VIEW to the U transcribed
Season 4: An Eye on 'Why'?; Episode #2
Professor Vincent Kuuire
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Vincent Kuuire (VK):

The work that I do with immigrant integration and wellbeing, I think is more broadly significant to the multiculturalism project that Canada has embarked on.

My name is Vincent Kuuire and I'm an assistant professor in the Department of Geography, here at UTM.

Of course there's the idea that people who come into Canada can continue to maintain their identities and live lives within the broader Canadian society, is an important one to celebrate. I think that some of those ideas that are driving my interest in immigrant integration wellbeing are also directly connected to celebrating black history.

[theme music fades in]

Carla DeMarco (CD): **Immigrant Wellbeing and Global Health.**

For this next season of View to the U, we tap into the amazing breadth of expertise on the UofT Mississauga campus, and focus on a main driving question for the series this year or an eye on why. For this particular episode we focus on, although low and middle income countries like Ghana, Kenya and Malawi are urbanizing at a rapid pace.

Why is the spread of non-communicable and infectious diseases still so prevalent? I am delighted to say that we are turning to professor Vincent Kuuire from UTM's Department of Geography for an answer to this question along with some other insights related to his research.

Hello and welcome to VIEW to the U: An Eye on UTM Research.

I'm Carla DeMarco at UofT Mississauga. VIEW to the U is a monthly podcast that will feature UTM faculty members from a range of disciplines who will illuminate some of the inner workings of the science labs and enlighten the social sciences and humanities hubs at UTM.

Over the course of the interview, we covered Vincent's work, which includes a broad range of considerations including social inequities associated with access to healthcare and immigrant integration dynamics with regards to the healthcare system in Canada, as well as health care for older populations and maternal health, particularly in Sub-Saharan Africa.

CD: Vincent explains things they haven't placed there like the double burden of disease and the pro-poor policies that exist in insurance schemes. Vincent also emphasizes the importance of global health research and collaboration in this area for times as we have seen recently during a virus outbreak.

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CD: Vincent Kuuire is an assistant professor at UofT Mississauga where he has been on faculty in the Department of Geography since 2017. He is also a Canada research chair in immigrant wellbeing and global health. He completed undergraduate studies at the university of Ghana and obtained his masters and PhD in geography with migration and ethics relations at Western University in London, Ontario.

From 2015-16 Vincent was a Postdoctoral fellow on a Social Sciences and Humanities Research Council of Canada funded project. Age friendly communities friendly for whom, under the supervision of professor Mark Rosenberg, the Canada research chair in development studies at Queens university.

VK: I'm a health geographer by training and I study two broad areas within health geography. The first area that I am interested in is related to global health and within global health I study things about access to health care, not the typical geography in terms of accessibility and distance and those things, but more really to the social inequities associated with access to health care. What groups of people are not having access to healthcare.

In that area of research I focused on all the populations as well as maternal health. But I'm mostly interested in non-communicable diseases as well as the change in health dynamics that we see in many low and middle income countries. I focus on Sub-Saharan Africa for this research. I also do research on immigrant integration wellbeing.

I'm interested in what factors are associated with the integration pathways of immigrants, but particularly how are those factors impacting their overall wellbeing in terms of social health in particular. Those are the two broad areas that I do as a researcher.

CD: You know I didn't realize that you study maternal health. Are you then working with mothers who are pregnant or after they have a baby?

VK: The few projects that I've done on maternal health have really been trying to assess what factors influence positive maternal health outcomes. We looked at Malawi and Nigeria over the course of almost two decades. What have they seen improvements and what factors are associated with those improvements in maternal health outcomes.

Particularly related to the use of antenatal care and the use of post-antenatal care services, because these two factors are associated with positive maternal health outcomes. We also

together with some collaborators that we looked at whether health insurance improved maternal access to health care services in Ghana.

