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The Social Determinants of Health and Genocide: Towards a Public Health Integrated Framework of Genocide and Mass Violence

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Introduction: The Genocidal Legacies of Public Health
During the COVID-19 Pandemic, there was a noticeable uptick in public health research on structural violence and the social determinants of health. The racial reckoning that occurred during the pandemic led researchers to interrogate the enduring systems of marginalization and discrimination that have produced markedly worse health outcomes of racialized and historically marginalized communities for generations.¹ The focus on how public health policies and outcomes are steeped in structural violence provides a natural bridge for scholars of genocide and transitional justice. In genocide scholarship, it has been widely recognized that violence and injustice against victims and survivors do not end when the direct mass killings stop. The structures and institutions of genocide that perpetrators establish prior to the onset of direct violence can long endure even after regime change. The legacies of these systems can continue to visit structural, psychological, and epistemic violence upon victims and survivors.²

Yet curiously, despite this natural synergy, the sets of literature on the social determinants of public health and the legacies of genocidal systems and structures remain siloed. Genocide scholarship has long studied the physical and psychological traumas of mass atrocities, which can be transmitted for generations, scholars recognising that the effects of this mass atrocity often results in worse social, economic, and political opportunities and outcomes for groups that have already been marginalized and discriminated against.³ However, there have

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not been systematic attempts to theorize the embeddedness of genocidal violence within public health policies and infrastructures as both mechanisms and legacies of genocide. Scholars of genocide have also acknowledged that without structural transformation, these historical and legacy effects of genocide create obstacles to the transitional justice process. As such, approaching the legacy effects of genocide from a public health framework has the potential to reveal insights and practical tools for justice and reconciliation. While much emphasis has been placed on accountability of the perpetrators, memorialization of the events, and reparations for the survivors, without addressing the underlying systems and ideologies of discrimination and marginalization, and seeing how they remain durable, barriers will continue to be erected against justice and reconciliation.

In this article, we conduct a comparative analysis of how public health systems were weaponized at the outset of the 1994 Rwandan genocide and the colonial genocide against the Indigenous Peoples in Canada, and demonstrate their enduring destructive effects on victims and survivors even after the displacement of the perpetrators. Even though these two genocides occurred in drastically different ways along drastically different timelines, we show public health outcomes as an adjunctive effect of genocidal structures, thus creating continued challenges for transitional justice and reconciliation. Regardless of whether the mass killing phase of genocide occurs in one-hundred days or via attrition over centuries, we argue that the rhetoric of health and epidemiology remains an integral part of the perpetrators’ designs for destruction. Furthermore, in both cases, despite the ostensible removal of the perpetrators and their genocidal policies, the social determinants of health for victim and survivor groups remain starkly divergent from the majority populations. In the case of Rwanda, despite the efforts of the post-genocide government, rates of HIV/AIDS prevalence, social stigmatization, and gender-based violence (GBV), especially in the form of intimate partner violence (IPV), continue to increase in tandem with the diagnosis of post-traumatic stress disorder among survivors. These legacies, as a direct result of events of 1994, continue to threaten the sexual and reproductive health and rights (SRHR) of Rwandan women, who were some of the primary victims of the genocide. The continued victimization of survivors is exacerbated by limited resources and social barriers to essential care. While in Canada, the intergenerational trauma endured by Indigenous communities through the Indian Residential School (IRS) system consistently leads to drastically shorter life expectancies and double the rate of suicides compared to non-Indigenous, or settler, populations. These public health outcomes are explicitly linked to mental and physical trauma, loss of culture, and lack of access to proper care and resources such as income and education for Indigenous communities. Furthermore, the embedded anti-Indigenous racism in the public health systems in Canada continue to reproduce genocidal outcomes.

By engaging in this comparative analysis of cases that demonstrate a great deal of difference, we show that no matter how genocides are perpetrated, the public health crisis created against the victims and survivors at its onset will path-dependently affect survivor...
The Social Determinants of Health and Genocide

communities generationally. By drawing the explicit link between public health, structural violence, and genocide, we intend to demonstrate the continuation of structural violence against target communities long after the original architects of genocide have been displaced or prosecuted. Without explicitly improving the social determinants of health outcomes of victims and survivors, significant barriers to justice and reconciliation remain to make these communities whole so long as genocidal legacies manifest as inequities in the social determinants of health.

Public health as a holistic system is often an overlooked domain when examining instances of mass violence, both as a method of perpetration and mechanism for justice in the genocide and transitional justice scholarship. Much of the existing research focuses on individual health outcomes, either physical or psychological, for the survivor communities without interrogating the underlying system. We see the explicit integration of public health transformations as an essential component of the transitional justice process. Therefore, we argue that in a post-genocide context, reformation of health systems, in addressing the needs of victim and survivor communities along physical, mental, and epistemic dimensions, are among the necessary steps for transitional justice. Public health officials and policies must recognize how health inequities were embedded in the same systems of discrimination that facilitated genocide. The inaccessibility of essential health resources, and systematic neglect leading to mass disparities in health outcomes faced by victim and survivor groups is, in fact, the deliberate infliction of conditions of life calculated to bring about their physical destruction. Therefore, from a normative standpoint, without reformation and addressing the structural violence embedded in public health, societies and states abdicate their legal and moral obligation in providing reparations to victims and survivors. Our analysis therefore calls upon scholars of genocide to integrate a public health analysis across all cases.

