Vol. 10 No. 1, pp. 33–40 March 2023

Canadian Food Studies La Revue canadienne des études sur l'alimentation

Commentary

Ethnic food practices, health, and cultural racism: Diabetes risk discourse among racialized immigrants in Canada

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Abstract

Type 2 diabetes is more prevalent among racialized immigrant groups in Canada compared to the general population. Hence, "ethnicity" is identified as a risk factor for diabetes, focusing on ethnic differences in health behaviours. By linking ethnic differences and diabetes risk, ethnic food cultures are problematized. Using the concept of cultural racism, this paper explores the ways in which ethnic food cultures are used to explain racial inequities in health. This paper will conclude by supporting the naming of racism, rather than ethnicity, as one of the root causes of diabetes among racialized immigrant populations and health inequities in Canada.

Keywords: Ethnic food; diabetes; racism; immigrant; traditional foods; social determinants; health inequities

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DOI: 10.15353/cfs-rcea.v9i4.548
ISSN: 2292-3071

Résumé

Le diabète de type 2 a une prévalence plus élevée chez les groupes immigrants racisés du Canada par rapport au reste de la population. Par conséquent, l'« ethnicité » est considérée comme un facteur de risque du diabète, ce qui pointe du doigt les différences ethniques en matière d'habitudes de vie. Relier les différences ethniques aux risques de diabète implique de problématiser les cultures alimentaires ethniques. S'appuyant sur le concept de racisme culturel, cet article explore les manières dont les cultures alimentaires ethniques sont utilisées pour expliquer des inégalités raciales en santé. La conclusion à laquelle nous arrivons ici est plutôt que le racisme lui-même, et non l'ethnicité, constitue une des principales causes du diabète chez les populations immigrantes racisées et des inégalités en matière de santé au Canada.

Introduction

Diabetes is more prevalent among racialized populations in Canada and is inequitably distributed by social factors such as education and income (Gagne & Veenstra, 2017; Public Health Agency of Canada [PHAC], 2018). Diabetes is a chronic health condition that can lead to complications such as heart disease, kidney failure, and depression (PHAC, 2017). Over 3.4 million people in Canada were living with diabetes in 2017 to 2018 (PHAC, 2021); 90 percent of cases are Type 2, which is considered to be preventable or delayable by behavioural interventions (Diabetes Canada Clinical Practice Guidelines Expert Committee, 2018). The literature recognizes social factors as contributors to Type 2 Diabetes (T2DM; Hill-Briggs et al., 2020). Yet the dominant discourse about diabetes risk centres on biological, cultural, and behavioural factors rather than the distal social determinants of health such as the racialization of poverty, exclusion of racialized immigrants in the labour market, and systemic racism (Block & Galabuzi, 2011). For example, the Public Health Agency of Canada (2012) identifies ethnicity as a risk factor for T2DM, "the influence of ethnicity reflects both biological and behavioural differences that influence diabetes risk" (p. 69). Diabetes Canada Clinical Practice Guidelines Expert Committee (2018) identifies these "higher risk" ethnic groups as peoples of "African, Arab, Asian, Hispanic, Indigenous, or South Asian descent" (p.S24). These "ethnic behavioural differences" imply that the healthy eating and physical activity behaviours of "non-white" "ethnic" cultures are the explanation for the racial inequities in health. The linking of behavioural differences and ethnicity to diabetes risk reinforces white healthism[1] ideals and blames racialized groups for their own ill-health.

In this paper, I argue that invoking "ethnicity" as a risk factor for Type 2 Diabetes functions as a form of cultural racism by essentializing ethnic food practices among racialized groups and attributing ethnic food practices to higher diabetes rates. I will first briefly review the literature on cultural racism and then apply the

[1] Healthism refers to the idea that individuals have the moral responsibility to maintain good health where the "problems and solutions of health are situated at the individual level" (Crawford, 1980, p. 369).

concept to ethnic food practices in the diabetes risk discourse. I will conclude by highlighting the calls to address systemic racism as a root cause of health inequities. While diabetes rates among Indigenous peoples in Canada are particularly alarming due to the negative impacts of colonial policies and anti-Indigenous racism, I will focus on racialized immigrants in this paper because of the development of the cultural racism literature studying post-war immigration to Europe.