VK: At a time that we did this work, Ghana's health insurance was just a little over a decade old and one of the things that people were really interested in understanding is, have these premium exemption policies for mothers or pregnant women led to successes in achieving some of the targets that the WHO recommends for what is categorized as good maternal health strategies.

We did make some interest in findings that yes, there were positives as far as the health insurance is consenting. In other words, people who had health insurance are more likely to use these services. I've since moved on particularly I have focused on health access of older populations. Ghana is one of the few countries that has a National Health Insurance Scheme on the sub Saharan African continent.

Its insurance came is described as a pro-poor insurance scheme and being pro-poor what it means is that they have specific groups of people that are exempted from paying premiums. If you are 70 years or above, if you are pregnant, if you are under the age of 18 and if your society describes you as poor or indigent. My interest really was to assess using various metrics whether people who are 70 years or older have access to healthcare service.

One of the firsts work that we did try to examine whether wealth status impacted people's access to health insurance. Because as pro-poor policy, one of the aims is to eliminate disparities based on wealth. That's why the premium exemption policies were implemented for peasants who are 70 years.

VK: In other words they could just show up to an insurance place and be registered, paying really minimum fees. They don't pay the premium, they pay the enrollment charges. But we did find that despite the elimination of the premium for these groups of people in other ways, people who are 70 years and older, there were still disparities in wealth.

We decided to follow that up with other research to examine whether, for example, people who have what is called unmet needs. Unmet need is when you are sick and you need health care, but you do not get a healthcare. It means you have an unmet need. We decided to find out whether all the people had an unmet need based on some of these initial disparities that we saw.

Again, we saw that these existed both among men and women, but the extent to which these disparities existed among men and women were different. For example, the way wealth or pretend within women was much more pronounced than it did for men, which still suggest that the pro-poor intentions of the health insurance policy are not exactly been met.

I'm really interested in those socioeconomic disparities and access to healthcare, not the typical geography, spatial analysis, access issues that many of my colleagues deal with.

CD: Do the wealthier people had better access to healthcare, what was then that attributed to? Is it because they were able to pay? Is there some privatized?

VK: There were a number of other studies that we did still in relation to that. Consistently we think that there are other fees or other costs associated with enrolling in health care that do not have anything to do with premium exemptions. For example, transportation costs. Depending on where people live, they may have to pay a transport fee to get to their registration point.

If you are poor and not having access to money to engage in that trip, then you will not be enrolled. There may be other cost elements that are not visible or not accounted for within the premium exemption policies. Accounting for the disparities we see.

I think this, for example, is an opportunity for some really great qualitative work to be done to see that, well, within these groups are some of these hunches that we have reasonable explanations for the disparities we see between rich old people and poor old people as far as access to health insurance and access to other healthcare services are concerned.

CD: I was reading about your research and I see that although low and middle income countries like Ghana, Kenya and Malawi are urbanizing at a rapid pace. I understand that there has still been a spread of noncommunicable and infectious diseases and so I'm wondering why you think that's still so prevalent.

VK: I got interested in this work through some collaborations with colleagues, Eric Tenkorang at Memorial University, he's a sociologist there as well as one of my PhD supervisors, Isaac Logan at Western. Initially we were interested in finding out what factors were associated with noncommunicable disease incidents within the general population in Ghana. Consistently we saw that certain demographics were more likely to have different noncommunicable diseases.

Initially we started with hypertension and we expanded the research to at other noncommunicable diseases using secondary data. What I became more aware of during the period of collaborating with these colleagues was that even though infectious diseases continue to be the most important cause of death and disease in completions, but increasingly many people, especially in even in demographics, that you will do not expect them to be having noncommunicable diseases, particularly middle aged people tended to be associated with these conditions as well.

VK: These are the result of rapid urbanization and associated changes in lifestyles. In many low and middle income countries, you tend to have two groups of people that are benefiting or if you like not benefiting from their rapid economic growth as well as rapid urbanization trends that are happening.

The first group of people are the ones who are slightly more educated and therefore are taking advantage of all the opportunities that are imagined. They can afford certain lifestyle changes which predisposed them to these noncommunicable diseases.