The Nexus of Public Health, Genocide, and The Social Determinants of Health

The scholarship on structural violence has long noted the latent ways by which societal systems and institutions generate divergent life outcomes for different social groups without having to resort to the smoking gun of direct policies of violence. Structural violence can be defined as forms of violence whereby social structures or institutions visit harm upon both groups and individuals through denial of life-sustaining needs; this can be embedded in policies that deny economic opportunities, political representation, or access to essential social services that disadvantage groups as a whole, whether by conscious design or willful neglect. While genocides are often associated with acts of direct mass violence, visceraelly represented by gas chambers, machete wielding militias, or forced deportations, these acts are often couched in and enabled by the underlying structures of violence that have already normalized the differential treatment of disadvantaged social groups. Our analysis therefore recognizes genocide not as an event, but a process, and that the mass violence of genocidal killings is almost always preceded by the establishment of structures and institutions designed with the explicit purposes of denying the basic rights and humanity of the target groups and victims. Often, these institutions shape norms, values, and behaviors in ways that exacerbate tensions between the perpetrator and target groups such that genocidal killing occurs in path-dependent ways.

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therefore also recognizes that genocides do not end with the last massacre or pogrom, but the complete transformation and dismantling of mutually reinforcing systems of violence. Therefore, a normative post-genocide society not only acknowledges the legal obligation of the state to remediate the direct consequences of the violence, but to undertake structural transformations to mitigate the legacies of violence and prevent its continuation or recurrence.

As Maja Davidovic points out, one of the biggest challenges facing the full and effective implementation of transitional justice are those necessary transformations to institutions and norms in order to guarantee non-recurrence. Similarly, Pádraig McAuliffe highlights the inherent difficulties of implementing a transformative approach due to the necessity of sustained change overtime, embedded in both top-down institutions of government as well as bottom-up everyday practices. Just as the genocidal process does not begin with the onset of mass killings, but with the construction of institutions of polarization and dehumanization, the end of genocide is only realized by the total transformation of those processes that enabled the mass violence in the first place through the equitable distribution of social and economic outcomes. Without this total transformation, the legacies of genocidal violence against victims and survivors remain enduring through generations, and institutions continue to diffuse the outcomes of structural violence.

More importantly, because genocide scholarship recognizes how genocidal violence and their legacies are embodied in victims and survivors, this analysis should also be embedded within a public health context. This is because individual medical interventions are insufficient for communal healing and reconciliation as they will not systematically address the legacies of systemic violence that targeted communities continue to experience, such as those structural barriers to the full and equal access to social and economic life. The utilization of public health systems as a mechanism of genocide has been noted by some genocide scholars as an indirect method of destruction that does not necessarily involve overt acts of physical violence. Often, perpetrator groups deliberately re-engineer and transform public and social institutions to create conditions of deprivation to generate perceptions of threat and deliberate acts of neglect against target groups. Helen Fein observes that architects of genocide often marshal their public health infrastructure against target groups to commit genocide by attrition. The case in point was that during the Holocaust, Nazi doctors were instrumental in the development of the ghettoization policy due to the racist belief that diseases were endemic among the Jewish population who therefore needed to be isolated. The stripping of essential services to Jewish communities through ghettoization thus created a self-fulfilling prophecy where malnutrition and disease became rampant, which further justified the policy of dehumanization under the auspices of public health. Similarly, that access to adequate food, clean drinking water, sanitation, and other essential health services being either limited or wholly denied to target groups, can be observed during the course of nearly all recorded cases of genocide whereby the victims are not only forced into gas chambers or on to killing fields, but allowed to die in mass numbers over time under entirely preventable conditions that were deliberately put into place. Therefore, Fein calls on scholars and practitioners to adopt a public health approach when it comes to the provision of humanitarian assistance to the victims.

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However, this approach to amelioration only scratches the surface of the public health implications of genocide. Scholars have also made note of the discourse of genocide that perpetuates an epidemiological perception and belief of the target groups. Mass violence perpetrated against target groups during genocide is often couched euphemistically in the language and discourse of public health, whereby the target groups themselves are positioned as a threat to the body politic. Genocidal rhetoric all too often refers to particular social groups as metaphoric “diseases” or “cancers,” while at the same time ascribing physical pathologies onto these populations to justify a “cleansing” of society. Through genocide by attrition, public health policies ensure that the victimization of target groups endures over time, and the implication for a societal transition towards a post-genocide standpoint means that although the restoration of access to the material necessities of life for victims and survivor groups after genocide is necessary, it is insufficient for substantive transformative justice and reconciliation.