What is cultural racism?

According to Mukhopadhyay and Chua (2017), cultural racism is a "form of racism that relies on cultural differences rather than on biological markers of racial superiority or inferiority. These cultural differences can be real, imagined, or constructed" (p. 377). This concept emerged after World War II from the nationalist reactions to the influx of immigrants to Europe (Barker, 1981; Balibar, 1991). Scholars conceptualized "cultural racism" to understand this "new" form of racism that is rooted in the perceived *cultural* superiority of Europeans, compared to the earlier form of racism which is rooted in biological and genetic arguments (Wren, 2001).

There are two overlapping features of cultural racism in the literature: cultural essentialism and colour-blindness. Both are still prominent ideologies embedded in mainstream understandings of racial differences in health through white neoliberal healthism. Cultural essentialism bounds the essence of groups and individuals to static homogenous cultural communities (Siebers & Dennissen, 2015). Culture is essentialized as overly simplistic, ahistorical, stereotypical, and bounded to the past (Mukhopadhyay & Chua, 2017). Racism is "disguised" as cultural difference, pointing to immigrants' lack of agency to reflect on their own culture and to "adapt" to Western culture (Wikan, 1999) and their "supposed cultural deficiencies" (Li, 1999, p. 5). In complement, colour-blindness denies racism as the explanation for racial inequality (Wikan, 1999), often represented by phrases such as "we don't see colour" or "we treat everyone equally." Based on the neoliberal ideology of meritocracy, racialized immigrants are judged by their effort to adapt their culture (Balibar, 1991; Mukhopadhyay & Chua, 2017) and to overcome hardships from marginalization (Li, 1999).

Social scientists have been interested in the relationship between diabetes and culture due to its complex "biological, demographic, social and behavioral factors" (Ferzacca, 2012, p. 412). Cultural knowledge about racialized immigrants can contribute to the stereotyping of the "other" (Said, 2018). Tuchman (2011) argued that "science, medicine, and culture all worked together to produce believable narratives" (p. 29). She showed that research on ethnic associations of diabetes shifted from the Jewish population to African Americans along with the implementation of racist policies such as the GI Bill and Jim Crow Laws (Tuchman, 2011).

Diabetes risk, ethnic food practices, and cultural racism

Socially constructed categorization of race/ethnicity within clinical studies shapes how we understand diet and diabetes; such Eurocentric knowledge is then reinforced in nutrition policies and professional practices. We can use the concept of cultural racism to critique the linking of ethnic food practices with the risk of T2DM among racialized immigrant populations. First, the identified ethnic groups are targeted for nutrition interventions to reduce their risks (Diabetes Canada Clinical Practice Guidelines Expert Committee, 2010). These nutrition interventions focus on modifying ethnic food practices and diets. Often "non-compliance" to these interventions is again explained through cultural differences rather than structural barriers to healthy eating (Keval, 2015), such as the lack of access to fruits and vegetables among racialized neighbourhoods, Eurocentric dietary advice provided by health practitioners, and the racialization of poverty.

Second, the categorization of the at-risk ethnic groups is socially constructed through colour-blindness, which muddles ethnicity, culture, and race (Wikan, 1999). "Ethnicity" and "culture" are poorly conceptualized in diabetes research (Keval, 2015) and racial bias is often reinforced through ethnic categorization (Ahmad & Bradby, 2007) via the white medical gaze. "African, Arab, Asian, Hispanic, Indigenous, or South Asian" are racial and political categories. These identities emerged within political, historical, and social contexts and often in response to racism, white supremacy, and colonization. In research, the genetic-biological basis for diabetes risk combines with cultural risks to fuel cultural racism discourse and shape interventions. Differences in ethnic food practices are used as rationale for interventions to address the intake of fat, carbohydrates, and salt among racialized populations in a reductionist manner. For example, the website for the Asian Diabetes Prevention Initiative (n.d.) states that "Unfortunately, current Asian diets have white rice as a main staple. Salt is another major part of Asian diets that is consumed in excess." This form of reductionist and medical understanding of dietary practices overlooks the historical, economic, and cultural contexts behind the use of salt and the intake of grains in immigrant populations. In addition, "at-risk" ethnicities are grouped together and assigned the same "risk." There is much diversity in the food practices among peoples of "African, Arab, Asian, Hispanic, Indigenous, or South Asian descent."

