The Political And Legal Determinants Of CALD Communities: An Unhealthy (Modern) Healthcare Paradigm

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Abstract
Culturally and Linguistically Diverse (CALD) groups experience disproportionately poorer health outcomes in Canada and Australia due to a secular-humanist ontology. The intergenerational trauma caused by widespread systemic discrimination has led to a higher prevalence of chronic illnesses, mental health disorders, poorer health literacy, lower income status, geographic displacement, and food insecurity. To accurately conceptualize these health outcomes, a life-course approach incorporating a phenomenological lens that accounts for the social determinants of health is adopted. Such a framework will elucidate the disparities unique to different cultures adhering to an epistemology beyond secular humanism. Our commentary provides greater insight into the impact of structural intermediary factors – socio-economic, legal, environmental, and political – to understand better the healthcare experience and outcomes of CALD and Indigenous groups in Canada and Australia – including the Pacific diaspora in Australia. This analysis will help develop tailored advocacy strategies and clinical practice guidelines to implement and reframe the unhealthy (modern) healthcare paradigm into a culturally sensitive strength-based intervention approach. Such a model will help promote resilience and address the underlying implicit biases that reinforce institutional prejudices, thereby bridging the gap in health equity. The manuscript concludes by suggesting five clinical practice guidelines moving beyond a Western biomedical model of care.

Keywords: Cultural and Linguistically Diverse (CALD), Cultural Competence; Denial of Coevality, League of Nations, Life-Course Approach, Pacific Diaspora, Secular-Humanist, Sovereignty

Introduction
With domestic or international migration, the structural landscape and demographics within a country diversifies due to expansion of urbanization. Over the past decades, there has been a growing population of culturally and Linguistically Diverse (CALD), Indigenous[1], and immigrant groups in Canada and Australia (Javanparast, Naqvi, and Mwanri 2020; Verdon, Wong, and McLeod 2016). The concept of CALD is defined by the Australian Bureau of Statistics (ABS) as unique linguistic and cultural characteristics that comprise a population and involves a set of primary indicators, such as birth country; main language spoken at home outside of English;

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[1] I use the term "indigenous" even though I am aware of the essentialist connotation it holds especially in geographical spaces that have been historically denied "sovereignty". For instance, the French would call peoples from the Arab *Maghreb* and Arab *Mashreq* – especially Muslims – Indigène, Indian, Sarcaen, and/or indigenous to highlight their cultural uncivility and temporal backwardness.

English proficiency; and Indigenous status (le Pham et al. 2021). Many studies have highlighted that Indigenous communities experience disproportionately more significant healthcare challenges, such as poor healthcare accessibility and higher risk of chronic illnesses, than those of Anglo-Canadian or Anglo-Australian background (Durey et al., 2012; Kim et al., 2019).

More significant inequities in healthcare are also experienced by CALD people in Australia from barriers such as institutional prejudices, resulting in reduced health outcomes compared to mainstream Australians (Javanparast, Naqvi, and Mwanri 2020). To overcome these barriers, the healthcare delivery process must take an interconnected, multisystemic approach to meet unique health service needs at the individual, community, and societal levels. As health systems and provider factors play a significant role in the accessibility and utilization of health services, the structural determinants of health and political context must be explored (Javanparast, Naqvi, and Mwanri, 2020).

Through a life-course approach predicated on developmental and structural perspectives, greater insight can be gained into the etiologies of health inequities (Jones et al., 2019). It enables an exploration of socially patterned exposures at various stages of human development and their impact on health within and across generations (Jones et al., 2019). This approach can be combined with a phenomenological lens that delves into lived experiences and their meaning to those who live them (Mushquash et al., 2021). By doing so, such a framework will help advance the understanding of risk factors and unfavorable exposures in multiple domains, the complexity of their interactions; and suffering through unique lived experiences in shaping overall health outcomes (Mushquash et al., 2021; Jones et al., 2019).

Conceptualizations of health and wellbeing that are culturally relevant and community-based will then be reflective of CALD and Indigenous groups. Consequently, practical strategies that intersect to promote the determinants of health can be employed to close the current healthcare gap. Fostering longitudinal decolonization processes and using resilience models to promote primordial, primary, secondary, and tertiary prevention will help reset the modern health system approach and empower marginalized communities (Al-Kassimi, 2021; Mushquash et al., 2021; Javanparast, Naqvi, and Mwanri 2020; Barnabe, 2021). This commentary evaluates the structural – socio-economic, environmental, legal, and political – and intermediary determinants of health to gain deeper insight into the intersectional healthcare experience and outcomes of CALD and Indigenous communities. This knowledge will garner the development of tailored advocacy approaches that account for historical events, political forces, and life contexts. Otherwise, we risk employing a generalized approach lacking the cultural competency to engage with patients and collaboratively reach well-informed healthcare decisions reciprocally. Below, we pinpoint structural and intermediary factors synergistically contribute to the poor health outcomes experienced by CALD communities, older Indigenous Samoan men in urban Australia, the Indigenous Canadian Inuit, and the Pacific diaspora in Australia.

2.1. Historical Mistreatment and Distrust

Modern health outcome disparities are rooted in secular-humanist (i.e., Western) social values and the resulting enforcement of colonial healthcare delivery on CALD and Indigenous peoples (Al-Kassimi et al., 2022; Linney et al., 2020). Mainly, political systems are structured in ways that marginalize specific communities, given that health inequities are strongly associated with political action or inaction (Dawes, 2020). The exclusion of cultural approaches within a dominant "Western" biomedical model, in both practice and policy, highlights the inherent power imbalance that reifies interest at the expense of morality – naturalizing a separation between law and morality (Al-Kassimi et al., 2022; Linney et al., 2020; Boyer, 2017). The (secular-humanist) approach accenting the current biomedical approach has limited our understanding of conscientiously noticing the intimate relationship between coloniality and modernity, resulting in some communities being extended services prioritizing their well-being while others are destined to remain unhealthy (i.e., uncivilized).