The World Health Organization (WHO) defines health broadly as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” While definitions of public health systems vary across governments and agencies, a key feature is the organized measures aimed at promoting those health outcomes. In essence, public health systems are one of the key drivers in the social determinants of health for populations which includes, but is not limited to, access to income and social security, education, gainful employment, humane working conditions, food security, quality housing and early childhood development, and social inclusion, all in addition to affordable and quality health services. The public health literature has long noted that an integrated approach to health along these dimensions has substantial impacts on the social and economic outcomes of historically marginalized communities. For example, Kim Blankenship et al. argue that “health is a function of social, economic and political power and resources” and therefore structural interventions are required to enable communities facing stigmas to gain access to resources so that they can promote better autonomy and agency. Similarly, Alec Irwin and Elena Scali find that the social determinants of health, as well as marginalization, can occur in mutually reinforcing ways as a vicious cycle, whereby the social roots of health inequities compound and create more inequities. Furthermore, Foster Baah et al. find that while advances in healthcare have occurred by leaps and bounds, the benefits have not been equitably distributed to marginalized communities, thus leaving them further behind and widening the socio-economic disparities in society. Recent studies on the impacts of the COVID-19 pandemic have come to similar conclusions whereby the public health crisis created by the pandemic is unevenly borne across societies: while public health systems have vulnerabilities and fragilities, it is the historically disadvantaged segments of society that bore the brunt of these burdens. Despite this rich oeuvre of study on the social determinants of health, Hazel Dean et al. note that while policy-
level interventions are required to shape the outcomes of these determinants of health, actual actions taken to implement these policies have been lagging and deficient.24

What the public health literature misses, however, is how the very systems that need reformation to address the social determinants of health for marginalized communities, can often be deliberately engineered to facilitate the marginalization of these communities, even up to the point of wholesale destruction. Similarly, we also note relatively little bridging between the scholarships of structural violence, public health, and genocide, and the systematic theorizing of this relationship given their inextricable link. A recent article by Clare Herrick and Kirsten Bell calls for further dialogue between these sets of literatures.25 There is also evidence that major international organizations are recognizing this critical nexus between public health and social and economic life, as evinced by the WHO Constitution calling on states to take “responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.”26 As such, we aim to bridge this gap in the literature by showing that when states abdicate that responsibility, genocidal regimes weaponize public health systems against segments of society, either through active belligerence or neglect in structurally violent forms.27 These inequities compound over time and place marginalized populations in what Achille Mbembé characterizes as a “state of injury,” whereby the healing and growth of a group is prohibited to maintain a status quo social order of domination and destruction within the state.28 This form of violence is interwoven within social structures, norms, and institutions that have been built over decades and even centuries. Therefore, in genocide and transitional justice scholarship, when examining the transition from a genocidal to post-genocidal society, it is critical to evaluate the measures taken to address the structural violence embedded within this essential public sector, not only to cease the harm underway, but also to remediate the damage already visited upon the victims. By confronting these structures of violence, scholars gain valuable visibility of the unequal power dynamics that both impede justice, as well as insights into how direct forms of violence flow from these structures.29

We take this line of argument one step further and argue that unless the entire public health system in a genocidal regime undergoes transformation, transitional justice remains incomplete. Systems must be reoriented to address and ameliorate the specific harms and risk factors, both physical and psychological, of victim and survivor communities that are the direct result of the genocidal process. We show that although different genocides are carried out through different processes, they produce similar outcomes in the worsening of the social determinants of health for survivors and victims. We also show that the urgency to replace and denounce the original architects of these policies must be matched by the urgency to also transform the systems of violence that they have put into place, lest the public health outcomes continue to worsen for victims and survivors in latent ways. Through comparative analysis of the public health outcomes in the aftermath of the Rwandan genocide and the colonial genocide of Indigenous Peoples of Canada, we highlight where the public health systems continue to fail to adequately meet the needs of survivors and victims, and that these gaps create critical barriers to the transitional justice and reconciliation of societies.

25 Herrick and Bell, Concepts, Disciplines and Politics, 295–308.
26 WHO Constitution.
The Rwandan Genocide: The Gendered Violence of HIV/AIDS

During the one hundred days of the 1994 genocide in Rwanda, an estimated 800,000 Tutsi men, women, and children, as well as other opponents of the Hutu Power regime were killed. The mass killings were punctuated by intense and endemic sexual violence, whereby women were specifically subject to a deliberate and targeted policy of genocidal rape. The use of sexual violence as a weapon of war was not the result of decentralized and impulsive decisions made by militia commanders on the ground, but an overarching strategy of the genocidal regime to ensure the long-term destruction of the Tutsi population. Pauline Nyiramasuhuko, the Minister for Family Welfare and the Advancement of Women at the time of the genocide, delivered orders to militia commanders, including her own son, Arsène Shalom Nahobali, to commit rape against Tutsi women prior to killing them. Disturbingly, the International Criminal Tribunal for Rwanda (ICTR) found that the intentional transmission of HIV/AIDS was employed as a tactic whereby “hundreds of male AIDS patients were released from hospitals and assembled into rape squads. Their goal was to rape and thereby cause a slow, inexorable death.” Furthermore, perpetrators of sexual violence themselves are reported to have explicitly taunted their victims, saying: “We are not killing you. We are giving you something worse. You will die a slow death.” These accounts show the layered logic of how the perpetrators thought about the enduring effects of mental and physical trauma to inflict continued harm upon victim communities. On the one hand, it affirms the masculinities and power of the perpetrators, while subjecting the victims to humiliation and physical destruction of individual bodies in the immediate short-term; on the other hand, it engineers a future public health crisis among survivor communities through the deliberate spreading of sexually transmitted diseases, while also stigmatizing and alienating victims and survivors from their own communities, thus destroying communal and social relations over a much longer span of time.