Third, ethnic food practices are subjected to essentialization, which risks stereotyping and victim blaming. Cultural practices are reduced as homogenous, static, and resistant to change (Bradby, 2012). For example, one study stated that "South Asians cultural values place a high premium on the enjoyment of good, tasty food, which is at the heart of family life, and hospitality towards family and friends" (Bhopal, 2013, p. 37). This view labels South Asian food practices as "risky" in contributing to the development of diabetes (Keval, 2015). A scoping review by Sanou et al. (2013) found forty-nine Canadian studies examining the changes in dietary habits among immigrants by comparing their maintenance of "traditional diets" with the adoption of "host country lifestyle." They noted the "risks and benefits" associated with maintaining traditional ethnic diets (Sanou et al., 2013). Such studies reinforce the reductionist notion of ethnic food practices and construct a false dichotomy of traditional-host food cultures. We can also point to the racial bias in the literature by contrasting the ways studies discuss the

health benefits of the "Mediterranean Diet" (Burt, 2021) against the risks of "South Asian" diets.

There are limitations in applying cultural racism to food and nutrition. Cultural racism as a concept draws from anti-immigrant policy analysis (Wren, 2001). Also, analysis requires deeper explorations of the complexity of the cultural meaning of food, eating, and health among racialized and diaspora communities (Keval, 2015). Lastly, Leach (2005) argued that cultural racism is not "new" but part of the same phenomenon of systemic racism and white supremacy; racism is often normalized, subtle, and rooted in historical and geopolitical contexts.

Racism and the social determinants of health

Practitioners and scholars have started to shift the focus away from cultural explanations of health disparities to social-structural ones (Ferzacca, 2012; Ahmad & Bradby, 2007). Socioeconomic factors and racism align with the Social Determinants of Health framework (Commission on Social Determinants of Health [CSDH], 2008) in explaining racial inequities in health. This framework attributes health inequities as "avoidable and unjust" distribution of power and material resources (CSDH, 2008). Factors such as food insecurity, race, housing, and income distribution (Mikkonen & Raphael, 2010) intersect with each other to create racial inequalities in health. Examples of these factors include the lack of access to healthy foods in lower-income neighbourhoods (Jack et al., 2012) and the racialization of lower-paying jobs (Block & Galabuzi, 2011). Ogunwole and Golden (2021) reframed racism as a "fundamental root cause of diabetes disparities that lead to maladaptive health behaviours" (p. 12). A systematic review of 293 studies by Paradies et al. (2015) found that racism was associated with poorer mental health and physical health, including diabetes.

Conclusion

I call on health practitioners to reflect on our racial bias and participate in advocacy to address systemic racism while working with racialized communities to improve their nutritional health (Ng & Wai, 2021). The labeling of racialized populations as "at-risk" often masks the root causes of social inequities (Parker, 2020). Therefore, ethnicity should be removed as a risk factor in education materials targeted at individuals and communities; instead, evidence of racial inequities should inform policy to address systemic racism in our food environments and inequitable access to healthy foods. The purpose of this paper is not to discount the

role of culture and traditional foods in shaping healthy eating and wellbeing. Ethnic food practices must be considered when planning nutrition interventions that are community-based and culturally safe. We can recognize the meanings of ethnic diets of diverse racialized immigrants by sharing their lived experiences in the context of the social determinants of health (Ristovski-Slijepcevic et al., 2008; Lawton et al., 2007; Lucas & Li, 2020).

Acknowledgements: I thank Dr. Cheryl Teelucksingh for her guidance and Mikahelia Wellington for her support.

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References

Ahmad, W. I. U., & Bradby, H. (2007). Locating ethnicity and health: Exploring concepts and contexts. *Sociology of Health & Illness, 29*(6), 795-810. doi:10.1111/j.1467-9566.2007.01051.x

Asian Diabetes Prevention Initiative. (n.d.) *Asian diets: Health benefits and risks*. https://asiandiabetesprevention.org/how-to-reduce-your-risk/asian-diets-benefits-risks

Balibar, E. (1991). Is there a neo-racism? In E. Balibar, and J. Wallerstein, (Eds.), *Race, Nation, Class: Ambiguous Identities* (pp. 17-28). Verso.