The unethical material consequences of such an irreligious medical approach informing the logic of global health relations manifest in mainstream medical models continuously valorizing a "competition" lens when assessing "cultural differences." This presupposes "cultural antagonism"

as a necessary medical disciplinary ethos separating and deciding which bodies are worthy of *healthcare* (Al-Kassimi, 2022; Sandset, 2021). As such, the long histories of colonization and negative experiences of systemic prejudices faced by those deemed unworthy significantly hinder the development of trusting relationships with healthcare providers and, thus, access to healthcare.

The historical trauma caused by the Canadian Residential Schools and forcible removal of Indigenous Australian children, the "Stolen Generation", from their homes has contributed to difficulties in accessing appropriate mainstream primary healthcare services (Linney et al., 2020; Boyer, 2017; Cronin, 2017; Markwick et al., 2019; Horrill et al., 2018). Moreover, Indigenous communities in Australia have expressed how their traditional medicine practices, which help strengthen cultural ties and emphasize interconnected wellbeing, are not acknowledged as alternative medicine and remain undermined by the conflicting Western biomedical value of physical health (Shahid et al., 2010; Oliver, 2013). Hence, these transgressions against the Indigenous peoples of Canada and Australia have resulted in direct and intergenerational impacts that exacerbate the vicious cycle of disease prevalence and challenges in healthcare accessibility (Hunter & Gray, 2017). Similarly, CALD communities are at a higher risk of developing chronic illnesses and face more significant challenges in accessing healthcare in Canada, such as language barriers, unlike their Canadian-born counterparts (Lambert et al., 2021). In Australia, a cross-sectional survey has shown that CALD communities experience racial discrimination as a regular occurrence, which is linked to a greater risk of mental illness (Ferdinand, Paradies, and Kelaher 2015).

Mistrust of the government's healthcare minimizes positive health-seeking behavior and impedes accessibility to beneficial services (Oliver, 2013). Cooperative behaviors promoting mutual well-being and shared goals become disabled, leading to alienation from the healthcare system (Awofeso, 2011; Hunter & Gray, 2017; Markwick et al., 2019). With the prevalence of discrimination, continued experiences of social exclusion hinder their development of "linking social capital," thus impairing their health and well-being (Awofeso, 2011; Hunter & Gray, 2017; Brockie et al., 2021). Consequently, these marginalized communities face barriers to civic and social participation, which hinders their representation in the development of governmental policies and programs. Hence, this circuit of systematic barriers is a contemporary reflection of the systemic discrimination faced by non-Anglo-Canadians or non-Anglo Australians, ultimately resulting in health status inequity (Brockie et al., 2021). Using a phenomenological lens embedded within a life-course approach, the structural barriers faced by each CALD community can be identified and addressed according to the biopsychosocial medical model. This knowledge can inform the building of culturally safe clinical practice guidelines and healthcare policies, such as Indigenous and Pacific migrant aging programs to promote community-based exercise activities and personalized health education (Wettasinghe et al., 2020).

2.1.1. *Immigration Laws and Policies*
In Australia, there is a long, complex history of Pacific migration and mobility, not-withstanding the pre-colonial movements between islands among Indigenous peoples and historic 'black-birding' for labor purposes (Lee, 2009). An increasing number of Māori and Pacific peoples have settled in Australia primarily as economic migrants since the 1990s (Brown, 1995; Ravulo, 2015; Hamer, 2009). Establishing the Trans-Tasman Travel Arrangement (TTTA) in 1973 contributed to further Māori and Pacific migration between New Zealand, Australia, and Pacific Islands nations. The TTTA was established to encourage all New Zealand and Australian residents to visit and migrate to other countries freely. However, concerned with the growing numbers of New Zealanders settling in Australia, the Australian Government restricted access to social welfare, attempting to drive New Zealander residents back to New Zealand. To the detriment of many Māori and Pacific peoples who have migrated to Australia since 2001, visa holders after this date are ineligible for social security and have limited access to the National Disability Scheme, disaster relief payments, public and emergency housing, transport concessions, and other assistance (Smith, 2018). This has contributed to barriers such as significant financial hardships exacerbated by the inability to access public housing, social protection, and other social services, poor overall health (Queensland Health, 2011), and over-representation in the justice system (Shepherd & Ilalio, 2016). Māori and Pasifika peoples are more likely to be hospitalized and face

premature mortality from chronic conditions such as diabetes, and these figures are underestimated due to the misrepresentation in the Australian census where many Pacific people migrating through TTTA are classified as New Zealanders (Hill et al., 2017; Queensland Health, 2011). These listed factors mean that Māori and Pasifika communities are vulnerable and face more significant disadvantages and health inequity (Akbar 2022a and 2022b; Queensland Health, 2011).