More insidiously, the devastation of the public service infrastructure in Rwanda as a direct result of the genocide meant that the public health crisis caused by genocidal rape and the HIV/AIDS epidemic would continue to worsen even after the victory of the Rwandan Patriotic Front (RPF). Transmission of a deadly disease continued to spread among a post-war country that lacked the resources to cope with the scope of the emergency. The U.N. Special Rapporteur on Rwanda estimates that at least 250,000 women were raped during the genocide, and a study reported by Amnesty International found that as many as two-thirds of the women who survived the genocidal rape were HIV positive. In some areas of Rwanda, WHO estimates found that HIV prevalence jumped from 1% to 11% after the conflict. In the immediate aftermath of the genocide, the Rwandan healthcare system faced critical capacity-related challenges, due to the fact that most healthcare workers were either killed or fled the country, and there were essential resource and equipment shortages. These problems were further compounded by the lack of effective therapeutics as well as adequate knowledge and expertise.
of the disease at the time. Given the immediate priorities surrounding food security, access to clean drinking water, and acute illnesses such as malaria, it took until 2000 for the Kagame government to tackle the spread of HIV/AIDS as a national priority. By this point, the disease had been spreading unchecked within the country for over half a decade.

In 2001, Rwanda had only fifteen operational health facilities with the capacity to provide free counseling and testing services for HIV. Among them, just eleven were equipped to screen pregnant women and prevent in-vitro transmission of HIV. During this period, infection and prevalence rates of HIV/AIDS continued to grow. It was not until 2004, a full decade after the genocide, before Rwanda received the first major international assistance for the treatment of HIV. This larger international campaign provided the impetus for donors to start providing programing and antiretroviral treatments to the then estimated 500,000 Rwandans living with the disease. Yet, the influx of international assistance around HIV/AIDS treatment would not come without conditions. Even though women were the most affected by the policy of genocidal rape and the tactic of deliberate infection, they were not prioritized by the programs; instead, the perpetrators and witnesses for the ICTR trials were given access to the life-saving medications first as a condition that was part of the US Emergency Plan for AIDS Relief in Rwanda. During this phase of the post-genocide AIDS epidemic, the prevalence rate climbed to 13%, one of the highest rates amongst the East African Region, and mother-to-children transmission rate reached a high of 30.5%. The result of this neglect was that nearly two decades after the genocide, “the leading causes of mortality in Rwandan hospitals include HIV/AIDS and related opportunistic infections.” David Newbury characterized post-genocide Rwanda as the epicenter of the global AIDS pandemic, and since HIV infection rates run highest in the military, rape was often a means by which these women also contracted HIV. Rape was often a sentence of death; the expression “survivors of rape” has an especially dramatic and poignant meaning in Rwanda.

In this instance, while a pragmatic decision was made to prioritize treatment for perpetrators and witnesses to expedite transitional justice, this very goal was undermined by the denial of treatment for the victims for whom justice was supposedly serving. In the decades following the genocide in Rwanda, some progress was made towards recovery and the rehabilitation of SRHR for women with the assistance of the international donor community. Targeted healthcare investment as well as improved public health communication and education have seen both the rates of HIV/AIDS transmission as well as associated mortality steadily decrease. With the Health Sector Strategic Plans, Rwanda became the first country in sub-Saharan Africa to successfully implement universal healthcare through mandatory community-based health insurance programs. The efficacy of these public health interventions is reflected in recent data, which show that the country has a reduction in HIV/AIDS prevalence rates.

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40 Binagwaho et al., Rwanda 20 Years On, 372.


42 Vogel, Rwanda Turning Tide on HIV/AIDS, E782.


46 Chemouni, The Political Path.
prevalence rate, from the high 13% to less than 4%. In early 2020, the Rwandan health minister announced that “at least 84% of infected people in Rwanda are aware of their HIV status, 97% among them are on antiretroviral drugs, and 90% of those under treatment have suppressed their virus load” and that the country is well on track to improve those statistics. By implementing the public health programs focusing on education, prevention, and treatment, Rwanda, with the support of the donor community, seems to have mitigated some of the impacts of the epidemic within the last two decades.

Although strides have been made in the treatment and prevention of the individual and physical health outcomes of HIV/AIDS following the genocide, progress on the psychological and social ramifications continues to lag. Because the strategy of genocidal rape employed by the perpetrators was not only intended to inflict harm on the individual, and physical bodies of targeted groups, but to impart lasting psychological and social harms to the group as a whole, it is critical for the delivery of transitional justice to the victims and survivors of genocidal rape to address not just the individual needs, but the group needs for recovery as well. As recently as 2022, it is estimated that the HIV/AIDS prevalence rate among women is still nearly 1.7 times higher than that of men, and that women are three times more likely to receive new infections.

