behaviour, and mental illness as the impairment of an individual’s cognitive and affective state that contributes to dysfunction and distress in everyday life (Ministry of Mental Health and Addictions, n.d.).

The “3-I” framework is a policy analysis model that associates the development of policies to three, interrelated topics: ideas, institutions, and interests (Gauvin, 2014). Ideas are contextual information, such as research and beliefs, that impact the framing and feasibility of a policy (Gauvin, 2014). Institutions are agents and precedents that guide the enactment of a policy, including the likelihood and manner a policy is enacted (Gauvin, 2014). Lastly, interests reflect the values of involved stakeholders–affected parties–and the consequences a policy may have on them (Gauvin, 2014). Stakeholders who regard a policy as a priority are considered concentrated interests, whilst stakeholders who do not prioritize a policy are considered diffuse interests (Deber, 2018). The "3-I" framework is frequently used in health policy; it explicitly denotes the core elements shaping, promoting, and providing barriers to the development of health policies, and builds on the listed components to provide a guideline for analyzing a policy's relevance, feasibility, and acceptance (Gauvin, 2014). Chauhan (2022) employed this framework in Volume XIV of Health Perspectives to analyze the relationship between housing and Ontario's healthcare system, and Mitri (2021) analyzed a policy in Ontario targeting the management of health-related test results and its effects (Deber, 2018). The application of the "3-I" framework to analyze the health inequities affecting mentally ill homeless individuals in Ontario has not, as of yet, been undertaken.

Ideas

The current perceptions towards mental health and housing in Canada conflict with the legacy of a welfare state and emergent neoliberalism. Prior to the 1950s, mental health was treated in institutionalized facilities, aligning with the Victorian belief that mentally ill individuals required care to function and should be isolated to prevent the spread of disease (Trainor et al., 2017). In the 1950s, the unmet health needs of World War II veterans and Canadian immigrants spread the welfare ideology, which asserted that governments must provide conditions for equity among citizens, especially for those benefiting the economy (Deber, 2018; Trainor et al., 2017). With this, mental healthcare began deinstitutionalizing into the community and social programs providing housing for low-income Canadians were created (Trainor et al., 2017). After economic difficulties in the 1970s, the concept of neoliberalism spread, advocating that "rights" in a welfare state—like housing—were privileges and commodities that citizens had individual responsibility in obtaining (Trainor et al., 2017). Additionally, popular discourse began defining ideal citizens as independent, hardworking, and steady economic contributors (Trainor et al., 2017). This circulated the perceptions that individuals were personally obligated to attain their own housing, and that ill individuals must follow physicians' orders and perform health-promoting behaviours to return to ideal citizens contributing to the economy (Trainor et al., 2017).

Neoliberalism's focus on individual responsibility generated persisting stigmas inducing discrimination against mentally ill homeless individuals. With hardships in obtaining housing, homeless individuals are often dehumanized and regarded as lazy (Vásquez & Panadero, 2020). Moreover, chronically mentally ill individuals are perceived as both incapable and dangerous due to their constant need for support and deviant behaviour (Trainor et al., 2017). Individuals suffering from substance abuse are cited as possessing a fault in responsibility which translates to emergency departments, where mentally ill homeless individuals are labelled as drug-seekers and under-prescribed (Gilmer & Buccieri, 2020; Trainor et al., 2017). Further, mentally ill homeless individuals continually readmitted to inpatient facilities are treated as defective objects who use healthcare for a place to stay (Gilmer & Buccieri, 2020).

Both becoming homeless and developing a mental illness are associated with a complex interplay of socioeconomic, systemic, and personal factors, such as increasingly scarce and expensive housing, issues with social assistance, and domestic violence (Gaetz et al., 2013; Strobel et al., 2021). Additionally, homelessness and mental illness have a reciprocal relationship. Homeless individuals are more likely to develop mental health issues from social isolation, high levels of daily stress, exposure to trauma from living in unsafe areas, and reliance on self-medicating for health issues (Gilmer & Buccieri, 2020; Munn-Rivard, 2014). Conversely, mental illness may also contribute to homelessness by affecting one's ability to perform daily tasks, maintain an income, and rent property from proprietors who refuse to house mentally ill individuals (Munn-Rivard, 2014). Being both mentally ill and homeless bears an especially arduous burden on individuals since they are forced to make frequent health-compromising decisions. To exemplify, homeless mentally ill individuals may have to choose between medication, food, and rent due to financial constraints, and their compromise may further affect the state of their housing and mental health (CMHA Ontario, 2014).

With the accumulation, accentuation, and complexity of their problems, scientific literature has associated the comorbidity of homelessness and mental illness with additional burdens on the healthcare system, justice system, and public (Gaetz et al., 2013). Annually in Toronto, healthcare costs associated with homelessness range from $52,237 to $66,085 Canadian dollars per individual (Latimer et al., 2017). Moreover, 55.8% of mentally ill homeless individuals have yearly contact with the police (Kouyoumdjian et al., 2019). Mentally ill homeless individuals can also pose a risk to public safety—notably those with mental health conditions that progressed to a severe state—as reflected by the increase of violent acts in Toronto homeless shelters associated with mental health disturbances (Vincent, 2021).

Institutions

Policy legacies produce a financial barrier for mentally ill homeless individuals. The Constitution Act of 1867 denotes that anything of national interest and great expense falls under federal power whilst other matters—such as housing and healthcare—are under provincial rule (Deber, 2018). The Canada Health Act of 1984 distinguishes that medically necessary healthcare services—hospital, physician-provided, and in-hospital dental-surgical services—are publicly funded for citizens with the delivery of healthcare determined by provinces (Deber, 2018). Extended healthcare services include services traditionally considered medical that are not deemed necessary—such as mental health treatment and outpatient pharmaceutical drugs—and are, therefore, not covered publicly (Deber, 2018). Despite having the ability to label additional services as medically necessary to have them publicly covered, no provinces have. These policies, separating housing from mental health, prohibit housing from being covered by health insurance or recommended as a treatment (Martin, 2017). Moreover, the private funding of extended services can render mental health treatment and medication unaffordable for mentally ill homeless individuals, which manifests in a high prevalence of psychiatric comorbidities (Weins et al., 2022).

The federal and provincial governments are prominent institutions that impact the societal barriers regarding healthcare and housing. The growth of egalitarianism in Canada influenced the development of national non-profit alternative housing with live-in support for mentally ill homeless individuals and housing initiatives chiefly for low-income individuals (Trainor et al., 2017). However, with neoliberalism, several of the federal housing initiatives and responsibilities were transferred to the provincial governments and private sector, increasing for-profit supportive housing and establishing housing as an economic matter (Trainor et al., 2017). The re-allocation of community support was slow compared to deinstitutionalization, and the lack of publicly covered community mental health services and supports for societal reintegration—like searching for housing and making doctor appointments—generated financial and functional barriers for mentally ill individuals in obtaining shelter and mental health treatment (Trainor et al., 2017; Vandyk et al., 2013).

Non-profit policy networks providing housing and mental health support to homeless individuals have decreased barriers. The Mental Health Commission of Canada, created in 2007 with endorsement from the federal and provincial governments, recognized the importance of housing for mental health and initiated the five-year project At Home/Chez Soi in five cities, including Toronto, in 2008 (Trainor et al., 2017). This project provided housing to mentally ill homeless individuals without requiring treatment, though optional supportive services were available for residents. With the attainment of secure housing, participants saw improvements in daily functioning and quality of life, and required less healthcare usage (Trainor et al., 2017). Since these findings, the policy network CMHA Ontario (2020), with aid from the Ontario Ministry of Health, has provided 30% of Ontario's supportive housing. This demonstrates how coordinated efforts may be a prospective technique to decrease health inequities for mentally ill homeless individuals.

Interests

Most interests are harmed by this issue regardless if they consider it a priority. Concentrated interests are mentally ill and homeless individuals as well as low-income individuals at risk of becoming homeless or developing a mental illness. Despite being most affected by the associated negative implications, these individuals lack the power to prevent becoming homeless and mentally ill as housing and mental health barriers are structural: mentally ill homeless individuals are more likely to die prematurely, have multiple chronic conditions and comorbid substance abuse issues, and develop mental illnesses severe enough to place public safety at risk (CMHA Ontario, 2020; Reid et al., 2022). Conversely, both the federal and Ontario provincial governments—who represent diffuse interests—have the power to alter societal barriers, but nevertheless, maintain them by preserving mental health as an extended service and housing as an economic matter. The negative health outcomes associated with these barriers impact governments by contributing to high economic, legal, and social costs

(CMHA Ontario, 2020; Martin, 2017). For instance, the annual national economic cost for homelessness is around $7.05 billion Canadian dollars, and the average monthly provincial fees for homelessness are $10,900, $4,333, and $1,932 Canadian dollars for hospitals, provincial jails, and homeless shelters, respectively (Gaetz et al., 2013).