2.2. Geographical Displacement

At the turn of the 20th century, a dominant secular-humanist science enabled the League of Nations—especially France and Britain—to divide and identify geographic territories as Class A, B, and C (Al-Kassimi, 2021). Class C territories consisted of various former German-held territories that mandate powers subsequently administered as integral parts of their territory, such as New Guinea (assigned to Australia), Western Samoa (now Samoa, assigned to New Zealand), the islands north of the Equator in the western Pacific (Japan), and Nauru (Australia, with Britain and New Zealand) (Al-Kassimi, 2021). Such an abstract classification category not only accents the technocratic objectives of the mandated project, informing a "Western" approach to medicine, but also makes salient the scientific approach adopted by the League to alter geographic, demographic, and cultural aspects of the said territories (Al-Kassimi, 2021). While the logic of Sovereignty dictates the League's spatial reorganization, understood as the "power to separate violently", Al-Kassimi reminds us that "the boundaries of the empire, in the end, were the result of bureaucratic reactions to the indigenous agency" (Al-Kassimi, 2021, p. 242). The peculiarities of each territory and method of bureaucratic administration strengthened, rather than disrupted, the master science it sought to produce. The peculiarities of Class C territories represented a "scientific laboratory experiment" assimilated into the mandate system, which, in turn, enabled it to adjust and perfect the League's effort in altering "different" cultural values to that informing "Western" civilization. It, therefore, follows that if "particular native practices were to justify themselves now, they had to do so against the massive system of scientific truth constructed by the mandates, which could now make new and more powerful claims to being universal" (Al-Kassimi, 2021). Sovereignty was conceptualized as a cognitive process that could be created not only in its juridical form but also in its sociological form. By dissecting the supposed "threatening interior" of a "non-secular" society while universalizing a "scientific (cultural) standard," which cast Class C subjects as pre-discursive or unconscious, this ultimately provoked the development of desacralized techniques. These techniques are now understood as the territory in terms of resources and economic development; population in terms of health issues, mortality rates, hygiene, and labor concerns; and government in terms of the reform of native political institutions to meet the advanced scientific models that supposedly lead to economic development and social progress. Therefore, in the mandate system, the dynamic of difference operates concerning the most intimate (interior) aspects of non-Western civilization—their psychology, customs, ethics, morals, and health—all of which could be characterized as degenerative by "recognized sovereigns" that encompass the Family of Nations who are supposedly naturally familiar with the "standard of well-being (Al-Kassimi, 2021).

Incorporating historical and political dimensions into the phenomenological lens helps to contextualize further the causes (i.e., power asymmetries at the international and domestic levels) behind the perpetuating health disparities. As a result, adopting this adapted lens will guide novel large-scale changes to forge a path toward recovery and reconciliation.

2.2.1. *Climate-Related Mental Health Outcomes*

Land and sea are critical drivers of health, psychological well-being, and cultural identity, where climate changes disproportionately exacerbate the vulnerability of Indigenous communities (Middleton et al., 2020; Cianconi, Betrò, and Janiri 2020). Place disruption due to unanticipated displacement following weather disasters, such as high tides in the Torres Strait Islands, severs spiritual and cultural connections to the land, which is intimately tied to their identity, especially among the Canadian Inuit (Cianconi, Betrò, and Janiri 2020; Middleton et al., 2020). Limited land access also prevents the handover of Indigenous traditional and local knowledge from Elders to youth, leading to stress and fear, thereby removing protective factors to climate-related mental health outcomes (Middleton et al., 2020; Bowles, 2015). Many Pacific Island nations also

face adverse health impacts due to climate change and the socioeconomic disadvantages of living in small island developing states (Ash et al., 2016; Campbell, 2015; Locke, 2009; McIver et al., 2016). The resulting food insecurity and population movement influx from rural outer islands to urban central islands ultimately leads to a decline in general livelihood (Campbell, 2015; Locke, 2009; McAdam et al., 2020; McIver et al., 2016).

2.2.2. *Food Insecurity*

Food insecurity emphasizes the interface between climate change and mental health, where environmental-based disruptions of local food systems have led to malnutrition, emotional distress, and erosion of culture (Akbar, 2020; Bowles, 2015). This loss of food sovereignty is a by-product of the widespread Westernization of food environments and relocation to remote reservation lands or substandard urban areas with crowding and poor dwelling conditions (Browne et al., 2020; Blue Bird Jernigan et al., 2021). These changes have shifted the diet from traditional healthy foods to dependence on manufactured convenience foods (Akbar et al., 2022). Consequently, elevated obesity, Type 2 Diabetes, and other diet-related chronic illnesses were observed among older Samoan Australian communities due to poor lifestyle behaviors impacted by systemic inequities (Hill et al., 2017; Ndwiga et al., 2020; R. Jones, 2019). These inequities are embedded in large corporations' targeted marketing strategies that shape supply-demand dynamics, incentivize unhealthy behaviors, and constrain the food supply options available to Indigenous governments (Akbar et al., 2022; Jones, 2019; McKay, 2019). As Indigenous food systems are founded on ancestral knowledge and tied to their identity, external regulations are needed to promote health-promoting business practices and prevent political influences toward business interests (Blue Bird Jernigan et al. 2021). For the Māori and Pasifika diaspora, food serves as a primary vehicle for building and preserving social capital. Due to changes to the TTTA, as mentioned above, the resulting system creates more excellent rates of unemployment, under-employment and precarious employment associated with low incomes and inequitable conditions—all of which promote food insecurity (Akbar 2022a and 2022b; Shepherd & Ilalio, 2016; Smith, 2018). Thus, this highlights the need to create a food sovereignty approach that improves cultural food security and considers the elements of hospitality, identity, mana, reciprocity, and spirituality. Practical solutions that impact the social determinants of health and can sustainably manufacture and distribute affordable and nutritious food must be developed to help marginalized communities thrive (Akbar 2022a and 2022b).

2.3. Lower Income Status

Poverty and earning disparities experienced by Indigenous communities stem from their overrepresentation in non-standard work, such as temporary agency work le (Pham et al., 2021). Type of employment is a significant factor influencing health disparity—especially among Indigenous migrants in urban areas (Akbar 2022a and 2022b; le Pham et al. 2021; Smith, 2018). The gap in health disparity among Indigenous Canadians was largest when involving formal employment (Lamb & Verma, 2021). Similarly, Indigenous Australian men had an unjustifiable earned income reduction of 9.3%, possibly attributable to discrimination and lower full-time employment rates (Birch et al., 2018). Hence, lower occupational mobility is associated with poorer healthcare outcomes through higher rates of psychological distress, dietary behavior, and smoking—ultimately leading to lower labor market engagement (Taylor & Bellt, 1996).