The uneven rate of infection cannot be divorced from the path-dependent and gendered ways in which genocidal violence, particularly sexual violence, were carried out. Furthermore, because of the possibility of in-utero transmission from mother to child, women with HIV are further stigmatized by their positivity status. In a 2022 study, Donatilla Mukamana et al. find that Rwandan women with HIV/AIDS are subject to widespread discrimination, harassment, abuse, and dehumanization that disturbingly echoes some of the processes of the 1994 genocide. Myriad studies have also found that HIV-positive Rwandan women are twice as likely to report all forms of IPV. Moreover, numerous studies have also made the direct linkage from those who have experienced the 1994 Genocide to post-traumatic stress disorders as a significant risk factor for IPV in both men and women. Social stigma often keeps these women feeling trapped in their abusive relationships out of fear of further violence or economic abandonment. Furthermore, stigma and fear of social ostracism also actively prevent women from seeking treatment and disclosing their status, which has the potential to create cycles of infection that stunt the public health progress made on this front. As a result, it is the women victims and survivors of the genocide that are doubly subjected to the harm of stigmatization.

The problem is compounded by the fact that psycho-social support for this population is limited due to the structure of mental health service provision in Rwanda. Unlike the concerted state-led effort to address HIV/AIDS, the mental healthcare infrastructure is much more decentralized than primary care because it is characterized as secondary. Consequently, it

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49 Mukamana et al., *Dehumanizing Language*, 2.


51 Mukamana et al., *Dehumanizing Language*, 7.


is perceived as a less urgent public health priority, which places access barriers such as cost and physical distance in front of those most in need of those services. In this instance, major gaps remain in the system to address the psychological traumas of Rwandan women who were subject to the deliberate infection of HIV/AIDS, and the GBV and IPV they continue to endure as a result of stigma, social exclusion, and inability to participate in social and economic life. During the COVID-19 pandemic, although Rwanda has been praised for its robust public health responses, early studies have shown that elderly Rwandans, particularly those who survived the genocide, are at higher risk of both acute infection as well as psychological distress, especially since the onset of the pandemic coincided with the commemoration week for the 26th anniversary of the genocide. Over the world, the economic impacts of lockdowns and other restrictive measures severely and disproportionately impacted the most marginalized communities such as women and people living with pre-existing health conditions. Although no studies currently exist on the impact of the pandemic on those genocide survivors living with HIV/AIDS, they ought to be assumed to be the group most at risk for domestic violence, loss of income and employment, in addition to health risks, both physical and psychological. These gaps in the public health infrastructure in post-genocide Rwanda remain legacies of a patriarchal structure, which continue to pose challenges for the full realization of a transformative transitional justice, particularly for those victims and survivors of genocidal rape and deliberate infections.

Colonial Genocide of Indigenous Peoples in Canada: IRS and Genocide Continued

Despite gaps for the victims and survivors of the Rwandan Genocide in terms of public health and transitional justice, the Rwandan government has made deliberate efforts towards transformative change in their recovery and healing processes. The same cannot be said for the Canadian government, which, unlike the post-genocide RPF government in Rwanda, is a continuation of the perpetrator regime that attempted the deliberate cultural and physical destruction of Indigenous Peoples across the country. While the method of genocide that our analysis focuses on is the IRS, operated by both the state and the church, it should be noted that the process of colonial genocide did not begin with the establishment of the first IRS nor cease with the closure of the last between 1834 and 1997. It is important to note that the IRS system is one among a suite of settler colonial genocidal policies which includes other acts such as the deliberate utilization of biological warfare, rape and other forms of sexual violence, forced displacement, famines, creation of the reserve system, and prohibition of cultural practices in the effort to establish the colonies of British North America and later the consolidation of the Canadian state. James Daschuk provides a detailed account of the colonial genocide process in Canada. He shows that the Canadian state weaponized public health, social pathologies, and economic outcomes against Indigenous communities through deliberate policies of disease and starvation; simultaneously, the state politicized the resultant nadir of Indigenous health to justify further displacement and dispossession of Indigenous Peoples from their lands. Although IRS have been abolished in Canada, and a Truth and Reconciliation Commission (TRC) concluded in 2015, the vast majority of the 94 Calls to Action found by the TRC remain unfulfilled nearly a decade onwards. As such, the settler colonial genocide process against Indigenous Peoples in Canada, including the First Nations, Métis, and Inuit peoples, are still replicated through Canada’s public health system, through both neglect and active

discrimination, thus producing grossly uneven social and economic outcomes between Indigenous and settler Canadians.