Players within the healthcare and housing sectors represent both diffuse and concentrated interests. Individuals who build, sell, and rent real estate–diffuse interests due to their involvement through housing–benefit from the housing market's privatization and scarce real estate; privatization enables power and control over housing production and capital, and increased demand provides more monetary gains through competition (Deber, 2018; Rosa, 2018). Conversely, hospitals–who are primarily diffuse interest–are negatively impacted by this issue due to its burden on their resources; mentally ill homeless individuals consistently rank in the top 5% to 10% of healthcare users and disproportionately occupy hospital beds (CMHA Ontario, 2020; Weins et al., 2021; Weins et al., 2022). Some hospitals are becoming concentrated interests by combining both silos: the University Health Network (University Health Network [UHN], 2021) will provide housing and healthcare to homeless individuals with support from the City of Toronto and United Way Greater Toronto and is prospected to benefit with less healthcare burden and funding from having homeless individuals reside in its housing. Additionally, mentally ill homeless individuals are foreseen to have improved life quality with support and fewer financial and structural barriers (UHN; 2021). This illustrates how integrating the housing and mental health sector may enable cheaper and more efficient solutions by recognizing and targeting the complex connection between mental illness and homelessness. Moreover, this supports that representing the values and needs of the concentrated interests, specifically those most affected, can benefit all parties involved.

Conclusion

The disproportionate health inequities that mentally ill homeless individuals face contribute to discrimination, structural barriers, and worse health outcomes. These consequences highlight the need for increased efforts to address disparities afflicting this vulnerable population. Research establishes that publicly funded community-level support lessens the individual, healthcare, and economic burdens associated with this concern; however, this solution only serves to treat the consequences of being mentally ill and homeless and, by neglecting to address its roots, likely will not lower the overall prevalence of the issue and its associated negative outcomes (Trainor et al., 2017). Analysis with the "3-I" framework suggests that involving and reflecting the ideas and values of all stakeholders–particularly concentrated interests–in institutions with power can reap the most benefits. This may be related to how many of the negative consequences associated with mentally ill homeless individuals are due to the formation and maintenance of the population. Consequently, preventing the development of both mental illness and homelessness could lower the prevalence of mentally ill homeless individuals and the issue's negative impacts on affected individuals, communities, and societal systems.

The challenge, however, is that both housing and mental illness currently rely on private funding to achieve resolution. The embedded neoliberalism in this issue's "3-Is" makes it unlikely that privatized sectors will deviate from their financialized mindset and execute actions aligning with a more welfare ideology. Consequently, a viable action is for the Ontario government, an institution whose interests involve its citizens' well-being and values, to make this issue public by transitioning mental health services into a medically necessary service and including housing as a health matter–placing mental health and housing in the same silo—for accessible and affordable mental health treatment and safe, stable housing.

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Indigenous Childhood Obesity in Canada

Mei Timpson

Childhood obesity describes youth 18 years old and younger with an extreme body fat percentage compared to what is considered healthy for their age and sex group (World Health Organization [WHO], 2021). Childhood obesity has been an epidemic in Canada, especially among Indigenous youth: in 2005, 11.7% of Canadians 5 to 17 years old were obese, compared to 20% of off-reserve Canadian Indigenous youth (Bhawra et al., 2015). Increased childhood obesity has resulted in traditionally adult chronic diseases and their associated health conditions commencing in youth, which has significant implications on the Canadian healthcare system and economy, as well as the quality of life and health outcomes of future Canadian generations (Public Health Agency of Canada [PHAC], 2011). Obesity increases the risk of chronic health conditions, notably type two diabetes, high blood pressure, cardiovascular disease, breathing difficulties, bone and balance issues, and certain types of cancer (Government of Canada, n.d.; National Aboriginal Health Organization [NAHO], 2012). Moreover, obesity contributes to approximately 66,000 annual Canadian mortalities, and 12% of Canada's healthcare costs (Lytvyak et al., 2022; Shentow-Bewsh & Zuberi, 2018). Indigenous populations have more obesity-related chronic diseases and a disproportionately lower life expectancy compared to non-Indigenous Canadians, which can be tied to their colonial history and prevalent societal inequities (Bartfay & Bartfay, 2020; Willows et al., 2012). This report synthesizes and critiques surveillance and epidemiological data regarding obesity among Canadian Indigenous youth and critically analyzes public health strategies and interventions attempting to combat this public health crisis.

Definitions

Surveillance—the systematic collection, examination, and dissemination of the distributions of health-related components—plays an essential role in informing and evaluating public health research and implementations (Bartfay & Bartfay, 2020; Rao et al., 2016). Epidemiology measures additional factors that may contribute to or be associated with the health-related component being surveyed, such as the characteristics of individuals, environments, and times when and where the component is most concentrated (Bartfay & Bartfay, 2020). A common technique utilized in obesity surveillance is body mass index (BMI), which divides an individual's weight in kilograms by their height in meters squared (kg/m2) to determine if their body mass is at a healthy level (WHO, 2021). BMI levels—such as underweight, healthy, overweight, and obese—for those 18 years old and older are determined by a standardized cut-off score, whilst, for those under 18 years old, BMI levels are specific for each age group to take into account childhood developmental changes (WHO, 2021). Nevertheless, BMI is created with standardized population trends on weight and height and may not reflect specific community health tendencies, such as the health of a remote Indigenous community (Centers for Disease Control and Prevention [CDC], n.d.). Moreover, BMI neglects other covariates' contribution to weight and height, such as muscle mass, meaning BMI may not be representative of an individual's actual health status (CDC, n.d.; WHO, 2021).

Bartfay and Bartfay (2020) define Canadian Indigenous as the original inhabitants of Canada. In Canada, there are three primary Indigenous populations: the Inuit, First Nations, and Métis (Bartfay & Bartfay, 2020). First Nations include all Canadians—both status and non-status—recognized as descendants of the initial inhabitants of Canada (Bartfay & Bartfay, 2020). Inuit primarily reside in Canada's Arctic and Northern regions and are distinct from their Thule ancestry (Bartfay & Bartfay, 2020). Indigenous individuals with mixed European and Indigenous ancestry are regarded as Métis (Bartfay & Bartfay, 2020).

Discussion

There is a lack of recent surveillance on childhood obesity in Canada. Based on an analysis of self-report data from national surveys conducted in 2014 and beforehand, the Public Health Agency of Canada found that childhood obesity is increasing both with time and age (Rao et al., 2016). Compared to one-fourth of children in 1978, one-third of children in 2014 were overweight and obese (Rao et al., 2016). Moreover, the prevalence of obesity increased by 5.3% between the age groups of 10 to 15 years old and 15 to 17 years old, and boys had higher rates of being obese and overweight than girls (Rao et al., 2016). As Rao et al. (2016) found prevalence rates to be relatively stable, the prevalence of childhood obesity in 2014 may be comparable to the current rates. However, this assumption should be taken lightly, considering the sedentary nature of the COVID-19 pandemic.

Similarly to national data, there is an absence of recent surveillance on Canada's Indigenous childhood obesity rates. A 2017 study systematically reviewed articles from the past three to four decades that used BMI to describe the trends of Indigenous obesity in Canada (Kolahdooz et al., 2017). Studies were screened, requiring all participants to be healthy and representative of the population, and excluding studies containing unreliable, unrepresentative, and duplicate data (Kolahdooz et al., 2017). After the screening, there were no studies involving data regarding the prevalence of obese and overweight Métis children (Kolahdooz et al., 2017). Overall, the prevalence of obesity among Indigenous youth increased from 25% to 26.5% between 2000 and 2005 and, unlike the national trend, obesity was more prevalent among girls than boys (Kolahdooz et al., 2017). Inuit children had the highest prevalence of being overweight, while First Nations children had the highest rates of being obese (Kolahdooz et al., 2017). However, Kolahdooz et al. (2017) found that Métis adults had the highest prevalence of obesity and being overweight. This may reflect that Métis children may have higher overweight and obesity rates than Inuit and First Nations children, respectively, and, consequently, that the calculated rate of obese and overweight Indigenous children may be an underestimation of the true prevalence due to the exclusion of Métis children

(Kolahdooz et al., 2017). It is also important to note that all studies utilized in Kolahdooz et al.'s (2017) meta-analysis employed internationally standardized BMI levels, meaning that obesity measurements may have not been reflective of the actual health trends in Canadian Indigenous youth.