VK: At the same time, we have a team in number of people, particularly people who are migrating from rural areas in search of opportunities in urban areas, living in really dilapidated slum like conditions. These conditions are rifle, their continuous presence of many types of infectious diseases. Whether, their lifestyle infectious diseases all related to the nature of their environment.

There is that concurrence of the noncommunicable diseases, but also the persistence of infectious diseases, which has strongly defined the health profile of many low and middle income countries. It's led to a situation where it's called, as I've described it as a double bed of disease.

What basically that means is that both infectious diseases and noncommunicable diseases, because of the conditions that many of these locations find themselves in are persistent at the same time. It has a dwelling part of the population in terms of a lot more people suffering from noncommunicable diseases, but also infectious diseases.

But it also has a dwelling part on the healthcare system that it has to concurrently deal with these two conditions. It's important to state that it is also these low and middle income countries that have weaker health delivery systems and are able to manage with the burdens that are associated with these diseases.

There are all these global factors that are resulted in [inaudible 00:13:28] growth, but it's also associated with the lifestyle changes that has resulted in the increasing incidence of noncommunicable diseases because of the lifestyle changes.

CD: That's called the double burden where it's the noncommunicable and the infectious diseases that…

VK: Yeah. What is known as a double burden of disease is facing the populations as well as the health systems. Within populations, for the longest time, we have always known that infectious diseases are the most important cause of death for populations in low and middle income countries like Ghana where I focus on and in Kenya and Malawi where I'm trying to expand my project to.

But at the same time, increasingly particularly in the last three decades, there's a rapid increase in incidents of noncommunicable diseases, hypertension, stroke, cancer, et cetera. Because of the rapid increase of incidents of infectious diseases and the persistence of noncommunicable disease, these two together impact population health as well as the health care system.

That's why it's called the double burden of disease because within the disease profiles of most societies. There is a theory that's called epidemiological transition. What the theory suggests is that populations usually move from a phase of infectious diseases being the main cause of illness and death to a phase where degenerative conditions such as chronic diseases or manmade diseases become the dominant.

VK: If you take the case of Canada, there are few incidents of infectious diseases, so that is the expected profile and that these movement from infectious diseases to non-infectious diseases is sequential. But in the case of low and middle income countries, we don't see that sequential move. We see concurrently that infectious diseases are still important causes of death and disease but also rising or rapid increases of noncommunicable diseases as a cause of mortality and morbidity within the population.

That scenario is what is called a double bed of disease because they have not moved sequentially from infectious diseases being the dominant to noncommunicable disease being the dominant disease profile of the population.

CD: Thank you for that explanation because I think that clarifies it and then I can't help but ask because everyone's talking about COVID-19 or Coronavirus. Have these countries been affected at all?

VK: As of this recording, I am unaware of any infection on a sub-Saharan African continent, but I think it's important to make a case for global health research. I think this should be a wake up call because what happens in one country invariably has impacts or consequences in other countries and so incidents of infectious diseases such as COBIT 19 or Ebola, which we saw a massive outbreak in 2014-2015 which caused a global scare and SARs and MARs previously.

These are all signs indicative of why global health research should be a collaboration between global North and the global South. Even though the original, the disease might not be from here.

CD: Based on the research that you've done in these areas, have you seen patterns emerging in the occurrence of infectious and noncommunicable diseases?

VK: One of the patterns that has led me to do further research is that consistently, particularly for noncommunicable diseases, we saw in some of our findings that populations in urban areas were always more likely to be the ones that had these noncommunicable diseases. But even more interesting particularly in the case of women that more highly educated women and women in upper socioeconomic status class generally particularly those with higher wealth tended to be the ones that have these noncommunicable diseases.

In a sense there's what is called an inverse of the social gradient of health. The social gradient of health basically explains that there's a relationship between your socioeconomic status and health and that populations with low socioeconomic status tend to have higher incidence of diseases generally or poor health generally.