In Canada, the IRS system’s main objective was to assimilate Indigenous children into Christian and Western societal norms as a means of displacement and dispossession of Indigenous Peoples from their territories. The earliest documented boarding school arrangement began in 1620 in what is now modern day Quebec by a Franciscan order, which attempted enforced cultural change on Indigenous youths.57 During this initial experiment, settlers remarked on the resistance of the Indigenous populations and the difficulties of assimilation, and still sustained these institutions over the next several centuries by subsequent waves of settlers.58 This practice continued through the confederation of Canada and was legislated into a state-led institution by the Indian Act of 1876, under the John A. MacDonald administration, which “for the first time solidified Canada’s commitment to enforced education of Aboriginal children.”59 MacDonald, in an 1880 address to the House of Commons, outlined the rationale of this policy and asserted that: “...it would be better. If the Indians were to disappear from the continent, the Indian question would cease to exist.”60 A generation later, in 1920, Duncan Campbell Scott, the Deputy Superintendent General of Indian Affairs in Canada, proposed an amendment to the Indian Act by mandating school attendance for all First Nations children between the ages of 7 and 16, favoring “residential schooling to eliminate the influences of home and reserve and hasten assimilation.”61 Scott, who first entered the public service in the department of Indian Affairs under the MacDonald administration, echoed the sentiments of the former Prime Minister in an address to a special parliamentary committee, saying at the time “our objective is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic, and there is no Indian question.”62 Throughout the operation of the IRS, it was estimated that 150,000 Indigenous children were forcefully removed from their communities and homes and placed in the 134 state- and church-run residential schools.63 These institutions were chronically underfunded with their residents subject to both neglect and deliberate abuse while at the same time isolating the Indigenous children under their care from the families and support systems of their home reserves. School operations were poorly staffed and often depended on the forced labor of the children, who also faced harsh and often fatal punishments including beatings, isolation, forced starvation, denial of care, humiliation, electric shocks, and sexual abuse. As a result, malnutrition and outbreaks of preventable diseases became endemic throughout the IRS, with tuberculosis becoming one of the leading causes of death among pupils. Despite knowledge of the epidemics facing Indigenous children, the Department of Indian Affairs continued to underfund and overcrowd the schools.64 As Sproule Jones noted:

As late as 1907, residential school principals maintained that the high rate of tuberculosis among their students was

63 Andrew Woolford and James Gacek, “Genocidal Carcerality and Indian Residential Schools in Canada,” Punishment & Society 18, no. 4 (2016), 400–419.
inevitable given the weaker constitution of the native people... Government officials, assuming that tuberculosis was incurable, saw no need to allocate funds for the medical care and treatment of afflicted native adults and children. Indeed, Clifford Sifton viewed the dropping prairie native population as an opportunity to reduce expenditure on services like education and medical attention.65

As disease continued to ravage the Indigenous pupil population across the IRS in Canada, their health outcomes were further exacerbated by well-documented and deliberate abuse at the hands of staff, where they were denied essential nutrition in addition to basic medical care and sanitation. Children who attempted to escape these conditions often faced deadly risks of hypothermia, exposure, or drowning.66 The result, as found by the TRC, was that death rates at some schools can be as high as 60%.67 In 2015, to the chagrin of some observers, the limited scope of the TRC only went as far as recognizing the IRS as “cultural genocide” in its final report, with many noting that the “cultural” qualifier softened the physical and structural realities of this violent system.68

Despite the closure of the last residential school in 1997, the systemic public health crisis facing Indigenous communities across Canada showed no signs of abating. Indigenous communities fare drastically worse than settler communities across all health indicators, both physical and mental. Statistics Canada have reported year after year that Indigenous populations have higher rates of chronic conditions such as obesity, heart disease, and respiratory illnesses, which influence the overall disparity in life expectancy, compared to settler populations.69 Numerous findings of the TRC’s Final Report note an explicit discrepancy in Indigenous health and healthcare rights. These findings led the Calls to Action to specifically address the recognition of their autonomy in healthcare, identifying the healthcare gaps between the Indigenous and settler populations, addressing the distinct healthcare needs of Métis, Inuit, and First Nations peoples, providing funding for Indigenous health centers, increasing representation in healthcare, and making Indigenous health issues part of medical school curriculums.70 A 2017 study by Ashleigh Tuite et al. found that between 1970 to 2010, the proportion of active tuberculosis cases amongst Indigenous communities increased from 14.7% to 21.2%, nearly a decade and a half after the final residential school was closed.71 Furthermore, the study found the prevalence rate of tuberculosis among some Inuit communities is nearly fifty times that of the overall Canadian population.72 The authors note that the source of this disproportion is directed related to the paucity of public health measures available for these communities, which include education and awareness campaigns; more importantly, the social determinants of health in these communities, such as cramped living conditions with poor ventilation, food insecurity, and income inequality, greatly increase the risk factors for the

69 Gionet and Roshanafshar, Select Health Indicators.
72 Ibid., 2.
transmission of tuberculosis. The prevalence of the disease is compounded by comorbidities experienced by the Indigenous populations in the forms of higher rates of other chronic illnesses compared to settler populations. These outcomes are directly linked to social factors on Indigenous reserves such as poor infrastructure, malnutrition, and lack of access to economic opportunities, in addition to unequal access to interventions and therapeutics used to treat preventable illnesses. Moreover, access barriers to publicly funded and culturally based care for on and off-reserve Indigenous Peoples further contribute to adverse health outcomes.