As there is a dose-response relationship between increased weight and health complications and comorbidities, children who are obese have a higher risk of developing mental and physical health conditions than their overweight and normal BMI counterparts (Halfon et al., 2013). Consequently, the disproportionately higher presence of overweight and obese children in Indigenous populations places Indigenous children at an inequitable propensity for negative health outcomes. This illuminates the gravity of determining the etiology of Indigenous childhood obesity in Canada and its viable interventions.

The etiology of childhood obesity in Indigenous populations can be described with an ecological model, which describes the complex interplay between individual, interpersonal, and sociocultural environmental factors (NAHO, 2012; Willows et al., 2012). Individual factors include biology, early life events, and psychology; interpersonal factors consist of family and community practices; sociocultural environmental factors reflect socioeconomic, environmental, political, and historical components (NAHO, 2012; Willows et al., 2012). Surveillance on this issue's etiology found that Indigenous children are burdened by unique risk factors related to colonization (NAHO, 2012; Willows et al., 2012). During colonization, Indigenous individuals were displaced from traditional lands onto reserves, which created barriers to participating in traditional activities, and geographically isolated them from services promoting health—such as accessible food markets and hospitals (NAHO, 2012; Willows et al., 2012). This influenced more sedentary lifestyles and substituted traditional, nutrition-dense foods with non-nutrition-dense foods (NAHO, 2012; Willows et al., 2012). Moreover, the Canadian government promoted and funded the residential school system between the 1800s and 1900s, removing Indigenous children from their families and displacing them into isolated schools run by Jesuit missionaries for assimilation purposes, which included attempts to condition children to be embarrassed and repulsed by their heritage (Bartfay & Bartfay, 2020). Being related to someone who attended a residential school increases the risk of obesity, as intergenerational trauma related to unhealthy eating habits from residential schools persists in parenting styles (Bartfay & Bartfay, 2020; Willows et al., 2012).

Colonial policies and geographic isolation resulted in lasting socioeconomic disparities associated with obesity, such as worse education, overcrowded housing, chronic impoverishment, and high levels of food insecurity in Indigenous populations (Bhawra et al., 2017; Willows et al., 2012). Chronic impoverishment and food insecurity—an indicator of available nutrient-sufficient food—are significant risk factors for obesity: 19.2% of low food security and 44% of the most impoverished Indigenous children are overweight or obese (Bhawra et al., 2017). Obesity also contributes to worse health outcomes: 50% of Indigenous youth at a high risk of diabetes are overweight or obese, with 8.3% having a metabolic syndrome (Ronsley et al., 2013). This is worrisome, as Indigenous youth are two to six times more likely to have type two diabetes than the general population, another disparity associated with their colonial history and pervasive socioeconomic inequities (Ronsley et al., 2013).

Stakeholders—involved parties—are essential for effective interventions, as they determine the ability for an intervention to occur (Bartfay & Bartfay, 2020). Stakeholders with power who are representative of target populations—such as Indigenous health organizations—can implement suitable interventions focusing on the roots of an issue and gain the trust and receptivity of the target population (Bartfay & Bartfay, 2020). While community-run interventions may be catered, they may be difficult to maintain long-term without funding, which illustrates the importance of partnerships (Bartfay & Bartfay, 2020). National and provincial governments—who are influential stakeholders with the funds and power to make widespread interventions—have not yet implemented effective public health strategies regarding Indigenous childhood obesity despite their recognition of the problem (PHAC, 2011). Towns et al.'s (2014) systematic review of recent Indigenous childhood obesity public health interventions found only seven initiatives targeting this issue, most being partnerships between researchers and Indigenous communities and none resulting in long-term impacts on obesity rates. One of these seven interventions was the 2004 to 2005's Study of Health Assessment and Risk Evaluation in Indigenous Peoples (SHARE-AP ACTION), which sought to decrease sedentary behaviour and unhealthy food intake in Indigenous populations whilst simultaneously increasing the population's water ingestion and physical activity (Anand et al., 2007; Towns et al., 2014). Researchers implemented household interventions for six months, providing families with Indigenous dietary and fitness counsellors, drinkable water, child physical activity programs, and education about healthy lifestyles (Anand et al., 2007; Towns et al., 2014). There were no statistically significant differences in physical measurements, physical activity, or nutrition between the intervention and control groups; however, Anand et al. (2007) stated that there were small, promising changes, with children reporting a better understanding of healthy diets and families being more physically active, and suggested that these household programs may be effective if implemented long-term alongside interventions at the structural level (Towns et al., 2014).

While the interventions provided valuable advice and information about healthy lifestyles to Indigenous families, they did not target social determinants and intrinsic motivation barriers to participating in healthier behaviours (Anand et al., 2007). Children were found unable to participate in physical activity after-school programs despite encouragement because parents were unwilling to drive them (Anand et al., 2007). Additionally, there was a lack of utilization of walking trails because of their far proximity to individuals' homes (Anand et al., 2007). Fruits and vegetables were not readily available or affordable on reserves and had a short shelf-life, providing barriers to their consumption (Anand et al., 2007). The involvement of political stakeholders—such as the government or a powerful non-profit—could help effectively target these barriers through funding and long-term efforts, especially if they collaborate with individuals or organizations in the community who can create and cater programs. For example, political stakeholders could increase the availability of, and provide subsidies for, fruit and vegetables and build more walkable areas in tandem with individualized Indigenous health counselling, which could tackle micro-, meso-, and macro-level disparities.

One of the more effective interventions—not included in the 2014 meta-analysis—involved Healthy Buddies TM, a common Canadian school-wide intervention that targets physical activity, healthy eating, and healthy body image in children (Ronsley et al., 2013; Towns et al., 2014). This program was created with the consideration that child public health programs may be more effective when implemented at school, as children spend a considerable amount of time there (Ronsley et al., 2013). In Healthy Buddies TM, older students are taught health-related lessons by teachers and are later instructed to reteach these lessons to younger students (Ronsley et al., 2013). Lessons involve raising awareness about what contributes to health—such as social media, environment, and nutrition—and participation in physical activities (Ronsley et al., 2013). In 2013, a collaboration between the University of British Columbia and three Indigenous communities implemented a catered First Nations Healthy Buddies TM program in two Indigenous schools and compared outcomes to an Indigenous school without the program (Ronsley et al., 2013). Waist circumference, obesity, and blood pressure levels significantly decreased in children who attended schools with the program while all significantly increased in the control group (Ronsley et al., 2013). Moreover, students' self-rated self-esteem, body image, and food knowledge improved after the implementation of the program (Ronsley et al., 2013).

What may have contributed to this program's effectiveness is that the implementers were teachers and students. This meant that community members were directly involved—thereby increasing individual participation and social cohesion—and that additional workers and funding were not needed (Ronsley et al., 2013). Furthermore, the cultural relevance of the program ensured that participants were educated on topics relevant to them (Ronsley et al., 2013). However, this program primarily focused on individual behaviours and neglected that an individual's background circumstances influence the feasibility and acceptability of behaviours. For example, children may be taught about nutritious food, but are unable to consume it at home due to impoverishment. This program also failed to tackle the complexity of the contributors to Indigenous childhood obesity, like intergenerational trauma (Willows et al., 2012). To combat this issue long-term, more than just education is needed: interventions targeting all levels of the ecological model are necessary (NAHO, 2012). In particular, implementations should involve catered community-based approaches and the re-establishment of traditions to target the unique Indigenous colonial legacies and societal disparities (NAHO, 2012).

Conclusion

Despite the recognition that childhood obesity rates in Indigenous communities are disproportionately high, there is a lack of recent surveillance and epidemiology on this issue (PHAC, 2011). This may be responsible for this topic's limited research, interventions, and policies. Due to the complexity and longevity of the disparities linked to Indigenous childhood obesity, interventions that target the root causes—such as colonial policies and geographic isolation—are necessary, which may require government partnerships and political changes (NAHO, 2012). However, to investigate the most effective interventions for certain communities, the first step is increasing surveillance and epidemiology to determine the distributions of and main contributors to the childhood obesity epidemic among Canadian Indigenous youth.