But in this case we are seeing that the obsession of the population within the higher socioeconomic status bracket are the ones that are also having these noncommunicable diseases.

CD: Hypertension and others.

VK: Exactly. In those instances, the social gradient of health is invest and I think many people who do global health research are familiar with these findings.

CD: And this happens primarily in women?

VK: Yes. Particularly in the case of Ghana where we had done these studies, not only were estimatesreally big for women but they were consistent because you think that because noncommunicable diseases are associated with lifestyle that when you control for lifestyle factors that if nothing at all it was tenured or reduce some of the effects that we see.

But especially for women, even when we control for lifestyle factors, those were not important and the results always remain really robust for in the case of women. That leads to further questions that what is it about women in urban areas with higher socioeconomic status in particular that even when you control for lifestyle factors, they seem to be no attenuation of the relationship as far as noncommunicable diseases are concerned.

That is part of the reason why I'm embarking on the new phase of the project that I'm currently working on to try to understand whether for example, are there specific things within the urban environment, within these contexts particularly, taking the case of Ghana for example, that are responsible for the results that we've seen so far.

CD: I know that you touched on this a little bit, but sometimes neighborhoods are the determining factor related to health. I'm just wondering why you're finding that others.

VK: One of the reasons why I've decided to focus on neighborhoods moving forward with this research is because the neighborhoods that we see in many low and middle income countries are really rapidly evolving locations. They are important that you can really test out whether yes, specific things related to the different neighborhoods, for example, that may be responsible for some of the findings that we have seen.

For example, in some of the studies that we've done, and these are yet to come out and we've seen consistently that one neighborhood factors seem to be associated with all the health conditions that we've studied. The Ghana statistical service calculates a genie index for every neighborhood or as many neighborhoods as they can in most metropolitan areas and of course the genie index is just a number that shows the extent of inequality within the society.

We studied six neighborhoods and we found consistently that neighborhoods that we categorized as having a higher than average inequality consistently was associated with the various types of noncommunicable disease that we've looked at. No amount of controlling for factors, attenuated relationship always remained very robust.

It gives me a sense that there are a number of things that are potentially ongoing that are possibly related to inequalities being measured through these inequality instrument that we included in our study that speaks to the relationship with a negative health outcomes in particular.

VK: This is the next phase of the way to try to come up with indices or a skill that is relevant to the context by speaking with people on the ground to see what factors are important for going to this skill. Hopefully the intention is to be able to say that as far as if you use, whether it's an activity skill or is an environmental quality skill or we still haven't come up with that yet.

We hope to speak with people on the ground to be able to understand what may go into this, but knowing what exists in [inaudible 00:21:56], we already have some ideas of where to go with this. But in the end we are hoping to be able to see that because of these specific living environment conditions in neighborhoods that is why consistently we are seeing these findings.

There's something special about neighborhoods that we haven't understood yet, at least in the context of Ghana that I think will throw more light on why we're seeing these results so far.

CD: I know from speaking to someone else how important it is to talk to people on the ground because I'll never forget when I was talking to someone on geography also does research related to health and access to health care. Then she said sometimes the literature didn't necessarily reflect what people, once they got to interviewing them in some focus groups and surveys. It really didn't match up so it was so important to get that more complete picture.

VK: Yeah, definitely. Especially because most of the work that we've done so far have been quantitative and especially using secondary data sources. They do not capture some of the intricacies and really the idiosyncrasies that are associated with locations that may be important for explaining those results that we've seen so far.

It is really important to talk with people on the ground to see what are the factors that they are dealing with and how do those connect with health outcomes or the health profile of those locations.

CD: Are people in Ghana, do they do like a census thing?

VK: Yeah, 2020 is a census year and I think it starts in a few months from now. I'm really excited about that too because it's going to also give us new measures in terms of poverty headcount, which was one of the variables we used in our study, again the inequality measure, the genie index coefficient for each of those neighborhoods and many other, there're things related to percentage of people with potable water in their homes and things like that.