The availability of government subsidies is a significant facilitator in the accessibility of healthcare for low-income individuals. Specifically, The Closing the Gap PBS Co-Payment and travel grants increased treatment adherence (Nolan-Isles et al., 2021). However, since the control of funding and resource allocation is based on a population rather than a community approach, the unique needs of older Indigenous individuals usually need to be understood (Nolan-Isles et al., 2021; Habjan, Prince, and Kelley, 2012). Without access to appropriate support, Elders develop mistrust towards governing bodies, and the absence of family caregivers further deepens disempowerment as younger generations are forced to seek external employment (Horrill et al., 2018; Habjan, Prince, and Kelley, 2012). For Pacific migrants, many do not have access to PBS and are ineligible for healthcare and other social services due to the 2001 changes to the TTTA (Smith, 2018).

2.4. Poor Health Literacy

Low health literacy stems from the inability to apply health information—which affects perception of healthcare needs and self-determination in making healthcare decisions (Nash and Arora 2021; Rheault, Coyer, and Bonner 2021). During clinical consultations, poor communication involving medical jargon and feelings of shame associated with the inherent power differential leads to poor physician-patient relationships and health-seeking practices (Lambert et al. 2014; Nash and Arora 2021; Rheault, Coyer, and Bonner 2021. As health literacy is contextual and changes over time with evolving health problems, continuity of long-term culturally safe healthcare with the same provider serves as a key enabler for willingness to develop symbiotic partnerships and access healthcare (Rheault, Coyer, and Bonner 2021).

2.5. Cultural Values and Traditions

The relativist cultural dynamic of difference distinguishing between civilized/healthy and uncivilized/unhealthy communities has been crucial in maintaining an exclusionary biomedical paradigm. Johannes Fabian describes the "denial of coevalness" within ratiocinated Latin-European philosophical theology as the "persistent and systematic tendency to place the referent of anthropology in a Time other than the present of the producer of anthropological discourse" (Al-Kassimi 2022). Thus, in secular-humanist anthropological accounts of non-Western societies, a temporal difference is bound to a violent dynamic classifying diverse cultures as "unsociable" and naturally unhealthy. The result of perceiving peoples as being temporally backward – therefore lacking civil-legal personality that make them worthy of health-care – can be deduced. Specifically, Samoan culture is imagined as destined to remain stagnant in the past by not only perceiving its inhabitants as bodies lacking "cultural dynamism", but more importantly, denying them sovereign security—therefore, viewed as situated "outside" civil law. In other words, those who exist in the "present" are seen as agents of knowledge or knowing subjects whose well-being is prioritized, whilst peoples who exist in the "past" are perceived as unworthy objects whose health is trivial as they lack modernity's secular-humanist idea of social belonging emphasizing individualism.

2.5.1. *Reciprocity and Hospitality*

Australian Samoan communities alongside Canadian Inuit's value reciprocity and hospitality, where the practice of sharing food serves as an important cultural tradition (Akbar 2022). Without access to nutritious food due to food deserts and financial burden—costing 30% of disposable household income—the pressure of upholding traditional food practices in social settings can increase the sharing of unhealthy foods (Lee et al. 2016; Perkins et al. 2016). Specifically, higher rates of consumption of discretionary foods and low consumption of vegetables underscores the need for culturally appropriate nutrition interventions to amend dietary habits (Perkins et al. 2016; Dixon et al. 2007).

As church and religion are central to Samoan culture, these can serve as avenues to promote social cohesion. In this setting, trusted church ministers play a vital leadership role in positive health promotion, as shown by the improved control of diabetes among Australian Samoans with church-based interventions (Ndwiga et al. 2020). By facilitating traditional, cultural, and linguistic interactions, this allows for the development of positive cultural identities and strengthening of shared cultural beliefs and knowledge (Lesa et al. 2009). This signifies the need for appropriate cultural competency training among healthcare practitioners to incorporate culturally safe lifestyle education in medical management plans (Akbar 2022a and 2022b).

3. CONCLUSION

Acknowledging historical mistreatment and involving stakeholders in the healthcare policy-making system may be the first step toward reconciliation. Systematic changes within the healthcare system must be implemented to reframe the unhealthy (modern) healthcare paradigm. This model must address the implicit biases that reinforce institutional racism and promote resilience. With health defined as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, it is essential to no longer reify a secular-humanist (immanent) worldview. A life-course approach incorporating a phenomenological lens that does not emphasize Godless hubris can aid in achieving more extraordinary insight into the interplay of environmental, socioeconomic, and commercial

determinants of health and political forces that shape the health experience of CALD and Indigenous communities (Al-Kassimi, 2022; Lesa, 2009). This requires a shift in healthcare providers' knowledge, behavior, and practice to promote a therapeutic relationship founded on trust and respect (Wylie & McConkey, 2019). Extending beyond the Western biomedical model of care, we recommend that future clinical practice guidelines incorporate the following key elements: 1) cultural awareness and competency, 2) health literacy, 3) continuity of care model: incorporating bilingual community health workers (CHWs), 4) ethical frameworks and gaps in research, and 5) involvement of government agencies.