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Health Perspectives

SECTION 3

Going Global: Current Health Concerns from Around the World

The Political Economic Perspective on Improving New York City Air Quality and Health in the Lower East Side and Chinatown Through Green Space

Analyzing the Impacts of Criminalization of Same-Sex Relations on HIV risk in Uganda for Men Who Have Sex with Men (MSM)

Global Health and Climate Change: A Front for Neocolonialism

Navigating the HIV Epidemic in Malawi’s Female Sex Workers: A Country Profile

The Political Economic Perspective on Improving Air Quality and Health in the New York City Lower East Side and Chinatown Through Green Space

Eileen Murray

Outdoor air pollution is considered one of the "greatest environmental risk[s] to health" due to dangerous pollutants, such as ozone PM2.5, which stands for particulate matter and is made of a variety of components such as sodium chloride, sulphates, black carbon, and nitrates (World Health Organization, 2021). These pollutants such as PM2.5 are produced by various sources, such as motor vehicles, industry and transportation, and for this reason, pollutants such as PM2.5 particularly affects urban areas (World Health Organization, 2021; Southerland et al., 2022). Pollutants like PM2.5 are heavily associated with adverse health outcomes such as stroke, heart disease, lung cancer, and asthma, which are estimated to contribute to about 4.2 million premature deaths worldwide (World Health Organization, 2021).

Many cities globally, such as New York City (NYC), have addressed the amount of PM2.5 pollutants through air pollution control and monitoring, and the city has managed to lower air pollutants by 40% over the past twenty years (Misdary, 2022). Yet, the issue of air pollution continues to negatively affect New Yorkers and their health outcomes especially for New Yorkers who live near major transportation hubs (Misdary, 2022). In particular, residents of the Lower East Side (LES) and Chinatown neighbourhoods, who are located near the Franklin Delano Roosevelt East River Drive, are among the vulnerable New Yorkers to the adverse health outcomes associated with air pollution (Gessen, 2021; Misdary, 2022; NYC Health, 2018; NYC Health & Environment, n.d)

Now, this begs the question; why and how are certain New Yorkers in neighbourhoods such as the LES and Chinatown, more vulnerable to air pollution and its negative health outcomes? The political-economic perspective of health could be used examine and understand the factors that lead to the persistence of this problem, particularly within the gentrifying neighbourhoods of the LES and Chinatown, which have historically been referred to as "slums" due to the poor built environments inhabited by low-income populations (Gilbert, 2007; deNoyelles, 2020; NYC Health, 2018). For reference, the political-economic perspective of health seeks to understand how current and historical economic, political, and social factors influence health outcomes (Minkler et al., 1994). By using the political-economic perspective of health, we can begin to understand why the poor health outcomes due to air pollution persist in LES and Chinatown by understanding the present and historical contexts within which the neighbourhoods exist.

Political-Economic Perspective: Historical Context on Health

As mentioned previously, the political-economic perspective of health is how present and historical social, economic, and political-economic factors influence health outcomes (Minkler et al., 1994). When we consider the political-economic perspective of health, it is essential that we review how the intersection of historical policies and socioeconomic status has led to the issues of poor air quality, poor health, and premature deaths within these neighbourhoods. During the late 1800s and early 1900s, when the LES and Chinatown were considered slums. There were efforts by urban reformers such as Jacob Riis to shape the built environment to improve health outcomes, particularly through the implementation of small parks and improvements to housing (deNoyelles, 2020). However, it should be noted that during this era, improving health outcomes through the physical environment was heavily associated with "improving morality" (deNoyelles, 2020). Essentially "improving morality" and the built environment in this era was associated with the assimilation to White Anglo-Saxon Protestant middle-class American values, that meaning they wanted low-income and marginalized communities to completely conform to the values of the ruling-class (deNoyelles, 2020). By the 1920s, the city was facing a traffic congestion issue, and urban planners at the time believed the creation of a waterfront highway could alleviate this issue (Gutfreund, 1995).

Additionally, urban planners believed a highway could "revitalize" or "improve" the LES and Chinatown, which was still dominated by tenement housing, and sits near the current location of this proposed highway (Gutfreund, 1995). This would lead to the creation of the Franklin Delano Roosevelt (FDR) East River Drive, or more commonly referred to as the FDR Drive, in the 1950s (Gutfreund, 1995). To create this highway, tenements, which is a type of apartment building that has a negative connotation to it in NYC due to its deteriorated and neglected nature, were destroyed, and later replaced with public housing for low-income residents (Gutfreund, 1995; Nigro, 2018; Rauscher, 2017). However, these public housing units were placed near a significant pollutant source, the FDR Drive, in an area with very few parks (Rauscher, 2017; East River Park Action, n.d.; NYC Parks, n.d.).

However, one major park, the John V. Lindsay East River Park, also commonly referred to as the East River Park, was created during this period in an attempt to offset the pollutants generated (NYC Parks, n.d.). Unfortunately, around the same time, there was a mass exodus of middle-class white residents from the city to the suburbs, this exodus is known as White Flight (Lopez, 2012). The White Flight led to disinvestment in various social services such as housing, parks, and schools, as cities could not generate the tax revenues to maintain or improve these (Lopez, 2012). Additionally, those who remained in cities were from low-income and marginalized populations (Lopez, 2012). This all culminated in urban renewal efforts to reshape cities as cities were seen as they were now seen in a deeply negative light (Lopez, 2012). As it relates to this topic, American urban renewal was focused on creating car-centric cities, which is detrimental as it brings in more pollutants like PM2.5 into cities, which is known to negatively affect health.

These histories of the reshaping of the built environment and its adverse impacts on low-income populations, such as the placement of a major pollutant source, have led to the current situation of the LES and Chinatown. These neighbourhoods experience higher than average city levels of PM2.5, which is often produced from vehicular traffic, and this has led to higher rates of air pollution related illnesses in these neighbourhoods (NYC Health & Environment, n.d.; NYC Health, 2018; World Health Organization, 2021). As discussed in the political-economic framework of health, the policies and social and economic factors have significantly impacted the physical environment of the LES and Chinatown, and this has affected the health outcomes of the neighbourhood as it relates to outdoor air pollution.

Political-Economic Perspective: Present Context on Health

The historical social, economic, and political factors, as discussed from a political-economic perspective, continue to influence present-day health outcomes of the LES and Chinatown (Minkler et al., 1994). Historically these neighbourhoods, the LES and Chinatown, were considered slums, thus resulting in the lack of careful planning for these neighbourhoods (deNoyelles, 2020; Rauscher, 2017). As these neighbourhoods have been and continue to be home to low-income populations, this has resulted in various attempts to reshape the built environment neighbourhood to fit different agendas (deNoyelles, 2020; Gutfreund, 1995; Lopez, 2012). However, the issue of the lack of greenspace in the neighbourhood and the fact that public housing is near a major pollutant source remains an issue (Census Reporter, 2020; deNoyelles, 2017; East River Park Action, n.d; Rauscher, 2017). The lack of greenspace within these neighbourhoods, which is associated with an improvement in air quality, has especially negatively affected long-term low-income residents (NYC Health, 2018; Zhu et al., 2017). Low-income residents more likely to experience the effects of long-term exposure, such as lung cancer or premature death due to pollutants like PM2.5, which is often generated from highways (NYC Health, 2018; Southerland et al., 2022; World Health Organization, 2021). They are more likely to experience these effects as they are less likely to have the means to move to a better location or access healthcare resources that could address adverse health outcomes like asthma (Bruce et al., 2021; Hajat et al., 2015).

Presently, air pollution and its adverse health outcomes persist within the neighbourhood. However, it is essential to mention that the demographics of the LES and Chinatown are shifting, as it is one of seventeen neighbourhoods undergoing gentrification (NYC Health, 2018). Gentrification is best described as the process by which a neighbourhood's socioeconomic makeup changes as wealthier residents move in. It is often associated with adverse outcomes for long-term low-income residents, such as displacement (NYC Health, 2018; Urban Displacement Project, n.d.). In the context of the LES and Chinatown, these long-term low-income residents experience the burden of long-term exposure to pollutants, and additionally, they lack resources to move or access adequate healthcare resources (Bruce et al., 2021; Hajat et al., 2015; NYC Health, 2018). Additionally, when gentrification occurs, there is often an interest on the part of the government and other local actors to invest in the neighbourhood to appeal to wealthier, “desirable residents’’ whilst displacing low-income residents (Oscilowicz et al., 2022; Urban Displacement Project, n.d)

There is a global trend to generally improve various aspects of cities such as mitigating air pollution through the creation of, or improvement of green spaces (Zhu et al., 2017). Green spaces can provide a natural filter for harmful air pollutants and a place for the neighbourhood (Oscilowitz et al., 2022; Zhu et al., 2017). As previously mentioned, there is only one major source of greenspace near the LES and Chinatown, the East River Park by the FDR Drive (NYC Parks, n.d.). However, following extreme flooding during Hurricane Sandy in the neighbourhoods, a flood resiliency plan, the East Side Coastal Resiliency Project (ESCR), was developed (Gessen, 2021). There was some support for the initial plans of the design and goals ESCR as flooding is a genuine issue, and the park needs to be updated to prove co-benefits such as improved air quality (Bruce et al., 2021; East River Park Action, 2021; Gessen, 2021; Pedraza, 2021).

