Mental health of canadian indigenous people

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This article focuses on the literature in relation to mental health of the indigenous people in Canada. Indigenous people contribute to 370 million of the world’s population spread over more than 70 different countries (WHO, 2007) and are known by different names all across the globe. It is strongly believed by many scholars that an unequal burden of mental illness is being carried by the indigenous people all around the world. According to a number of studies it has been seen that colonialism and the process associated with it play an important role in determining the health of indigenous population internationally. This study was carried out since not much research has been done on the mental health of indigenous people in Canada.

Something that connects the indigenous people all around the world is the experience of colonialism even though the experience and the history differ greatly in various location and indigenous population. Health issues such as infant mortality, high incidences of acute or chronic pain, and injury have been associated by the international literature with social inequalities like poverty and racism emerging from colonialism.

It has been indicated by research around the world that we should be careful when concluding about the occurrence of mental illness without taking into account the colonial process. Studies related to the mental illness of indigenous people in Canada like elsewhere is being taken up by settlers who follow colonial and non indigenous concepts and epistemologies. They

also raised concern about the fixity of colonialism in health care system, which creates a problem for the indigenous people who need health care services especially for mental illness.

The aim of this study was to identify the extent of research on mental health of indigenous people in Canada, find out the gaps which may exists in the studies which have been done, and determine the extent to which mental health research is representative of indigenous populations and geographies in Canada.

This study was carried out in 5 stages. First, the research question was identified followed by finding out studies relevant to it, selecting them, collecting the data, and combining and summarizing the results. Studies were collected from 11 data bases and 2 indigenous- specific journals. The articles were grouped under social determinants of mental health, mental health services, prevalence of specific type of mental illness, mental health promotion, mental health research and the impact and effect of colonialism on mental health of indigenous people. Out of the 223 selected articles, majority of them emphasized on the different sides of colonialism as a factor of mental illness which exhibited the colonial plan in policy decision.

This study does not include the grey literature. Excluding such literature might led to overlooking at important strategies which may be practiced by various organizations. However the authors of this article believe that the 223 articles reviewed in this study give a gist of the research being carried out on indigenous people in Canada. Colonialism is a major issue addressed in this study in relation to mental health research. The term colonialism is

used to indicate the effect of colonialism rather than the structure itself. This can lead to misinterpretation of the term and cause a narrowed understanding. Interactions with different aspects of colonialism by the indigenous people vary and it is important to maintain this diversity and deal with it accordingly even though they all share the common effect of colonialism. There are only a few interventions which are culturally accepted. It is therefore very important to look deeply into the interventions and mental health programs which are beneficial and accepted by the indigenous community. When seeking help for mental treatment they feel stigmatized and when is it accompanied by racial discrimination and experiences of colonialism, it becomes even more difficult for the indigenous people to get them self treated. It is important to evaluate which programs and mental health practices are favorable for various indigenous groups.

This article has immensely broadened my view and knowledge about the mental health of indigenous people not only in Canada but all over the world. The huge effect of colonialism is not restricted to an individual but passes on from generation to generation. Culture plays a very important role in maintaining the health equity in different populations. The side effects of colonialism can be minimized by analyzing it as a cultural problem rather than a political, social or economic affair. Even in the 21 st century it is sad to know that the indigenous remain extremely aloof from the mainstream society even though they are the origins of their respective place.

Article 2

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Title: Socioeconomic status and non-communicable disease behavioural risk factors in low-income and lower-middle-income countries: a systematic review

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This article focuses on the socioeconomic status and non-communicable disease behavioural risk factors in low-income and lower-middle-income countries (LLMICs) which comprises of 39 countries.

One of the objectives of the Sustainable Development Goals (SDGs) is to reduce the premature deaths caused due to non-communicable diseases (NCD) by a third by 2030. The mortality rate due to NCD is reducing by 1. 8% in Brazil per year because of the spread and extension of primary health care. Thus it can be seen that the premature deaths due to NCD can be reduced to a significant amount by implementing government policies which focus on reducing behavioural risk factors. (WHO, 2007)

70% of the global deaths occur because of NCD. The relation between socioeconomic status and non communicable diseases is well understood in the high income countries but how behavioural risk factors are spread among the low-middle- income countries remains uncovered. This article aims to review systematically the relation between the socioeconomic status and harmful use of alcohol, tobacco, unhealthy diets and physically inactivity in LLMICs.

For this study, 13 databases were looked into. The studies that were included were from LLMICs showing data on various measures of socioeconomic status and use of tobacco, alcohol, diet, and physical activity. The exclusion criteria included studies that restricted equating between more or less advantaged groups. Age or language was not the criteria for exclusion of a study. A narrative way for data synthesis was used due to high heterogeneity. 4242 records were reviewed out of which 75 met the assigned criteria which comprised of 2135314 individuals, who were older than 10 years of age. This study was carried out in accordance with PRISMA and Cochrane guidance. Studies included in this review were of moderate to high quality having a cross-sectional and survey based approach. After systematically reviewing the records, it was found that the low socioeconomic groups had a higher prevalence of tobacco and alcohol use and low intake of healthy diet when compared with the high income group. On the other hand, less physical activity and more consumption of processed foods were seen in people form high socioeconomic group. The socioeconomic indicators that were used were income, wealth or assets, state defined poverty, literacy, education, occupational status and class, caste, job seniority, and researcher defined socioeconomic status.

This was the first systematic review conducted within LLMICs which analyzed the socioeconomic distribution of all 4 major behavioural risk factors. Using this broad range of socioeconomic factors enabled the researchers to find a significant difference between casts, classes, sexes, occupational groups, and educational strata. Looking at the dietary findings, there was a direct relation seen between the socioeconomic status and intake of healthy diet.

Low socioeconomic status group consumed more amount of processed food in high income setting and the opposite was seen in the LLMICs. Coming to physically activity, it was seen that rural low socioeconomic groups work in jobs which require more physical activity in LLMICs. In cities, this relation in reversed.

As the study is heterogeneous, it needs careful interpretation and the findings cannot be seen as absolute. Because of the huge data collected it was difficult to reach to the depth of each risk factor. More than half of the countries classified as LLMICSs were not seen in their search results and this was a major finding as well as a weakness. Half of the studies were in relation to India which proves to be high quality evidence but these results cannot be generalized to all the LLMICs. Hence it is necessary to conduct more research to find out if the results found in this study are true even where close observation does not take place. Strategies which are implemented by the policy makers and national development agencies in areas where the premature deaths occurring due to NCD is more, should be evaluated to check if they are appropriate to their setting and should implement their plan accordingly. The government can play an important role by improving the rate of literacy, standard of living, income along with the heath conditions as it is clearly seen that the low socioeconomic conditions are related to non communicable risk factors. Even though data is not available for all the LLMICs, appropriate and immediate action should be takes for countries where data is available.

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