For cultural awareness and competency, there must be an understanding and acknowledgment of the terms used to identify themselves; community-specific values, traditions, and communication practices; different perspectives on culturally safe care; intergenerational impacts of residential schools; perpetuation of negative stereotypes and inaccurate references to colonization present within the discourse on health care policy and land claim negotiations; and the importance of traditional medicines. For health literacy, healthcare professionals should recognize the disproportionate prevalence of HIV/AIDS, cervical cancer and poorer outcomes, mental illnesses, and sexual abuse and exploitation (Wilson et al., 2013). For the continuity of care model, greater access to translator services must be a priority, where bilingual CHWs act as trusted liaisons between the community and service providers and help educate and promote autonomy among CALD individuals (Ndwiga et al., 2021). An extension to this is incorporating community leaders and peer support facilitators to collaboratively develop culturally centered church-based interventions that address their communities' specific local health needs (Ndwiga et al., 2021). However, implementing church-based interventions and CHWs poses the challenge of effectively integrating sustainable development and expansion principles to bridge the health equity gap. For ethical frameworks and gaps in research, there must be no generalizations made among different CALD communities, increased collection of statistics, further exploration of mature women's health issues, and the incorporation of the OCAP (ownership, control, access, and possession) principles, Tri-Council Policy Statement, and community-specific guidelines (Wilson et al., 2013). Future research should focus on designing culturally appropriate e-Health services to overcome financial and geographic barriers, especially for the older CALD and Indigenous populations (Javanparast et al., 2018). Lastly, concerning the involvement of government agencies, health practitioners should acknowledge the ongoing controversies surrounding jurisdictional obligations that restrict CALD communities from accessing high-quality, timely, and culturally safe healthcare. Health professionals should be informed of the Non-Insured Health Benefit programming, including its eligibility, coverage requirements, and exclusions/special approvals (Wilson et al., 2013).

We herein proposed a list of recommendations for future clinical practice guidelines to reduce the gap in healthcare disparity among CALD communities. Additional research is needed to effectively incorporate these propositions into a practical and sustainable healthcare delivery model.

Conflicts of Interest: The authors declare no conflict of interest.

REFERENCES

Javanparast, Sara Syed Kashif Abbas Naqvi, and Lillian Mwanri. "Health Service Access and Utilisation Amongst Culturally and Linguistically Diverse Populations in Regional South Australia: A Qualitative Study." Rural and Remote Health 20, no. 4 (2020): 1–15. https://doi.org/10.3316/INFORMIT.616304175962675.

Verdon, Sarah, Sandie Wong, and Sharynne McLeod. "Shared Knowledge and Mutual Respect: Enhancing Culturally Competent Practice through Collaboration with Families and Communities." Child Language Teaching and Therapy 32, no. 2 (2016): 205–21. https://doi.org/10.1177/0265659015620254.

Pham, Thi Thu Le, Janneke Berecki-Gisolf, Angela Clapperton, Kerry S. O'Brien, Sara Liu, and Katharine Gibson. "Definitions of Culturally and Linguistically Diverse (CALD): A Literature Review of Epidemiological Research in

Australia." International Journal of Environmental Research and Public Health 18, no. 2 (2021): 737. https://doi.org/10.3390/ijerph18020737.

Durey, Angela, and Sandra C Thompson. "Reducing the Health Disparities of Indigenous Australians: Time to Change Focus." BMC Health Services Research 12, no. 1 (2012): 151–151. https://doi.org/10.1186/1472-6963-12-151.

Kim, Paul J. "Social Determinants of Health Inequities in Indigenous Canadians Through a Life Course Approach to Colonialism and the Residential School System." Health Equity 3, no. 1 (2019): 378–81. https:// doi.org/ 10.1089/heq.2019.0041.

Jones, Rhys. "Climate Change and Indigenous Health Promotion." Global Health Promotion 26, no. 3_suppl (2019): 73–81. https://doi.org/10.1177/1757975919829713.

Mushquash, Christopher, Elaine Toombs, Kristy Kowatch, Jessie Lund, Lauren Dalicandro, and Kara Boles. "Promoting Resilience within Public Health Approaches for Indigenous Communities." In Multisystemic Resilience: Adaptation and Transformation in Contexts of Change, 78–99 (2021). Oxford University Press. https://doi.org/ 10.1093/oso/9780190095888.003.0005.

Al-Kassimi, Khaled. "De-Historicizing (Mainstream) Ottoman Historiography on Tanzimat and Tahdith: Jus Gentium and Pax Britannica Violate Osmanli Sovereignty in Arabia." Histories 1, no. 4 (2021): 218–55. https://doi.org/ 10.3390/histories1040020.

Barnabe, Cheryl. "Towards Attainment of Indigenous Health through Empowerment: Resetting Health Systems, Services and Provider Approaches." BMJ Global Health 6, no. 2 (2021): e004052. https://doi.org/10.1136/bmjgh-2020-004052.

Al-Kassimi, Khaled. International Law, Necropolitics, and Arab Lives: The Legalization of Creative Chaos in Arabia. London (UK): Routledge, 2022

Linney, Catherine, Siyan Ye, Sabi Redwood, Abdi Mohamed, Abdullahi Farah, Lucy Biddle, and Esther Crawley. ""Crazy Person Is Crazy Person. It Doesn't Differentiate": An Exploration into Somali Views of Mental Health and Access to Healthcare in an Established UK Somali Community." International Journal for Equity in Health 19, no. 1 (2020): 190–190. https://doi.org/10.1186/s12939-020-01295-0.

Dawes, Daniel. 2020. The Political Determinants of Health. Maryland: Johns Hopkins University Press.

Boyer, Yvonne. "Healing Racism in Canadian Health Care." Canadian Medical Association Journal (CMAJ) 189, no. 46 (2017): E1408–E1409. https://doi.org/10.1503/cmaj.171234.