However, the initial goals and the designs have changed, leaving many residents concerned that the intentions driving this plan may not be as they originally appeared (East River Park Action, 2021; Gessen, 2021; Pedraza, 2021). For example, residents are confused as to why the park is cutting down over a thousand mature trees that could offset air pollutants, or why artificial turf is being used in parts of the plan, as that can’t absorb flood waters (Bruce et al., 2021; East River Park Action, 2021). Other residents mentioned concerns about the park’s closure such as that it could disproportionately affects the low-income residents, who live near the highway and park (Bruce et al., 2021;Gessen, 2021; Pedraza, 2021). These residents would be be less likely to have the means to move away, or access other green spaces, and therefore be more affected by negative health outcomes associated with air pollution (Bruce et al., 2021; Hajat et al., 2015; East River Park Action, n.d.). Additionally, residents have criticized the plan for not fully engaging the community and their concerns around gentrification and the further proliferation of poor air quality with the closure of the park (East River Park Action, n.d.; Gessen, 2021; Pedraza, 2021). This has led to speculation of some that the improvement of the park may be for gentrification and not for improving their health, especially as greenspace is associated with increases in property values and, therefore, rent (Anguelovski et al., 2022; Gessen, 2021). For these reasons, it is critical to examine from the political-economic perspective how gentrification, green space, and poor air quality influence adverse health outcomes in the LES and Chinatown.

In the context of the LES and Chinatown’s adverse health outcomes due to air pollution, the political-economic perspective has been crucial to understanding this issue. The political-economic perspective looks at the intersectionality of economic, social, and political powers and the influence they have on the health outcomes of a population (Minkler et al., 1994). It is clear that the lack of political and economic power of the long-term low-income residents to influence their own built environments of the LES and Chinatown as a result of their social status has negatively impacted them historically and could potentially continue to do so through gentrification.

Conclusion: Improving Air Quality and Health

Similar to other low-income urban areas throughout the globe, the LES and Chinatown are disproportionately burdened by air pollutants like PM2.5, which leads to adverse health outcomes like lung cancer, asthma, and heart disease (World Health Organization, 2021; NYC Health & Environment, n.d.; NYC Health, 2018). Through the political-economic framework of health, we can better understand why these neighbourhoods are burdened with poor air quality and these health issues. The political-economic perspective's emphasis on understanding the interplay of historical and present social, economic, and political factors that influence health allows us to better understand health issues in the LES and Chinatown. From the political-economic perspective, it becomes evident how the historic designation of the LES and Chinatown as a slum due to its high low-income populations led to the construction of a poor built environment (deNoyelles, 2020; Minkler et al., 1994; Lopez, 2012). Additionally, the lack of power held by low-income residents due to their socioeconomic status has led to the inclusion of a major highway near public housing and the lack of green space that has negatively contributed to the built environment (NYC by the numbers, 2021; deNoyelles, 2020; Gutfreund, 1995; Lopez, 2012).

In recent years, globally, there has been an emphasis on using and improving green space within the neighbourhood to improve air quality, health outcomes, and other issues such as flooding within cities (DePriest et al., 2019; Oscilowitz et al., 2022; Zhu et al., 2017). In the context of NYC, many have questioned the intentions behind the ESCR plan (Bruce et al., 2021; Gessen, 2021). Many residents are concerned the motivation of the city to improve the neighbourhood is for the purposes of gentrification of low-income communities and it attracting wealthier and more "desirable" residents (Gessen, 2021; Urban Displacement Project, n.d.). From the political-economic perspective, we can see that the economic and social disparities have a role in government investments in improving health outcomes such as outdoor air pollution and its related adverse health outcomes within communities such as the LES and Chinatown. While many residents support improving parks like the East River Park so that they can improve their flood resiliency and health through the reduction of air pollution in the neighbourhood, many are calling for a better plan that centres on the improvement of health outcomes for all (East River Park Action, n.d.; Gessen, 2021).

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Analyzing the Impacts of Criminalization of Same-Sex Relations on HIV risk in Uganda for Men Who Have Sex with Men (MSM)

Lauren Omoto

The HIV epidemic in Africa has disproportionately impacted key populations of people, one of which is men who have sex with men (MSM). However, most of the existing research surrounding the risk factors within this population scrutinizes only individual-level, rather than structural-level elements, that perpetuate the epidemic. One such element that has come to fruition in recent research is the criminalization of same-sex practices, specifically in Uganda; prohibition of same-sex practices under the 1950 Penal Code and continuity of anti-LGBT legislation in recent years severely criminalizes non-heterosexual interactions, evidently targeting MSM (Human Dignity Trust, 2022). Understanding the translation of legal infrastructure into homophobic social stigmatization of MSM is vital in grasping the complexity of the HIV epidemic. This paper highlights the detrimental impacts of criminalizing same-sex practices on the Ugandan MSM community and demonstrate how they integrate with macro and micro-level factors to fuel HIV spread. The criminalization of same-sex practices in Uganda exacerbates the HIV risk for MSM because it reinforces the social stigma against this population. Specifically, it deters MSM from seeking HIV-related healthcare, fosters educational and occupational discrimination against MSM, and causes frequent migration of MSM. The relationship between these factors with increased HIV risk will be further discussed with evidence from existing literature.

Current Literature

A critical component and barrier in the HIV epidemic is access to appropriate healthcare interventions, given the stigma that exists among Ugandan healthcare workers towards MSM. Many MSM in qualitative studies have reported a lack of trust in healthcare workers due to their potential to report same-sex practices to authorities (Musinguzi et al., 2015). Thus, in order to protect themselves from criminal persecution, MSM refrain from engaging in practices that risk visits to a health practitioner, however, increase their HIV risk (Musinguzi et al, 2015). For instance, many MSM will refrain from condom use for fear of the condom remaining stuck in the partner or from injuries associated with condom use, including bleeding and tearing, as these would result in the exposure of their sexual status to healthcare providers (Musinguzi et al., 2015; Nakiganda et al., 2021). Intercourse without a condom is identified as a major risk factor for HIV, however, many MSM believe that the risk of criminal prosecution outweighs the HIV risk and continue to refrain from condom use (Musinguzi et al., 2015). To confirm if healthcare workers upheld homophobic views, Matvou et al. (2019) surveyed Ugandan healthcare workers, coming to the consensus that they would be extremely uncomfortable treating MSM, justifying the uncertainties of this population. Many of the next steps outlined in the cited literature pertain to finding the availability of "safe-haven" clinics for MSM in Uganda. Apart from the Men's Sexual Health and Rights (SHARP) initiative, little information can be found surrounding this topic, elucidating the widespread impact that criminalization of the MSM community has in driving the epidemic (United Nations Office for the Coordination of Humanitarian Affairs, 2015).

Similar literature surrounding stigmatization faced by MSM in Uganda also notes the prevalence of occupational and educational discrimination against this key population. A study by King et al. (2013) analyzed workplace discrimination faced by MSM in Kampala, Uganda in light of the continued criminalization of same-sex relations. It was found that a majority of MSM included in the study reported not only within-workplace stigmatization for their sexuality but also repeated dismissal from their places of employment and education if outed (King et al., 2013). Upon further research to build on this existing literature, no anti-discriminatory workplace laws can be found protecting MSM due to the criminalization of same-sex practices (Equaldex,

2022). Thus, MSM are often rendered unemployed or experience abuse in the workplace along with insufficient education compared to counterparts outside of the key population; this is due to social stigmas and criminalization that hinder their involvement in society (Stonewall, 2019).

