Original Article

Bridging the commercial determinants of Indigenous health and the legacies of colonization: A critical analysis

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Abstract: To date, there has been scarce effort to consider the intertwining of colonization and the commercial determinants of Indigenous health. This is a vital omission, and one that this paper proposes to address. We propose how four losses of tradition borne out of colonialism are intertwined with four respective commercial determinants of Indigenous health: 1) loss of traditional diets and the ultra-processed food industry; 2) loss of traditional ceremony and the tobacco industry; 3) loss of traditional knowledge and the infant formula industry; and 4) loss of traditional support networks and the alcohol industry. Building on Indigenous efforts to decolonize spaces and assert control over their own lives, we argue that analyzing the mechanisms through which industry activities intersect with colonial legacies will improve broader understandings of Indigenous health disparities.

Keywords: tobacco, Indigenous health, determinants of health, equity/social justice, breastfeeding, food security, alcohol

Introduction

Scholars have increasingly identified how components of late-stage capitalism and poor health outcomes are fundamentally intertwined. A few industries, including tobacco, alcohol, and ultra-processed foods, are now major contributors of poor health and premature deaths in Canada and internationally (1). Though frequently selling very different products, these organizations often operate using similar strategies, including political lobbying, campaign donations, public relations committees, and greenwashing strategies, to diminish the focus on their broader harmful impacts (2). Bridging these industries and tactics are *the commercial determinants of health* (CDOH), a conceptual framework and academic field that refers to commercial determinants as drivers of health (3). The CDOH generally cover three main areas: first, unhealthy commodities that contribute to ill-health; second, the business, market, and political practices that harm health and are employed to sell these products and secure favorable regulatory environments; and third, the global drivers of ill-health, such as neoliberalism, that have facilitated the proliferation of these commodities and strategies (3).

Despite the growing focus on the CDOH, there has been a conspicuously absent consideration of their intersections with Indigenous health disparities. This is a crucial omission: a number of the most prevalent health issues within Indigenous communities, including high rates of commercial tobacco use, alcoholism, obesity, and diabetes (4–6), are significantly associated with private sector interests (7). Moreover, the CDOH have the potential of contributing to an investigation of upstream determinants of health, something that has been repeatedly called for when addressing Indigenous health inequities (see Carson *et al.*, (8); Kolahdooz *et al.*, (9)).

To date, there has been just one review of the commercial determinants of Indigenous health, by

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Crocetti *et al*. (10). Crocetti *et al*. conducted a systematic scoping review of available evidence on the commercial determinants of Indigenous health and well-being, identifying six industries: extractive (mining), tobacco, food and beverage, pharmaceutical, alcohol, and gambling. Our paper builds on the review by Crocetti *et al*. and existing knowledge of commercial determinants of Indigenous health by centering the intertwining of colonial loss and the commercial determinants of health.

Overall, the legacy of colonization, including the impacts of residential schools and broader assimilation practices, is recognized as the single most significant determinant of Indigenous peoples' health (11). In this vein, our paper proposes how four losses of tradition borne out of colonization are intertwined with four respective commercial determinants of Indigenous health: 1) loss of traditional knowledge and the infant formula industry; 2) loss of traditional diets and the ultra-processed food industry; 3) loss of traditional support networks and the alcohol industry; and 4) loss of traditional ceremony and the tobacco industry. We propose that progress in understanding the commercial determinants of Indigenous health – and Indigenous health inequities more generally – requires ongoing reflections on the intersections between colonial legacies and health-harming industries' activities that have largely gone unexplored to date.

Loss of traditional knowledge and the infant formula industry

Breastfeeding has clear and well-established health benefits, including reductions in childhood infectious diseases, mortality, and malnutrition for the child. Mothers who breastfeed see pronounced reductions in their risks of diabetes, breast and ovarian cancers, and cardiovascular disease (12). At present, the World Health Organization recommends children are breastfed exclusively from birth to six months, and that breastfeeding continues up to two years or more after the introduction of solid foods (13). Despite this, breastfeeding initiation rates for Indigenous women in Canada are 77.8%, compared with 88% for non-Indigenous women in Canada (14). This discrepancy, over entire Indigenous populations, has had enormous consequences for both Indigenous mothers' and children's health (14).