Sandset, Tony. "The Necropolitics of COVID-19: Race, Class and Slow Death in an Ongoing Pandemic." Global Public Health 16, no. 8-9 (2021): 1411–23. https://doi.org/10.1080/17441692.2021.1906927.

Cronin, Darryl. "Trapped by History: Democracy, Human Rights and Justice for Indigenous People in Australia." Australian Journal of Human Rights 23, no. 2 (2017): 220–41. https://doi.org/10.1080/1323238X.2017.1373739.

Markwick, Alison, Zahid Ansari, Darren Clinch, and John McNeil. "Experiences of Racism Among Aboriginal and Torres Strait Islander Adults Living in the Australian State of Victoria: A Cross-Sectional Population-Based Study." BMC Public Health 19, no. 1 (2019): 309–309. https://doi.org/10.1186/s12889-019-6614-7.

Horrill, Tara, Diana E McMillan, Annette S H Schultz, and Genevieve Thompson. "Understanding Access to Healthcare Among Indigenous Peoples: A Comparative Analysis of Biomedical and Postcolonial Perspectives." Nursing Inquiry 25, no. 3 (2018): e12237–n/a. https://doi.org/10.1111/nin.12237.

Shahid, Shaouli, Ryan Bleam, Dawn Bessarab, and Sandra C Thompson. ""If You Don't Believe It, It Won't Help You": Use of Bush Medicine in Treating Cancer Among Aboriginal People in Western Australia." Journal of Ethnobiology and Ethnomedicine 6, no. 1 (2010): 18–18. https://doi.org/10.1186/1746-4269-6-18.

Oliver, Stefanie J. "The Role of Traditional Medicine Practice in Primary Health Care Within Aboriginal Australia: A Review of the Literature." Journal of Ethnobiology and Ethnomedicine 9, no. 1 (2013): 46–46. https://doi.org/10.1186/1746-4269-9-46.

Hunter, Boyd, and Matthew Gray. "Occupational Mobility of Indigenous and Other Australians." Australian Journal of Labour Economics 20, no. 2 (2018): 149–65.

Lambert, Sylvie, Ekaterina Loban, Jane Li, Tracy Nghiem, Jamie Schaffler, Christine Maheu, Sylvie Dubois, Nathalie Folch, Elisa Gélinas-Phaneuf, and Andréa Maria Laizner. "Chronic Illness Management in Culturally and Linguistically Diverse Patients: Exploring the Needs, Access, and Understanding of Information." Qualitative Health Research 31, no. 13 (2021): 2426–39. https://doi.org/10.1177/10497323211040769.

Ferdinand, Angeline S, Yin Paradies, and Margaret Kelaher. "Mental Health Impacts of Racial Discrimination in Australian Culturally and Linguistically Diverse Communities: A Cross-Sectional Survey." BMC Public Health 15, no. 1 (2015): 401–401. https://doi.org/10.1186/s12889-015-1661-1.

Awofeso, Niyi. "Racism: A Major Impediment to Optimal Indigenous Health and Health Care in Australia." Australian Indigenous Healthbulletin 11, no. 3 (2011): 14.

Brockie, Teresa, Terryann C. Clark, Odette Best, Tamara Power, Lisa Bourque Bearskin, Donna L. M. Kurtz, John Lowe, and Denise Wilson. "Indigenous Social Exclusion to Inclusion: Case Studies on Indigenous Nursing Leadership in Four High Income Countries." Journal of Clinical Nursing, 2021. https://doi.org/10.1111/jocn.15801.

Wettasinghe, Pamela Ming, Wendy Allan, Gail Garvey, Alison Timbery, Sue Hoskins, Madeleine Veinovic, Gail Daylight, et al. "Older Aboriginal Australians' Health Concerns and Preferences for Healthy Ageing Programs." International Journal of Environmental Research and Public Health 17, no. 20 (2020): 7390. https://doi.org/ 10.3390/ijerph17207390.

Helen Lee. "Pacific Migration and Transnationalism." In Migration and Transnationalism, 7. ANU E Press, 2009.

Brown, Richard P C, and Adrian M. Walker. Migrants and Their Remittances: Results of a Household Survey of Tongans and Western Samoans in Sydney. Sydney: Centre for South Pacific Studies, University of New South Wales, 1995.

Ravulo, J. 2015. Pacific Communities in Australia. Western Sydney University.

Hamer, Paul. "Measuring Māori in Australia: Insights and Obstacles." Social Policy Journal of New Zealand, no. 36 (2009): 77–81.

Smith, Andrew MC. "The Fiscal Impact of the Trans-Tasman Travel Arrangement: Have the Costs Become Too High?" Australian Tax Forum 33, no. 2 (2018): 249–79. https://doi.org/10.3316/agispt.20180905001314.

Queensland Government and Department of Health, Queensland Health's Response to Pacific Islander and Māori Health Needs Assessment, in Chief Health Officer's Report 2011: Brisbane.

Shepherd, S. M., & Ilalio, T. (2015). Maori and Pacific Islander overrepresentation in the Australian criminal justice system—what are the determinants? Journal of Offender Rehabilitation, 55(2), 113–128. https://doi.org/10.1080/10509674.2015.1124959.

Hill, Kathleen, Paul Ward, Blair S Grace, and Jonathan Gleadle. "Social Disparities in the Prevalence of Diabetes in Australia and in the Development of End Stage Renal Disease Due to Diabetes for Aboriginal and Torres Strait Islanders in Australia and Maori and Pacific Islanders in New Zealand." BMC Public Health 17, no. 1 (2017): 802–802. https://doi.org/10.1186/s12889-017-4807-5.