Given the lack of resources within Uganda to protect and support MSM, members of this population are often left with few choices when outed if they wish to evade criminalization and societal discrimination. Past studies have found that this causes frequent migration of MSM, whether this be forced migration against their will or preferential to protect their safety (Scheibe et al., 2014). Experiences of blackmailing and harassment often force the migration of MSM from their current place of residence to neighbouring towns, cities, or countries (Scheibe et al., 2014). There have been many recorded incidences of eviction of MSM from residences and communities due to their social stigma, forcing relocation (Scheibe et al., 2014). It is important to build upon this literature and note that the passing of anti-homosexuality legislation in Uganda increases homelessness, unemployment, and reinforces MSM in their lower hierarchal status (Amnesty International, 2014). Many subsequent acts prevent landlords from renting homes to MSM individuals, continuously reinforcing the stigma and causing these individuals to uproot their lives (Amnesty International, 2014).

Analysis

After scrutinizing the existing literature and conducting further research surrounding social discrimination of MSM stemming from their criminalization, it is important to analyze the factors related to the HIV epidemic. First, the avoidance and fear of healthcare by MSM proves to be detrimental in increasing not only HIV risk, but also potentially the severity of the disorder. The research by Musinguzi et al. (2015) focused on the avoidance of condom use based on these fears, which evidently would heighten HIV risk, however, this issue spans beyond condom use.

Necessary HIV interventions and testing often need to be conducted promptly to control spread and symptoms; with persistent fears of healthcare administrators, MSM are less likely to obtain vital treatment, including pre-exposure prophylaxis (PrEP) and antiretroviral therapy (ART), and know their HIV status (Musinguzi et al., 2015). The downstream impacts of criminalization are at play here, where MSM experience institutional-based discrimination in a heteronormative society and develop a negative association with healthcare.

The anti-MSM legislature has also fuelled homophobia within healthcare providers, further damaging the relationship between MSM and healthcare workers and worsening the epidemic within the population (Matvou et al., 2019). While revoking anti-homosexual legislature might not be effective in immediately ameliorating homophobic views of healthcare workers, proper training programs and education surrounding MSM could be utilized to reduce discomfort, along with potential safe-haven clinics such as Doctors of the World (Doctors of the World, 2019).

Similarly, King et al. (2013) elucidated incidences where MSM in Uganda were discriminated against in educational and occupational settings, frequently being denied and dismissed from job opportunities. With a lack of education and formal job availability due to anti-homosexuality laws, many MSM will turn to unsafe practices, including commercial sex work, for a liveable income (Kuchu Times, 2018). Members of this key population become economically vulnerable, have more sexual partners, and have a higher probability of engaging in unprotected sex, all of which are high HIV risk factors (King et al., 2013). An outlook that was not considered in recent literature was coping mechanisms used by MSM for the added social and economic stress; many might turn to high-risk behaviours, including injected drugs, to cope with constant discrimination, another significant HIV risk factor (Agardh et al., 2016). Thus, criminalization of same-sex practices in Uganda can open many doors within the MSM community to detrimental risk factors, many of which have yet to be considered to a high extent in current literature.

Finally, the criminalization of same-sex practices in Uganda has influenced many MSM to uproot their current lives and migrate elsewhere to prevent prosecution, belittling, and discrimination. Actions so simple as renting out living space and leading a normal life become nearly impossible for those in the community who are outed; MSM are constantly at risk of eviction or are compelled to migrate as a result (Scheibe et al., 2014). With constant migration, not only are MSM depleting their financial resources, but also potentially face an increasing number of sexual partners and inconsistent access to HIV treatment (UNAIDS, 2014). If MSM are unaware of their HIV status and migrating, they are unknowingly transmitting HIV to the areas they migrate, intensifying the epidemic within and possibly beyond Uganda.

Conclusion

Overall, the subsequent impacts of Uganda's criminalization of same-sex relations have been nothing short of calamitous for MSM, especially as a key population in the HIV epidemic. Based on available literature and elaboration of presented ideas, criminalization insinuates and reinforces homophobic stigmas that target MSM and greatly reduce their ability to be accepted into society. Not only has it been found that MSM would risk contracting HIV over having healthcare practitioners discover their sexual orientation, but also that healthcare workers actively deny MSM treatment (Matvou et al., 2019). The laws have effectively translated into healthcare practices, forcing MSM to choose between sacrificing their health or their criminal record, a choice no innocent individual should have to make. The importance of safe-haven clinics remains vital to further study in Uganda. Discrimination on an institutional level remains an issue stemming from criminalization, increasing the likelihood of high-risk HIV behaviours by MSM as a result of employment and educational denial. Finally, MSM often undergo constant migration to evade prosecution and discriminatory action against them, forcing many to lead "double lives" to protect their identity at the cost of high HIV transmission. In summary, the criminalization of same-sex practices on a governmental scale inflicts prejudice on MSM at successive levels of society that multiply the HIV risk factors already present in the population. To effectively eradicate harmful ideologies targeting MSM, immense institutional and societal reform on each impacted level must be enforced, starting with the decriminalization of same-sex practices.

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Global Health and Climate Change: A Front for Neocolonialism

William Wynne

The planet currently is in the grip of two major, ongoing crises: poverty and climate change. Almost half of the world's population, primarily in the Global South, live on less than US$5.50 a day, while 10% live in extreme poverty (Development Initiatives, 2021). Reducing poverty has emerged as one of the main objectives of global health, with efforts to increase economic development within these regions. However, the notion that the goal of global health is to increase the health of marginalized groups through economic development is false and must be dispelled. Despite global health seeming to have good intentions, it has emerged as a tool to legitimize neocolonialism. The institutions that guide and determine global health policy use the notion of improving health outcomes for the marginalized as legitimacy for their economic exploitation in the Global South. This economic exploitation justified by global health initiatives increases greenhouse gas emissions and exacerbates climate change. Citizens from around the world but especially in the Global South must suffer and face worse health outcomes as a result of climate change. Therefore, the very citizens global health aims to protect are betrayed by its neocolonial and exploitative aims. A redefinition of global health must be developed in order to reverse Global South exploitation and lead to sustainable development.

Purpose of Global Health and Economic Development:

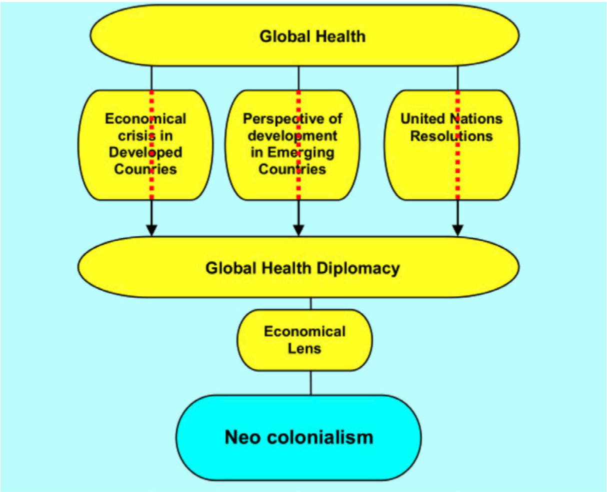
Global Health: Rooted in Colonialism

In its inception, global health, formerly known as tropical medicine, was used as a tool for colonial powers to maintain their hegemony over colonies and to justify exploitation (Holst, 2020). The foundation of one of the original global health schools, the London School of Hygiene and Tropical Medicine (LSHTM) was tasked by the British government to use global health as a means to promote colonialism by reducing disease spread in colonies in hopes of increasing colonial exploitation (Hirsch & Martin, 2022). This colonial mentality has not changed. Global North countries and multinational corporations use economic development and global health to undermine human rights in the Global South and profit from Global South labour. Despite calls for decolonizing global health in the 20th and 21st centuries, the legislation surrounding modern-day global health has only served to entrench this neocolonialism. Raphael Lemkin discussed the use of legislation as a means to uphold and justify human rights abuses (Lemkin, 1944).