At the broader neighborhood level we'll be able to get some of that information from the census, which will be done this year. But also talking more with people through those qualitative interviews will give us an insight on some of the things that may be related to health outcomes, which will then inform our development of any skill or index that we will then try to check his connection with noncommunicable diseases in particular.

[interlude music fades in]

CD: Coming up, Vincent talks about the importance of black history and celebrating black history month, how he got interested in this research area in the first place and the impact of his work.

[interlude music fades out]

CD: It's currently black history month and I know that your research, particularly the Canada Research Chair associated projects cover immigrant wellbeing. I'm wondering if you could briefly talk about this work and why it's important.

VK: Yes, it is indeed black history month and it's important to continue to celebrate black history month for a number of reasons. But before I get to those reasons, the work that I do with immigrant integration and wellbeing I think is more broadly significant to the multiculturalism project that Canada has embarked on.

Of course there's the idea that people who come into Canada can continue to maintain the identities and live lives within the broader Canadian society is an important one to celebrate. I think that some of those ideas that are driving my interest in immigrant integration wellbeing are also directly connected to celebrating black history.

One of the reasons why I think it's important to keep talking about all the activities about black history month and celebrating black history is because there's this tendency for us not to tell history properly in many contexts and Canada is not any different. I think that is important to continue to celebrate black history month because of that.

VK: In the Academy, many people are aware that the history of black people in this country goes way back to the 1600s and that black people together with indigenous people were enslaved people in Canada. In the Academy this is Popular knowledge, especially for people who do research on Canadian history and Canadian black studies in particular, but this is not popular culture.

I think what most people tend to know more about is this rule in the underground railroad and I think that in as much as that was important, it's also important to talk about the other historical facts that Canada has been associated with as far as black people are concerned. But even more broadly, it's important to underscore that for example, Canada has always been part of the British empire and the empire expansion project was largely associated with a history of enslavement and colonization.

It is proper to continue to celebrate black history because not just because black history is about slavery and colonization alone, but it's because it's important to tell those colonization and slavery histories properly, I would argue has not been done properly. But even more importantly, the United Nations for example, has talked about the fact that we are currently in what he described as the decade of people of African descent and issues around anti black racism continue to persist in many societies.

VK: Celebrating black history month and talking about black achievement beyond or even outside of slavery and colonization is important to take away some of the negative narratives that are

associated with anti-black racism. It is an important thing and I'm happy that we have many activities within UofT that I've seen around, but also within, there's been some activities that they see it like city counselor has been associated with us, but black history month celebration. I think these are all important discussions that we need to keep having.

CD: Yeah, absolutely. You're totally echoing something that someone else pointed out. She's a faculty member here in visual studies and English and drama. She's an indigenous performance artists. Maria Hartfield is newly onto campus, but she talked about the importance of indigenous people telling their own stories because she said historically other people have told the stories and not accurately.

VK: Exactly.

CD: It's time to take that back and tell the stories properly.

VK: Indeed, there are many stories to be told because you can categorize at least three broad groups and this obviously is an overgeneralization, but three broad groups of black people that are associated with this country. People who were here during the enslavement period of this country's own history, but people who also moved here after the American civil war.

But since after world war two there's been, large waves of migration from the continent itself, Africa itself and many people from Caribbean. There are all these groups of people who have different stories to tell about the existence within Canadian society.

I think its important for us as black people to continue to tell these stories and not just focus on the ones that have been carefully manicured by society and just talk about one aspect that... I don't know if it's proper to say that puts Canada only in a positive light. I think everything about the Canadian history as far as black people has to be told and black people telling those stories is really important in pushing their exact narrative instead of one angle which is only positive.

CD: Absolutely. The word propaganda is popping into my head. But that's what it boils down to. I'm curious because I know that when you started out, I saw your CV that you've been in geography for a long time, but I am curious how did you get interested in this area in the first place?