Prior to settlers' arrival, Indigenous women traditionally breastfed their babies (15). Historically, women in Indigenous communities commonly supported breastfeeding by assisting in the care of other children and/or breastfeeding when the biological mother was unable to (16). Fathers sought to provide the best cuts of meat to their partners to encourage higher quality of breast milk (16). Female Elders played important roles in advising pregnant women and new mothers, providing advice, and sharing knowledge (17). Many of these traditional practices, however, were lost as a result of colonization. The residential school experience strongly inhibited the transfer of traditional knowledge about childbirth, including breastfeeding (18). As a result of their forced removal, residential school survivors were forced to raise children without having experienced parenting skills. These deficits were passed on to their children, thus becoming another intergenerational trauma. Colonization also impacted family structures, reducing the company of female relatives and communal support (14). Land designations also went to males as a result of colonization, dismantling females' family roles and undermining caregiving (16).

In tandem with these colonial losses, the infant formula industry has exerted its enormous economic power to feed on parents' anxieties around normal infant behaviors, positioning infant formula as a solution to a range of babies' health and development challenges with little actual evidence. Rapidly growing into a $55 billion industry, the industry now spends more than $3 billion on marketing annually (19). Through a well-refined playbook, it seeks to influence families, health professionals, science, and policy processes. This occurs via advertising and promotion, the funding of professionals and science groups, lobbying, and through industry front groups (19). It is increasingly difficult for parents to find objective, industry-free information on breastfeeding, with new parents commonly seeing dozens of infant formula advertisements within the first year of their children's birth. This problem has become even more acute with the advent of digital marketing, with companies now able to target parents with algorithm-driven marketing at the precise moments when they are in their most vulnerable or concerned states around difficulties breastfeeding (13). Underlying these tactics, Nestlé and other infant formula corporations

have effectively used their status as biomedical experts, taking advantage of – and perpetuating – colonial notions of scientific dominance over Indigenous knowledges and wisdom in order to promote infant formula (15).

Loss of traditional diets and the ultra-processed food industry

Indigenous Peoples are nearly twice as likely to be obese than non-Indigenous individuals in Canada, with a significantly higher prevalence of type 2 diabetes and cardiovascular diseases (20). First Nations, Métis and Inuit communities' greater risks are rooted in a range of intersecting and combined factors, including the history of colonialism; poor access to healthy and affordable food; and an overall genetic risk for type 2 diabetes (9). Many of these disparities, however, can be traced to Indigenous communities' loss of traditional diets and to the residential school system, with Indigenous women connected to traditional ways up to 16 times more likely to breastfeed (21).

Indigenous communities' diets in the pre-colonial and early colonial periods largely consisted of traditional foods, containing a diversity of wild foods such as fish, game, and berries and other plants gathered off of the land (22). This diet was overall cost-effective, provided a range of nutrients, and served as a form of social cohesion through food preparation and sharing customs (22). The legacies of colonialism, however, have significantly disrupted this way of eating, including a nutritional shift to market or store-bought foods that emphasized high-energy, nutrient-lacking foods, and shifted customary practices away from traditional food harvesting and eating (23).

Food was also weaponized in the residential school system. Students were commonly fed scraps and 'porridge with worms in it,' and the federal government knowingly underfunded kitchens and food, leading to starvation (24). Residential school survivors reported a severe culture of socialization and assimilation, in which students were stripped of their identities, including in their relationships to food. One survivor shared, 'I can't cut up caribou meat; I can't cut up moose meat; work with fish and speak my language. So I was starting to become alienated from my parents and my grandparents; everything' (24).

Beginning in the second half of the 20th century, the loss of traditional foods has given way to a shift in dietary practices that emphasized particularly refined and industrial-formulated substances, often labelled as 'ultra-processed foods' (UPFs) (22). The concept of UPFs refers to industrial creations of mostly inexpensive ingredients and nutrients that are manufactured using a series of processes (thus 'ultra-processed') and contain limited whole foods, if any (25). Indigenous diets are now disproportionately made up of ultra-processed foods, with approximately 54% of Indigenous energy consumption coming from UPFs (22). This consumption of UPFs is of particular concern: international health organizations, including the Pan American Health Organization and the World Health Organization, have recommended using diets' energy share of UPFs as overall measurements of diet quality (26).