Global Health Organizations Embodying Neocolonialism

Despite the Global South constituting 85% of the world's population (World Data, n.d.), only three of the nine draftees of the Declaration of Human Rights (1948) were from Global South nations (UN, 2022). As a result, Global South ideologies, perspectives and beliefs surrounding medicine, healthcare and global development were severely underrepresented in legislation. Instead, neocolonial and capitalistic notions of healthcare and development were endorsed. These ideas, which include free market capitalism, were rooted in exploitation and served as a means to maintain the Global North's influence in the Global South. The use of legislation to define the nature of global health as inherently neocolonial allowed the Global North to justify control over the Global South. In the Declaration of Alma Ata and World Health Organization Constitution, global health was used to justify such control over these nations. In particular, the creation of the "right to health" creates an opportunity for Global North countries to be further economically involved in the Global South (WHO, 2022). As a result of this opportunity global health provides justification for the exploitation of Global South countries. This is seen in Figure 1 with global health being fundamentally shaped by Global North economic interests and global health diplomacy being the means to promote neocolonialism (Rubbini, 2018). These examples of global health legislation are clearly biased and only serve the interests of the Global North. The "international" organizations tasked in creating global health legislation never adequately listened to the interests and voices of Global South nations. Therefore, modern day global health legislation has no true validity and only serves as a thinly veiled justification for Global North neocolonial control over the Global South. This is evident through the three main global health-related international organizations: WHO, IMF and World Bank.

Figure 1: Global Health Diplomacy Through an Economical Lens



WHO

The annual budget of the WHO in 2021 was US$6.7 billion (WHO, 2022). Out of the top 20 contributors, 18 were Global North countries and organizations (UN, 2021). The entire contribution of continental Africa is only 3% of that contributed by the USA alone (UN, 2021). Such immense funding allows Global North and G7 countries to determine policy and agendas to strengthen their influence. Therefore, the suppression of Global South thought and hegemonic power allows countries in the Global North to control international institutions.

The result of the immense influence of the Global North is that global health is currently used as a means to legitimize Global South economic exploitation. This justification of economic exploitation can be seen with the current Sustainable Development Goals (SDGs) proposed by the WHO in 2015. The SDGs are the bedrock to all global health actions in the world aiming to promote physical, mental, social and environmental development through specific global health interventions. One of the major goals, SDG 8, encourages economic development with SDG target 8.2 being economic productivity (United Nations, 2022). This target, backed by Eurocentric academia, suggests that improving economic development is the way to improve health outcomes. While economic development does improve health outcomes to a degree, the use of capitalism ensures economic development is never shared equally. Through the justification of economic development, foreign industries are allowed to move in and exploit these regions to profit the Global North. It is clear that economic development is not aimed at actually improving health outcomes but rather is used as a front for neocolonialism. Multinational companies routinely underpay Global South workers and subject them to inhumane working conditions and treatment in order to reduce local development and maintain control. In 2015 alone, the Global North appropriated 12 billion tonnes of raw materials, 822 million hectares of land, 21 exajoules of energy and 392 billion hours of labour worth US$10.8 trillion from Global South countries (Hickel et al., 2022). Such exploitation is decidedly unethical, however under the framing of SDGs, economic exploitation is deemed beneficial for these very victims.

Neocolonial Narratives

The framing currently used by the global health field is similar to the justification used in historical colonial policies. Global North perspectives cite the contributions of Global North countries in alleviating the poor conditions of the Global South. However, the exploitation of the labour and resources of these regions burdens these marginalized citizens. Citing poor health outcomes for certain marginalized groups, Global North countries and multinational corporations have a de jure justification for their economic exploitation. Facilitators of this exploitation include Coca Cola, Nike and other multinationals. Coca Cola has factories that reduce and pollute water supply, causing citizens to rely on imported water to fulfil their basic needs (Singh et al., 2015). Two-thirds of Nike factories fail to meet standards and reports of worker abuse are common, with workers being called “dogs and pigs” by supervisors (Karmini & Wright, 2011). Despite these human rights abuses, ironically, global health goals such as

SDG 8 are fulfilled. It is clear that global health goals of economic development have little that pertain to the development of health and human rights around the world. When global health initiatives improve the health of marginalized citizens, it is often conducted in order to improve the economic productivity of workers, only leading to further exploitation of their labour (Neocolonialism and Global Health Outcomes, n.d.).

IMF and World Bank

The global health institutions of the IMF and World Bank also exploit Global South countries through cycles of debt. Within the IMF, patron nations are mostly from the Global North, with approximately 60% of voting power coming from these nations (IMF, 2022). As a result, Global North countries control the conditions of Structural Adjustment Programs (SAPs) and loans. The conditions of these SAPs emphasize economic exploitation through pro-Western ideas of stabilization, liberalization, deregulation, and privatization (Thomson et al., 2017). The conditions surrounding SAPs prevent spending on health, development or education programs. Such programs strip Global South nations of their autonomy and force them into cycles of debt (Biesma et al., 2009). These cycles of debt make the Global South dependent on raw resource industries and Global North investment and trade further exacerbating Global North hegemony (Reyes, 2001). Despite SAPs being the embodiment of SDG 8, SAPs have been linked with poorer health outcomes for marginalized citizens (Thomson et al., 2017). This dispels the notion that all economic development increases positive health outcomes in the Global South. Not one study illustrated a beneficial effect of SAPs on child health (Thomson et al., 2017). Studies indicate that SAPs add 85.6 additional under-5 deaths per 1,000 and 360 more maternal deaths per 100,000 live births. (Thomson et al., 2017). To put this in perspective, the additional under-5 mortality rate caused by SAPs would almost double the current under-5 mortality rate in Nigeria and increase its maternal mortality rate by roughly 45% (UNICEF 2022; Ope et al., 2020).

Impact of Economic Development on Climate Change:

Under the current notions of economic development ushered in by neocolonial global health institutions, climate change has only been exacerbated. Further, climate change leads to deleterious health outcomes for the marginalized. The WHO estimates that by the end of the decade, 250,000 people per year will die from the effects of climate change (WHO, 2021). Economic exploitation in the Global South increases total energy consumption and carbon footprints within these countries. This is due to energy often being from unsustainable sources, including carbon-heavy coal (Power Africa, 2022). As a result, the increase in GDP per capita and world GDP has a positive relationship with CO2 levels (Bolt et al., 2020).

Following modernisation theory, ideal societies crafted by economic development rely on high-mass consumption (Reyes, 2001). Such high consumption is exemplified in Canada's carbon footprint. As of 2019, Canada produced 738 megatonnes of CO2 or 19.63 tonnes per capita (Environment and Climate Change Canada, 2022; Environment and Climate Change Canada, 2022). However, certain Global South nations like the DRC produced an annual carbon footprint of 2.6 megatonnes of CO2 or 0.03 tonnes per capita (Ritchie et al., 2020). Despite having half the population of the DRC, Canada produces 284 times the amount of CO2 (Canada, 2007). This unsustainable promotion of economic development in Canada and the USA has disastrous effects on the world. If the planet had the average carbon footprint of an American it would take roughly five Earths to provide enough resources for this lifestyle (University of Michigan Center for Sustainable Systems, 2021)

Despite citing sustainable development, it is clear that such economic development has consequences for planetary health and for that of marginalized citizens. Global South countries often rely on the agricultural industry to fuel economic growth, with three quarters of citizens being involved in this sector (Mercy Corps, 2018). However, climate change will reduce staple crop yields (e.g. corn) by 24% (NASA, 2021). As a result, individuals experiencing climate change-related drought will experience worse health outcomes (Ellis & Albrecht, 2017). Thus, 1.2 billion marginalized citizens by 2050 will be displaced, and forced to migrate to better conditions (Zurich, 2012). Despite these alarming existential threats to humanity, the Global North fails to solve the climate crisis through sustainable economic strategies. Current proposals from COP27 indicate such a stance. During the conference, the G7 created a “Global Shield against Climate Risks” fund, pledging US$210 million for alleviating the effects of climate change faced by the V20 (United Nations, 2022). Rather than addressing the fundamental root causes of climate change, Global North countries are resorting to relief funding aimed at protecting their interests. Such protection funds are miniscule compared to the wealth extracted by these countries and never critically examine the true driver of climate change, the Global North. In order to truly prevent climate change, Global North countries must relinquish neocolonial control over the Global South. However, due to the nature of neocolonialism, such change will be unlikely.

Reforms and Conclusion:

Common narratives state that modern global health interventions help protect and promote the wellbeing of Global South citizens. However, this could not be farther from the truth. The use of economic development as a means to improve health outcomes has ironically caused the very poor health outcomes needing to be improved. Economic exploitation justified by global health produces disastrous health outcomes for Global South citizens and furthers climate change that in turn, harms health for all. Neocolonial notions of economic development have been both the issue and proposed solution for improving health outcomes in the Global South. Citizens from Global South countries cannot use the tools of the oppressors to free their oppression. As such, a Global South-centric redefinition of global health must occur. Global South unions, like that of the African Union, must exercise their power in reducing the immense control of Global North countries on Global South affairs in order to improve their health. Drastic measures such as the widespread repudiation of debt can be an important way to establish the power of Global South nations, protect their sovereignty and promote the interests of the international working class. Creating global health networks framed within a planetary health perspective must occur in order to prevent irreversible climate crises. Using progressive frameworks like that of One Health which emphasizes sustainable development of human, animal and planetary health may help curb climate footprints.