Akbar, Heena, Carol Windsor, Danielle Gallegos, Inez Manu-Sione, and Debra Anderson. "Using Talanoa in Community-Based Research with Australian Pacific Islander Women with Type 2 Diabetes." Progress in Community Health Partnerships 16, no. 1 (2022): 119–28. https://doi.org/10.1353/cpr.2022.0011.

Akbar, Heena, Charles J T Radclyffe, Daphne Santos, Maureen Mopio-Jane, and Danielle Gallegos. ""Food Is Our Love Language": Using Talanoa to Conceptualize Food Security for the Māori and Pasifika Diaspora in South-East Queensland, Australia." Nutrients 14, no. 10 (2022): 2020. https://doi.org/10.3390/nu14102020.

Middleton, Jacqueline, Ashlee Cunsolo, Andria Jones-Bitton, Carlee J Wright, and Sherilee L Harper. "Indigenous Mental Health in a Changing Climate: A Systematic Scoping Review of the Global Literature." Environmental Research Letters 15, no. 5 (2020): 53001. https://doi.org/10.1088/1748-9326/ab68a9.

Cianconi, Paolo, Sophia Betrò, and Luigi Janiri. "The Impact of Climate Change on Mental Health: A Systematic Descriptive Review." Frontiers in Psychiatry 11 (2020): 74. https://doi.org/10.3389/fpsyt.2020.00074.

Devin C. Bowles. "Climate Change and Health Adaptation: Consequences for Indigenous Physical and Mental Health." Annals of Global Health 81, no. 3 (2015): 427–31. https://doi.org/10.1016/j.aogh.2015.06.004.

Ash, J. and J. Campbell. "Climate Change and Migration: The Case of the Pacific Islands and Australia." Journal of Pacific Studies, 2016.

Campbell, John Richard. "Development, Global Change and Traditional Food Security in Pacific Island Countries." Regional Environmental Change 15, no. 7 (2014): 1313–24. https://doi.org/10.1007/s10113-014-0697-6.

Locke, Justin T. "Climate Change-Induced Migration in the Pacific Region: Sudden Crisis and Long-Term Developments." The Geographical Journal 175, no. 3 (2009): 171–80. https://doi.org/10.1111/j.1475-4959.2008.00317.x.

McIver, Lachlan, Rokho Kim, Alistair Woodward, Simon Hales, Jeffery Spickett, Dianne Katscherian, Masahiro Hashizume, et al. "Health Impacts of Climate Change in Pacific Island Countries: A Regional Assessment of Vulnerabilities and Adaptation Priorities." Environmental Health Perspectives 124, no. 11 (2016): 1707–14. https://doi.org/10.1289/ehp.1509756.

McAdam, J. and J. Pryke, Policy Brief 10-Climate Change, Disasters and Mobility: A Roadmap for Australian Action. UNSW Law Research Paper, 2020(21-20).

Akbar, Heena, Danielle Gallegos, Debra Anderson, and Carol Windsor. "Deconstructing Type 2 Diabetes Self-Management of Australian Pacific Islander Women: Using a Community Participatory Research and Talanoa Approach." Health & Social Care in the Community, 2021. https://doi.org/10.1111/hsc.13580.

Devin C. Bowles. "Climate Change and Health Adaptation: Consequences for Indigenous Physical and Mental Health." Annals of Global Health 81, no. 3 (2015): 427–31. https://doi.org/10.1016/j.aogh.2015.06.004.

Browne, Jennifer, Mark Lock, Troy Walker, Mikaela Egan, and Kathryn Backholer. "Effects of Food Policy Actions on Indigenous Peoples' Nutrition-Related Outcomes: A Systematic Review." BMJ Global Health 5, no. 8 (2020): e002442. https://doi.org/10.1136/bmjgh-2020-002442.

Valarie Blue Bird Jernigan, Tara L. Maudrie, Cassandra Jean Nikolaus, Tia Benally, Selisha Johnson, Travis Teague, Melena Mayes, Tvli Jacob, and Tori Taniguchi. "Food Sovereignty Indicators for Indigenous Community Capacity Building and Health." Frontiers in Sustainable Food Systems 5 (2021). https://doi.org/10.3389/fsufs.2021.704750.

Ndwiga, Dorothy W, Kate A McBride, David Simmons, and Freya MacMillan. "Diabetes, Its Risk Factors and Readiness to Change Lifestyle Behaviours Among Australian Samoans Living in Sydney: Baseline Data for Church-Wide Interventions." Health Promotion Journal of Australia 31, no. 2 (2020): 268–78. https://doi.org/10.1002/hpja.276.

Ndwiga, Dorothy W, Freya MacMillan, Kate A McBride, Ronda Thompson, Jennifer Reath, Olataga Alofivae-Doorbinia, Penelope Abbott, et al. "Outcomes of a Church-Based Lifestyle Intervention Among Australian Samoans in Sydney – Le Taeao Afua Diabetes Prevention Program." Diabetes Research and Clinical Practice 160 (2020): 108000–108000. https://doi.org/10.1016/j.diabres.2020.108000.

McKay, Fiona H, Bronte C Haines, and Matthew Dunn. "Measuring and Understanding Food Insecurity in Australia: A Systematic Review." International Journal of Environmental Research and Public Health 16, no. 3 (2019): 476. https://doi.org/10.3390/ijerph16030476.

Lamb, Danielle, and Anil Verma. 2021. "Nonstandard Employment and Indigenous Earnings Inequality in Canada." Journal of Industrial Relations 63 (5): 661–83. https://doi.org/10.1177/00221856211021128.

Birch, Elisa, and David Marshall. "Revisiting the Earned Income Gap for Indigenous and Non-Indigenous Australian Workers: Evidence from a Selection Bias Corrected Model." Journal of Industrial Relations 60, no. 1 (2018): 3–29. https://doi.org/10.1177/0022185617732365.