Intersecting with and exacerbating these changes to Indigenous diets is a food industry that has been repeatedly shown to heavily push UPFs at the expense of global health (27). This push operates through a range of strategies, including influencing governmental dietary advice, heavily marketing UPFs, promoting unhealthy foods in schools, lobbying policymakers, fighting efforts to promote healthy eating, and maintaining a relative monopoly over the global food system, multinational food and beverage companies have had a significant impact on UPFs, particularly in terms of UPFs (28). Lower childhood obesity is now clearly associated with stronger regulations on sales of unhealthy food and restrictions on food advertisements in schools (29). Moreover, the impacts of an overabundance of availability of UPFs and few restrictions on marketing of unhealthy foods is particularly likely to disproportionately impact marginalized communities, especially children that do not have the same abilities to critically push back at industry messaging (27).

Researchers have found that transnational companies, such as Nestlé and Coca Cola, continue to engage in corporate social responsibility initiatives that build brand images in Indigenous communities via sponsored scholarships and employment opportunities for Indigenous youth (10). Yet these same industries have shown little interest in reducing their role in exacerbating childhood obesity-related and diet-related diseases among Indigenous communities. UPF industries continue to engage in

lobbying, selective pricing, and marketing in order to drive consumption.

Loss of autonomy and the alcohol industry

Alcohol continues to plague traditional ways of life within Indigenous communities. Today, Indigenous youth are 43% more likely to report using alcohol than non-Indigenous youth, and begin drinking on average at earlier ages (30). In addition, alcohol use is disproportionately reported to be a result of 'depressive' symptoms, such as drinking to cope and binge drinking. Seventy-three percent of First Nations community members report that alcohol is a problem in their communities (31).

Alcohol was first introduced to First Nations People by the Hudson's Bay Company fur traders (32). Prior to the first wave of European colonization, few Indigenous cultures in North America had encountered alcohol (33). It quickly became standard practice to offer alcohol to Indigenous traders. Frank *et al*. (34) puts the crisis more bluntly, arguing:

> [The] roots of the epidemic of alcohol-related problems among many Native North Americans are sought in cultural responses to European arrival, the role of alcohol in frontier society, and colonial and postcolonial policies (p.344).

With the expansion of the liquor trade, the negative stereotype of the 'drunken Indian' began to take hold. European traders documented the harmful effects of alcohol on their Indigenous trading partners (33). Traders reported heavy drinking among Indigenous peoples, including consumption of large quantities of alcohol in short periods of time, and frequent bouts of violence and promiscuity. These incidents soon led to demands for an end to the liquor trade. The prevailing perception was that alcohol unleashed the 'savage' nature of First Nations peoples, rendering them completely incapable of holding their liquor and therefore unsuitable to drink at all (33).

As a result, European traders attempted to ban alcohol via the Indian Act. A hierarchy of Superintendents, Deputy Superintendents, Commissaries, Interpreters, and Missionaries was established in 1775, with a clear set of duties, including that: 'No Trader shall sell or otherwise supply the Indians with Rum, or other spirituous liquors, swan shot or rifled barrel led guns' (35). That set the tone for federal government's policies regarding First Nations communities and alcohol: through an amendment to the Indian Act in 1884, it became a felony for Indians to purchase, consume, or enter a licensed liquor establishment. The intention behind this law was largely commercial: it was anticipated that Indigenous people would more diligently focus on farming their land if they did not have access to alcohol (35).

In tandem with the impacts of colonization, the alcohol industry utilizes sophisticated marketing and pricing strategies to drive consumption (36). Alcohol marketing is associated with earlier initiation rates of drinking, higher rates of consumption, and positive expectations among youth populations (37). Despite this, alcohol companies continue to design new products and related campaigns with youth-friendly attributes. The industry has also used a range of tactics to influence policies and policymaking, including public campaigns that emphasize the individual and de-emphasize the corporation (38), attempting to push the responsibility of safe drinking squarely onto individuals and away from communal responsibility (36). Industry systematically encourages an emphasis on individual-level education and industry self-regulation, in combination with a 'personal responsibility' narrative (39). This has resulted in the industry averting warnings about alcohol use and pregnancy, as well as circumventing restrictions on availability and price (40). In combination, this has led to the targeted marketing of alcohol towards Indigenous populations, heavy lobbying, and an absence of community consultation by the alcohol industry when building alcohol outlets near Indigenous communities (10).

Loss of traditional ceremony and the tobacco industry

The recreational abuse and addiction epidemic of tobacco among Indigenous people remains one of the primary causes of premature death in Indigenous communities (41). There is a growing awareness of the disproportionate impacts that commercial tobacco use has on Indigenous communities, with Indigenous individuals more than twice as likely to smoke commercial tobacco (35.8–59.8%) than the

general Canadian population (18%) (41). The tobacco epidemic within Indigenous communities is of particular concern because of the ways in which the industry has seized on well-meaning harm reduction narratives within tobacco. Rather than truly investing in harm reduction strategies, the industry has seized on efforts to further cement its product in marginalized communities (42).