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Navigating the HIV Epidemic in Malawi's Female Sex Workers: A Country Profile

Lauren Omoto

It is indubitable that certain regions of Africa, specifically the Eastern and Southern, are disproportionately impacted by the HIV epidemic (Parker et al., 2021). One country within the Eastern region, Malawi, continues to endure the lasting impacts of major historical and current events that maintain high HIV prevalence rates in key populations, one of which is sex workers. Female sex workers in Malawi are disproportionately impacted by HIV, as observed through epidemiological data, due to poor socioeconomic and political conditions exacerbated by neocolonialism that lead to low education and resource accessibility. As a result, current government education programs are being implemented to target these shortcomings.

In order to understand the HIV disproportionalities that exist within the sex work community, the epidemiological data within Malawi's general population must first be scrutinized. In 2021, the overall HIV prevalence rate was found to be 5% of the total population, where approximately 1 million were currently living with HIV (UNAIDS, 2022). While the prevalence has remained fairly consistent over the past decade, the HIV incidence rate has steadily decreased to a 2021 value of 20,000 new cases (UNAIDS, 2022). When observing the data for sex workers in Malawi for the 2021 year, the HIV prevalence within this subpopulation is much higher, with a staggering 45% difference in prevalence between the general population and sex workers. It is important to note that the coverage of antiretroviral therapy (ART) is virtually identical between the general and sex working population (UNAIDS, 2022). While Malawi sex workers have high HIV testing rates, coverage of targeted prevention programs and methods remain extremely low relative to the soaring case counts (UNAIDS, 2022). Women in Malawi are also 2.5 times more likely to acquire HIV than males across all ages (Pemba, 2022). Given that female sex workers represent a group of highest risk, based on epidemiological data, it is vital to analyze various factors at play for this key population; there remain detrimental statistics that directly reflect current and historical systemic problems that will be further discussed.

To fully comprehend the current macro-factors that contribute to high HIV prevalence in Malawi's female sex workers, it is vital to first scrutinize the colonial history of the country and draw parallels between its past and current states. Malawi, previously known as Nyasaland, was under British colonial rule from 1891 to 1964 (Palmer, 2021). During this time, Malawi became

known as the 'Imperial Slum'; their already limited finances were invested in the expansion of transportation and trade infrastructure to benefit British powers, moving resources away from social services, education, and employment (Palmer, 2021). After 1964, the post-colonial government, largely appointed by the previous British government, introduced legislation that was detrimental to women's rights in particular, subsequently reducing their societal freedoms into the post-independence era (Drisceoil, 2022).

Political and economic control by European powers continued to be exercised in Malawi by means of neocolonialism in the post-independence era. As mentioned, finances were removed and redistributed away from education and social services, much to the expense of the Malawian citizens. In connection to the present-day economy, Malawi's poor economic status has persisted, with a 2021 GDP per capita value of merely USD 642.70 (The World Bank, 2022). Along with these economic factors, the political trajectory in Malawi has proven detrimental to specific populations. Oppressive legislation against women that prevailed through the post-colonial era, instated by the Malawi government, caused social stigma against women and female sex workers to increase. To this day, efforts to improve the socioeconomic status (SES) of women are virtually non-existent or restricted to a community level with insufficient funding, forcing women to find other means of supporting themselves and their families; leading to a major increase in the number of female sex workers (Wilson & Kachipande, 2020). In addition, lack of funding within families proves to be a major barrier to women attending school; only 13% of girls in Malawi end up attending secondary school, with less than 5% completing this level of education as of 2022 (Pemba, 2022). Often, young girls enter sex work to compensate for a lack of resources, dropping out or having never attended school as a result, and ignorant to the HIV risks that come with the line of work due to insufficient education (Doctors Without Borders, 2019). A lack of education paired with discrimination and precarious employment opportunity leads many women in Malawi to turn to sex work for liveable income.

In both past and current Malawian society, social stigmas targeting women, especially female sex workers, continue to fuel pernicious discrimination against this key population. The criminalization, anti-women legislation, and stigma surrounding sex work prevent many female sex workers from seeking treatment for HIV-related issues and obtaining proper education relevant to their work (Doctors Without Borders, 2019). This social discrimination went as far as to deny early HIV interventions to sex workers at hospitals, discouraging this population from seeking treatment at all (Doctors Without Borders, 2019). This can be related back to the fundamental cause theory, which highlights a correlation between poor SES and health inequity. There is a clear interaction between macro-factors that comprise the fundamental cause theory, specifically SES and sexism, that maintain the intergenerationally high HIV health risks and greater prevalence within the sex worker population in Malawi. A cyclical relationship exists between these fundamental causes and a lack of resources that perpetuate the HIV epidemic in sex workers; fundamental causes lead to a lack of resources, including education, money, and social connections, thus increasing high HIV-risk behaviours, including unprotected sex and sex with multiple partners, and HIV infection as a result (Rubin et al., 2011). For sex workers, who already typically lack HIV prevention resources in the first place, fundamental causes ultimately accentuate the impact of the epidemic within the population. It is important to note that the fundamental causes stem from systemic failures and are not necessarily the fault of the individuals themselves; systemic-level interventions are therefore needed to address these failures.

A resource that is constantly recurring in the discussion of assisting sex workers and reduction of the HIV impact within the population is education. Malawi's post-colonial government limited women and girls' access to education and employment; this increased general sexism and contributed to SES problems for families. One solution proposed was structural adjustment programs (SAPs), which attempted to facilitate economic growth in low-income countries, including Malawi. Although well-intentioned, SAPs placed fees on education, and schooling became unaffordable for most families. Given the choice, parents often selected their sons over their daughters to attend school (Obasi, 2010). This prevented young girls from having the opportunity to understand safe sexual interactions and HIV through in-class sexual health curriculum as well as greatly increasing the chance of exposure to commercial sex work as a last-resort employment option (De Vogli & Birbeck, 2005).

To respond to the lack of education in young girls and thus increased HIV prevalence in the sex work population, the Malawi federal government launched the Education Plus Initiative in partnership with the United Nations (UN) (Pemba, 2022). This program will run for five years, aiming to increase investments into women's education from a community to national level and provide free secondary education for all Malawian youth by 2025 (Pemba, 2022). It also covers the implementation of gender equity standards for young women and the protection of their health rights (Pemba, 2022). Proper sexual education, reductions in gender- and sexual-based violence, suitable employment opportunities, and improvements in SES are all promoted under this program (Pemba, 2022). This aims to decrease the number of youth who must resort to sex work to make a liveable income and in turn the HIV prevalence and risk in this population. Since the initiative was launched in early 2022, the efficacy is currently unknown, however, given the elements of the program, it can be presumed that improvements in HIV prevalence and incidence within the key populations will be reduced.

While the Education Plus Initiative will likely instate educational improvements to reduce HIV risk and prevalence, the aims focus largely on education at an individual level. Although this would be effective, there remain systemic problems within the government and Malawian society that must be addressed, including the patriarchal standpoint that is implemented into government practices. While the program has potential to provoke intergenerational change surrounding sexual safety, gender equity, and HIV, it has its shortcomings. For instance, there is no guarantee of an increase in available jobs despite an increase in the number of youth educated for such. This could provide leeway for young women into sex work for money without a full understanding of risks. While education for all individuals is vital, Malawi needs to work towards decriminalizing sex work and implementing similar institutional change to truly improve HIV conditions in the sex working population.

In summary, the HIV epidemic in Malawi, particularly for female sex workers, has been nothing short of an ongoing detriment to health and stigma. It is evident that an interplay between colonial history and current macro-factors of politics, SES, and sexism serves to mitigate HIV risk on an intergenerational scale. Oppressive legislature and anti-women ideologies have prevailed through the 21st century, reducing educational access for women and in turn increasing the number of young girls turning to sex work to merely survive. While the development of the Education Plus Initiative works to increase the number of young women able to access education and subsequently decrease the sex-working population in the coming years, greater systemic change is still required pertaining to the decriminalization of sex work to reduce the HIV epidemic and social stigma within this population. Lessening the level of individual responsibility for HIV within key populations is vital for inducing wide-scale change to eliminate the epidemic, not only in Malawi but in Africa as a whole.

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