A 2021 report by the Canadian Pediatrics Association found that the reasons tuberculosis has been nearly eliminated in settler populations, and yet continues to spread endemically among Indigenous populations, are the direct results of social inequities and discrimination, noting that “the drivers of TB have more to do with social and economic factors than with the pathogen itself.” Furthermore, the problem is exacerbated by frequent and ongoing jurisdictional disputes between the federal and provincial governments. Ambiguities surrounding which level of government is responsible for providing access to quality care and treatment for Indigenous communities frequently result in delays in the provision of life-saving care, thus leading to entirely preventable deaths, often in children.

Many community members are also reticent to seek treatment because decades of discrimination and abuse by healthcare professionals against Indigenous peoples have eroded trust between patients and practitioners. This is especially true among pregnant Indigenous women and substance users, against whom the Canadian public healthcare system has explicitly participated in a policy of forced family separation.

As recently as 2019, the British Columbian healthcare system disproportionately discriminated against Indigenous mothers by maintaining discretion to remove infants at birth without parental consent if the mother is deemed to be a high risk of substance use by healthcare professionals. This act of medical racism disturbingly echoes the policies of family separation during the IRS era with the collusion of public health. The institutional nexus of genocide between public health and other sectors is apparent in the Canadian foster care system, where Indigenous children are disproportionately overrepresented, comprising over 75% of all children in out-of-home care. In this same system, there are over 230,000 maltreatment investigations annually and in Ontario alone, “First Nations children are three times more likely than White children to be involved in child maltreatment related investigation.”

Even with the closure of the IRS, colonial genocide against Indigenous communities has continued through this nexus between public health, child welfare, and law enforcement systems. These institutional policies of neglect and explicit discrimination reflect nothing short of a deliberate abdication of the settler state’s responsibility to create conditions that sustain life for Indigenous populations across Canada. As such, although IRS are no longer operational in Canada, the system that allowed IRS to proliferate across the country is very much alive and well, and it continues to replicate conditions faced by the victims and survivors of IRS in their own communities on the reserves.

73 Radha Jetty, “Tuberculosis among First Nations, Inuit and Métis Children and Youth in Canada: Beyond Medical Management,” *Paediatrics & Child Health* 26, no. 2 (2021), e79.


Furthermore, the mental health crisis amongst Indigenous communities that correlates with comorbidities and early death is also directly linked to the intergenerational trauma created by the IRS and the Canadian public health system. Like the survivors of the Rwandan genocide, the mental health outcomes suffered by survivors of the IRS manifest alongside high rates of substance abuse, IPV, and increasing rates of youth suicide in Indigenous communities. There has been widespread consensus among the medical and public health communities that loss of culture also significantly contributes to these enduring mental health challenges faced by victims and survivors in addition to systemic physical, sexual, and psychological abuse. Many survivors of the IRS have lost the ability to read and write in their language or were never taught in the first place. The lack of ability for the social reproduction of identity for youths has been noted to be an additional negative indicator of the social determinant of health for Indigenous communities. A 2017 study conducted by Brittany Barker et al. found that in Indigenous communities where their languages were taught and community health practices were used, the suicide rate was virtually eliminated. Therefore, increasing access to mental health programs designed to connect Indigenous youth and IRS survivors to their languages, traditions, and cultures, is essential to substantive and transformational transitional justice, especially when the deliberate destruction of culture and the impacts of colonialism are recognized even by the Canadian state itself to be one of the main drivers of poor mental health outcomes in Indigenous communities.

However, a major barrier to addressing this public health crisis through transitional justice is the settler and colonial designs of Canada’s mental healthcare infrastructure. The existing system is often at odds with Indigenous approaches and concepts of spiritual wellness, which are necessary to provide culturally-based care to serve the needs of Indigenous communities whose epistemologies embody a much more emplaced and holistic worldview. Specifically, Western ideologies of health are individual-oriented and positioned as individual responsibilities, and thus fail to consider Indigenous conceptions of wellness as community-oriented and essentially tied to Indigenous spirituality and connections with one another. While the Canadian government recognized that reparations must be made to IRS survivors, the treatment protocols administered are largely disconnected from the broader effects of historical marginalization and colonial oppression, instead focusing on individual psychological harms. Despite the voluminous data available on this subject, including reporting by its own agencies, the Canadian government has done little to nothing to increase access to care or adopt alternative models of care. Some notable exceptions are the Aboriginal Healing Foundation, which aimed to facilitate Indigenous healing and the Indian Residential Schools Resolution Health Support Program, which was created specifically for IRS survivors who seek the reparations outlined by the Indian Residential School Settlement Agreement in 2007. However, the former program was cut by the Harper government, and the implementation of the latter program has been criticized for its limited scope, unclear application and disbursement processes, and attempts to absolve the Canadian state of its past actions by providing a “cure” to the centuries of harm visited on the communities through monetary settlements. Major gaps still exist for fully funded mental health and education programs and services by the Canadian government for IRS survivors. This disconnect between the various systems of care and their lack of cultural basis continues to discriminate against and neglect the well-being of Indigenous communities.