VK: I have always been interested in geography and I think for many people who get into this discipline, curiosity about different parts of the world is one of the ones that initially lead you to the discipline of geography. As a kid I was always interested in... In fact I participated in many quizzes, which were geography, but the way about landmarks across the world and capitals, the typical geography things.

When I went to high school and I did geography, then I realized I began to see that it's actually not about those things that before high school I was really interested in. There's a lot more to understand from the geographical perspective and that led me onto this journey. Then here I am today as a health geographer.

VK: Even though in my undergrad I wasn't exactly interested in health geography, I was interested in transportation and movement of people between locations and the mechanisms of drive transportation, but more importantly transportation's rule in the development process. Obviously because I come from a developing country and I had read all these things about how transportation does facilitates development.

My lens opening to all these possibilities that exist in geography is what made me decide to stay in the discipline because I think there's a lot that you can learn from a geographical perspective.

CD: Absolutely, and I can't help but think that of course some of the work that you're doing in Ghana would have ramifications for even like the health care like we have in Canada.

VK: I think it's important too to state that, especially because I'm interested in the different groups and how they interact with the healthcare system under the lens of this pro-poor policy that we have. It does have ramifications or implications for other locations even if they are not developing country context.

For example, one of them being that it's important that for every healthcare system that if you are targeting to eliminate disparities to try to see are there other factors that lie underneath. If for example, just wealth disparities, are there other factors that may be mediating the relationships?

I think within that broader context there's utility in understanding broader healthcare access issues, cross piece. It really doesn't matter whether you're in Canada or in a developing country context.

CD: I think it hearkens back to your earlier point about say in the case of COVID-19, the different areas of the world do need to collaborate to try and figure out a better solution.

VK: That point cannot be overemphasized because global health issues or health issues generally, especially when they have to do with infectious diseases like we have seen in the recent history of the world have a potential to impact us all. Of course some people's doomed this story is that an infectious disease is what is going to kill us or an epidemic is what is going to kill us.

Having robust systems in place through collaborations with scholars and the global South is really important for ensuring that when that big outbreak comes that we are ready for it. There is a need for North-South collaborations in health research.

CD: What do you feel is the biggest impact of your work?

VK: For me, I think that my work so far has allowed me to see new questions that I think potentially can be more impactful. For example, consistently we see that setting demographic of people and people in certain locations constantly or more impacted by noncommunicable diseases. I think that an Ethen those details are important but it also leads to other questions.

VK: I think trying to answer those questions is really where the impact lies for me moving forward. Because what is it about those conditions, those locations that are making these diseases persistent and prevalent that even when you account for all these other factors, they seem to still persist.

I think moving forward, I'm more excited about the questions that have been generated by the previous engagements that I've been involved in. I think the excitement really is in trying to push forward these boundaries that we know as far as the field of noncommunicable disease and health impacts are concerned.

CD: Absolutely, and the questions are yet to come, right?

VK: Yes. The questions that are yet to come, they really do excite us as researchers because you do see that every time you answer one question, there is one that remains unanswered and it really speaks to the fact that much more work still needs to be done in many of these areas.

CD: That's great.

I just wanted to thank you so much for coming in today to tell me about yourself.

VK: Thanks for having me.

[theme music fades in]

CD: I would like to thank everyone for listening to today's episode of VIEW to the U.

I would like to thank my guest Vincent Kuuire, for telling us about his healthcare research in UofT Mississauga's Department of Geography and as the Canada research chair in immigrant wellbeing and global health.

I like to thank the office of the vice principal research for their support. If you listen to the show through iTunes, please consider reading View to the U so that others can find the podcast and please for this new season, if you have other burning questions for our long list of experts at UTM, please send them my way.

Details for getting in touch are on our website, or send them directly to car.demarco@utoronto.ca. Stay tuned!

Lastly, and as always, thank you to the musical director, Tim lane for his tracks and support.

Thank you!

[theme music fades out]