Taylor, John, and Martin Bellt. "Population Mobility and Indigenous Peoples: The View from Australia." International Journal of Population Geography 2 (1996). https://doi.org/10.1002/(SICI)1099-1220(199606)2:2%3C153::AID-IJPG19%3E3.0.CO;2-U.

Nolan-Isles, Davida, Rona Macniven, Kate Hunter, Josephine Gwynn, Michelle Lincoln, Rachael Moir, Yvonne Dimitropoulos, et al. "Enablers and Barriers to Accessing Healthcare Services for Aboriginal People in New South Wales, Australia." International Journal of Environmental Research and Public Health 18, no. 6 (2021): 3014. https://doi.org/10.3390/ijerph18063014.

Habjan, Sonja, Holly Prince, and Mary Lou Kelley. "Caregiving for Elders in First Nations Communities: Social System Perspective on Barriers and Challenges." Canadian Journal on Aging 31, no. 2 (2012): 209–22. https://doi.org/10.1017/S071498081200013X.

Nash, Simone, and Amit Arora. "Interventions to Improve Health Literacy Among Aboriginal and Torres Strait Islander Peoples: A Systematic Review." BMC Public Health 21, no. 1 (2021): 248–248. https://doi.org/10.1186/s12889-021-10278-x.

Rheault, Haunnah, Fiona Coyer, and Ann Bonner. "Chronic Disease Health Literacy in First Nations People: A Mixed Methods Study." Journal of Clinical Nursing 30, no. 17-18 (2021): 2683–95. https://doi.org/10.1111/jocn.15757.

Lambert, Michelle, Joanne Luke, Bernice Downey, Sue Crengle, Margaret Kelaher, Susan Reid, and Janet Smylie. "Health Literacy: Health Professionals' Understandings and Their Perceptions of Barriers That Indigenous Patients Encounter." BMC Health Services Research 14, no. 1 (2014): 614–614. https://doi.org/10.1186/s12913-014-0614-1.

Lee, Amanda J, Sarah Kane, Rebecca Ramsey, Elizabeth Good, and Mathew Dick. "Testing the Price and Affordability of Healthy and Current (unhealthy) Diets and the Potential Impacts of Policy Change in Australia." BMC Public Health 16, no. 318 (2016): 315–315. https://doi.org/10.1186/s12889-016-2996-y.

Perkins, Kym C, Robert Ware, Lemalu Felise Tautalasoo, Ranandy Stanley, Lote Scanlan-Savelio, and Lisa Schubert. "Dietary Habits of Samoan Adults in an Urban Australian Setting: A Cross-Sectional Study." Public Health Nutrition 19, no. 5 (2016): 788–95. https://doi.org/10.1017/S1368980015001998.

Dixon, Jane, Abiud M Omwega, Sharon Friel, Cate Burns, Kelly Donati, and Rachel Carlisle. "The Health Equity Dimensions of Urban Food Systems." Journal of Urban Health 84, no. 3 Suppl (2007): i118–129. https://doi.org/10.1007/s11524-007-9176-4.

Lesa, Fa'afetai. "The Impact of Samoan Christian Churches on Samoan Language Competency and Cultural Identity." ProQuest Dissertations Publishing, 2009.

Struthers, Roxanne, and Cynthia Peden-McAlpine. "Phenomenological Research Among Canadian and United States Indigenous Populations: Oral Tradition and Quintessence of Time." Qualitative Health Research 15, no. 9 (2005): 1264–76. https://doi.org/10.1177/1049732305281329.

Jones, Nancy L, Stephen E Gilman, Tina L Cheng, Stacy S Drury, Carl V Hill, and Arline T Geronimus. "Life Course Approaches to the Causes of Health Disparities." American Journal of Public Health (1971) 109, no. S1 (2019): S48–S55. https://doi.org/10.2105/AJPH.2018.304738.

Wylie, Lloy, and Stephanie McConkey. "Insiders' Insight: Discrimination Against Indigenous Peoples through the Eyes of Health Care Professionals." Journal of Racial and Ethnic Health Disparities 6, no. 1 (2018): 37–45. https://doi.org/10.1007/s40615-018-0495-9.

Wilson, D., de la Ronde, S., Brascoupé, S., Apale, A. N., Barney, L., Guthrie, B., Harrold, E., Horn, O., Johnson, R., Rattray, D., Robinson, N., Aboriginal Health Initiative Committee, Alainga-Kango, N., Becker, G., Senikas, V., Special Contributors, Aningmiuq, A., Bailey, G., Birch, D., Cook, K. Society of Rural Physicians of Canada (2013). Health professionals working with First Nations, Inuit, and Métis Consensus Guideline. Journal of Obstetrics and Gynaecology Canada: JOGC = Journal d'obstetrique et gynecologie du Canada: JOGC, 35(6), 550–558.

Ndwiga, Dorothy W., Kate A. McBride, David Simmons, Ronda Thompson, Jennifer Reath, Penelope Abbott, Olataga Alofivae-Doorbinia, Paniani Patu, Annalise T. Vaovasa, and Freya MacMillan. "Using Community Based Research Frameworks to Develop and Implement a Church-Based Program to Prevent Diabetes and Its Complications for Samoan Communities in Southwestern Sydney." International Journal of Environmental Research and Public Health 18, no. 17 (2021): 9385. https://doi.org/10.3390/ijerph18179385.

Javanparast, Sara, Alice Windle, Toby Freeman, and Fran Baum. "Community Health Worker Programs to Improve Healthcare Access and Equity: Are They Only Relevant to Low- and Middle-Income Countries?" International Journal of Health Policy and Management 7, no. 10 (2018): 943–54. https://doi.org/10.15171/ijhpm.2018.53.