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Peoples in Canada, contributing to cycles of poor health outcomes and structural violence. The harms of colonialism are an embedded and integral aspect of the existing public health system, which not only fails to remediate the harm already done to the victims and survivors but continues to replicate them.

In 2021, the discovery of unmarked graves of Indigenous children at various former IRS sites across the country shocked the Canadian public. While government officials and the public have mostly ignored the calls to attention by Indigenous activists and community leaders to the existence of these graves for decades, the scale of discovery forced the settler society to confront the realities of colonial genocide in Canada in a way that it did not see even during the proceedings of the TRC. In the wake of the global racial reckoning spurred on by the George Floyd Protests and Black Lives Matter movements, settler Canadians also began to grapple with their complicity in a structure of violence and genocide. The magnitude of the grave site discoveries swept away the willful denial of the brutality of the system and voluntary suspension of belief that the IRS was conceived in benevolence with good intention.

Despite the ongoing national dialogue, the COVID-19 pandemic continued to exponentiate and accelerate the health inequities between Indigenous and settler populations as a direct result of the systemic discrimination built into the Canadian public health system. Indigenous communities are found to be disproportionately at risk of severe illness compared to settler populations; yet, little effort was made at the crucial beginning stages of the pandemic to collect disaggregated data on the effects of COVID-19 on Indigenous communities, which could have mitigated some of the more devastating effects of the pandemic. Studies have found that Indigenous communities are significantly, and disproportionately, experiencing greater levels of food insecurity, psychological distress, and fear of IPV during the pandemic. Amidst the continued discovery of mass graves at IRS sites, the federal government attempted to legally challenge “a landmark human rights ruling to compensate apprehended First Nations children harmed by the on-reserve child welfare system and under-funded child and family services.” Furthermore, mercury contamination among Grassy Narrows and Whitedog First Nations Communities, and the continued construction of pipelines, such as the Coastal Gaslink Pipeline through unceded traditional Indigenous lands, continues to threatens Indigenous health on a systemic level through infrastructural based colonization programs. Still, to this day, of the 94 Calls to Action outlined by the TRC, the Canadian government continues to delay their implementation. For the Indigenous communities, the lack of transformation of the Canadian public health system is not only a denial of transitional justice but a continuation of settler colonial genocide.

Conclusion: Towards an Integrated Analysis of Public Health, Genocide, and Transitional Justice
The adage that justice delayed is justice denied rings especially true in the public health sector of post-genocide societies. Public health ubiquitously and pervasively impacts the life outcomes of communities and reverberates through generations, not only in terms of their physical and mental wellbeing, but their full participation in cultural, social, political, and economic life. As

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85 David Waldner et al., “COVID-19 Epidemiology in Canada from January to December 2020: The Pre-Vaccine Era,” FACETS 6 (2021), 763.


such, it is imperative that any post-genocide and transitional society closely examines the legacies of structural violence that are embedded in its public health systems that were once deliberately built-in towards the destruction of entire groups. Therefore, equalizing and remediating the social determinants of health for communities previously targeted for destruction is an essential component of the transitional justice process. Reformations of public health must also be mainstreamed throughout any reparation process by the state in order to address the legacies of structural violence and help communities heal.

In our comparative analysis of the Rwandan Genocide and Colonial Genocide in Canada, we have shown that absent radical transformation of the public health system, victims and survivors are denied their due justice and reparations in the best-case scenario, and in the worst-case scenario, the very structure of the public health system itself continues to victimize them. In Rwanda, although strides were made in rebuilding and reforming its healthcare system, major gaps still exist to address the legacies of a policy of sexual violence and intentional HIV/AIDS infection during the genocide, as well as the mental health of those genocide survivors to facilitate both individual and collective healing. Meanwhile, in Canada, the status quo continues to visit structural violence and neglect through its public health sectors against the Indigenous Peoples across the country despite its own admission of “cultural genocide.” While the transitional justice process is theoretically underway in Canada, given the TRC’s 94 Calls to Action, little substantial progress has been made despite the increasing disparities of the social determinants of health between Indigenous and settler populations. Although IRS no longer remain in Canada, the system that supported them continues to exist and visits similar harms on Indigenous communities today. For the Indigenous communities in Canada, transformative justice for colonial genocide through land loss can only be meaningfully met through decolonization.

For scholars and practitioners interested in issues of genocide and transitional justice, there is thus the necessity to adopt an integrated framework of analysis to understand how public health systems are built into the overarching structures of genocide by design. It is therefore important for both genocide and transitional justice scholarships to engage more substantively with the research on public health to bridge the gulf between the literatures. At the same time, it is equally important for public health scholarship to engage with theories of genocide and transitional justice to most effectively realize the systemic outcomes of healing and prophylaxis that it sets out to achieve. More importantly, states and societies must recognize the need for a holistic approach to facilitate healing as an obligation to the victims and survivors of genocide.

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