Barker, M. (1981). *The new racism: Conservatives and the ideology of the tribe*. Junction Books.

Bhopal, R. S. (2013). A four-stage model explaining the higher risk of Type 2 diabetes mellitus in South Asians compared with European populations. *Diabetic Medicine, 30*(1), 35–42. https://doi.org/10.1111/dme.12016

Block, S., & Galabuzi, G. (2011). *Canada's colour coded labour market: The gap for racialized workers.* Canadian Centre for Policy Alternatives. https://www.policyalternatives.ca/publications/reports/canadas-colour-coded-labour-market

Bradby, H. (2012). Race, ethnicity, and health: The costs and benefits of conceptualising racism and ethnicity. *Social Science & Medicine, 75*(6), 955-958. https://doi.org/10.1016/j.socscimed.2012.03.008

Burt, K. G. (2021). Whiteness of Mediterranean diet: A historical, sociopolitical, and dietary analysis using Critical Race Theory. *Journal Critical Dietetics, 5*(2), 41-52. https://doi.org/10.32920/cd.v5i2.1329

Commission on Social Determinants of Health (CSDH). (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health.* World Health Organization. http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

Crawford R. (1980). Healthism and the medicalization of everyday life. *International journal of health services: planning, administration, evaluation, 10*(3), 365–388. https://doi.org/10.2190/3H2H-3XJN-3KAY-G9NY

Diabetes Canada Clinical Practice Guidelines Expert Committee. (2018). *Diabetes Canada 2018 clinical practice guidelines for the prevention and management of diabetes in Canada. Canadian Journal of Diabetes*, 42(Suppl 1), S1-S325. https://www.sciencedirect.com/journal/canadian-journal-of-diabetes/vol/42/suppl/S1

Ferzacca, S. (2012). Diabetes and culture. *Annual Review of Anthropology, 41*, 411-426. doi:10.1146/annurev-anthro-081309-145806

Gagné, T., & Veenstra, G. (2017). Inequalities in hypertension and diabetes in Canada: Intersections between racial identity, gender, and income. *Ethnicity & Disease, 27*(4), 371. doi:10.18865/ed.27.4.371

Hill-Briggs, F., Adler, N. E., Berkowitz, S. A., Chin, M. H.,

Gary-Webb, T. L., Navas-Acien, A., Thornton, P. L., &

Haire-Joshu, D. (2020). Social determinants of health and diabetes: A scientific review. Diabetes Care, 44(1), 258–279. https://doi.org/10.2337/dci20-0053

Jack, L., Jack, N. H., & Hayes, S. C. (2012). Social determinants of health in minority populations: A call for multidisciplinary approaches to eliminate diabetes-related health disparities. *Diabetes Spectrum, 25*(1), 9-13. doi:10.2337/diaspect.25.1.9

Keval, H. (2015). Risky cultures to risky genes: The racialised discursive construction of South Asian genetic diabetes risk. *New Genetics and Society, 34*(3), 274-293. doi:10.1080/14636778.2015.1036155

Lawton, J., Ahmad, N., Peel, E., & Hallowell, N. (2007). Contextualising accounts of illness: Notions of responsibility and blame in white and South Asian respondents' accounts of diabetes causation. *Sociology of Health & Illness, 29*(6), 891-906. doi:10.1111/j.1467-9566.2007.010

Leach, C. W. (2005). Against the notion of a 'new racism'. *Journal of Community & Applied Social Psychology, 15*(6), 432-445. doi:10.1002/casp.841

Li, P. S. (1999). *Race and ethnic relations in Canada*. Oxford University Press.