Many First Nations communities have had a respectful relationship with traditional tobacco, which is often used in ceremony, as well as ritual, prayer, in trade, and as a form of a contract (43). But this use of tobacco was absent from the commercialization and current mass production tobacco that has the chemicals, nicotine, and addictive properties it has in it today (43).

When the settlers discovered First Nations people interacting with tobacco, the voyagers were curious and brought it back to Europe with them. In the 16th century, Europe, East Asia, and West Africa were growing tobacco from the Americas because the Spanish were transporting the tobacco plant all over the world on their commercial voyages. The 17th century saw a further rise in the growth, harvesting, and exportation of tobacco as a recreational drug (44). Mark (45) explains 'As British colonialism in North America expanded, so did the tobacco plantations and, in time, tobacco served not only as the economic foundation of the colonies but as currency' (para. 3). The governments of Europe established monopolies on the sale of tobacco products and from there the tobacco industry in England was a privately owned business that received government subsidies in the form of higher tobacco taxes, thus making it a cash crop in colonial America (45). Tobacco farming needed to be expanded because of the high demand.

When establishing themselves in the Americas, farmers and settlers bartered with tobacco. With the advent of Bills of Credit, however, that practice was discontinued (45). While the colonies were fighting for independence from Europe, tobacco was used as collateral for loans received from France. Once the British discovered this, they began setting fires to destroy the crops and this continued until the end of the war.

There is abundant evidence that the tobacco industry has systematically promoted and targeted Indigenous peoples with commercialized nicotine products (41). The industry has employed a wide range of strategies, including lobbying against health-protecting regulations, exploiting tribal sovereignty through tax-exempt cigarette sales, targeted marketing, and ensuring widespread access to its products (41). The industry has also regularly used depictions of Indigenous people to promote its products, including using slogans such as 'Australians answer to the peace pipe.' In the United States, tobacco is frequently marketed with carved wooden Native American male figures outside of smoke shops, with an ongoing effort to create a commercial association between Native Americans and tobacco (46). These images were to represent the native crop used by First Nations Peoples who planted, cultivated, and harvested the plant for traditional, health, and spiritual uses.

More recently, the industry has increasingly tried to connect with Indigenous communities to promote e-cigarettes and non-combustible tobacco (47). Rothmans, Benson & Hedges hosted a 'Harm Reduction' forum to ostensibly help Indigenous people facing addiction (42). Yet as both Cree-Metis and settler allies have pointed out, there is a fundamental tension in the industry hosting an Indigenous health conference (48). The industry has a long, sordid history of appropriation and targeting marginalized groups with their products. The strategies also serve to downplay other strategies (with less commercial backing) that need to be put in place to help smokers quit – ranging from financial incentives to therapy – that do not benefit the industry and therefore fail to elicit their attention (49). Finally, it downplays Rothman, Benson & Hedges' actions in the Global South – while British American Tobacco and its related companies promote forms of 'harm reduction' in areas where tobacco control is strong, they continue to promote their products to Indigenous communities in the Global South, where there are fewer restrictions, and they have more financial freedom (41).

Conclusion

To date, there has been scarce effort to consider the intertwining of colonization and the commercial determinants of Indigenous health. This is a vital omission, and one that this paper proposed to address. These intersections have enormous consequences for Indigenous communities globally, particularly given

the frequent relegation of Indigenous priorities in health policymaking.

In this initial paper, we have outlined four areas in which we argue that the legacies of colonization and industry interests have intersected: 1) loss of traditional diets and the UPF industry; 2) loss of traditional support networks and the alcohol industry; 3) loss of traditional ceremony and the tobacco industry; and 4) loss of traditional knowledge and the infant formula industry. Each of these four examples illustrates how Indigenous communities have had to negotiate their relationship to health in the face of both colonization and the increasingly outsized influence of health-harming industries. Building on Indigenous efforts to decolonize spaces and assert control over their own lives, we argue that analyzing the mechanisms through which industry activities intersect with colonial legacies will improve broader understandings of Indigenous health disparities.

Author contribution

Both authors have made a substantial contribution to (a) the conception and design and/or the analysis and interpretation of data, (b) drafting the article or revising it critically for intellectual content, and (c) both authors approve the version submitted to *Global Health Promotion*.

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