Lucas, L., & Li, F. (2020). Growing food, sharing culture at the Rainbow Community Garden in Winnipeg, Canada. *Canadian Food Studies / La Revue Canadienne Des études Sur l'alimentation, 7*(2), 72–81. https://doi.org/10.15353/cfs-rcea.v7i2.439

Mikkonen, J., & Raphael, D. (2010). *Social determinants of health: The Canadian facts.* York University School of Health Policy and Management. http://thecanadianfacts.org/the_canadian_facts.pdf

Mukhopadhyay, C. C., & Chua, P. (2017). Cultural Racism. In J. H. Moore (Ed.), *Encyclopedia of Race and Racism*. (Pp. 377-383). Gale.

Ng, E., & Wai, C. (2021). Towards a definition of anti-oppressive dietetic practice in Canada. *Journal of Critical Dietetics, 5*(2), 10-14. https://doi.org/10.32920/cd.v5i2.1407

Ogunwole, S. M., & Golden, S. H. (2021). Social determinants of health and structural inequities-Root causes of diabetes disparities. *Diabetes Care, 44*(1), 11-13. https://doi.org/10.2337/dci20-0060

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest,N., Pieterse, A., Gupta, A., Kelaher, M., & Gilbert, G.. (2015). Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PLoS ONE 10*(9), e0138511. doi:10.1371/journal.pone.0138511

Parker, B. (2020). Consuming health, negotiating risk, eating right: exploring the limits of choice through a feminist intersectional lens. *Journal of Critical Dietetics, 5*(1), 45-57. https://doi.org/10.32920/cd.v5i1.1336

Public Health Agency of Canada (PHAC). (2012). *Diabetes in Canada: Facts and figures from a public health perspective.* Government of Canada. https://www.canada.ca/en/public-health/services/chronic-diseases/reports-publications/diabetes/diabetes-canada-facts-figures-a-public-health-perspective.html

Public Health Agency of Canada. (2017). *Diabetes in Canada.* Retrieved from https://www.canada.ca/en/public-health/services/publications/diseases-conditions/diabetes-canada-highlights-chronic-disease-surveillance-system.htmlPublic Health Agency of Canada (PHAC). (2018). *Key Health Inequalities in Canada: A National Portrait.* Government of Canada. https://www.canada.ca/en/public-health/services/publications/science-research-data/key-health-inequalities-canada-national-portrait-executive-summary.html

Public Health Agency of Canada (PHAC). (2021). *Diabetes in Canada, in review 2021*. Government of Canada. https://www.canada.ca/en/public-

health/services/publications/diseases-conditions/diabetes-canada-review-2021.html

Ristovski-Slijepcevic, S., Chapman, G. E., & Beagan, B. L. (2008). Engaging with healthy eating discourse(s): Ways of knowing about food and health in three ethnocultural groups in Canada. *Appetite, 50*(1), 167-178. https://doi.org/10.1016/j.appet.2007.07.001

Said, E. W. (2018). Latent and Manifest Orientalism. In T. Das Gupta, C. E. James, C. Andersen, G-E. Galabuzi, & R. C. A. Maaka (Eds.), *Race and racialization: Essential readings* (pp. 45-55; 2nd Ed.). Canadian Scholars.

Sanou, D., Sanou, D., O'Reilly, E., O'Reilly, E., Ngnie-Teta, I., Ngnie-Teta, I., Batal, M., Mondain, N., Andrew, C., Newbold, & Bourgeault, I. L. l (2014). Acculturation and nutritional health of immigrants in Canada: A scoping review. *Journal of Immigrant and Minority Health, 16*(1), 24-34. https://doi.org/10.1007/s10903-013-9823-7

Siebers, H. G., & Dennissen, M. (2015). Is it cultural racism? Discursive oppression and exclusion of migrants in the Netherlands. *Current Sociology, 63*(3), 470-489. https://doi.org/10.1177/0011392114552504

Tuchman, A. M. (2011). Diabetes and race: A historical perspective. *American Journal of Public Health, 101* (1), 24-33. https://doi.org/10.2105/AJPH.2010.202564

Wikan, U. (1999). Culture: a new concept of race. *Social Anthropology*, *7*(1), 57-64. https://doi.org/10.1017/S096402829900004X

Wren, K. (2001). Cultural racism: Something rotten in the state of Denmark? *Social & Cultural Geography, 2*(2), 141-162. https://doi.org/10.1080/14649360120047788