Session « Vie sociale » des neurosciences

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Cette session vise à analyser ce que nous désignons par la « vie sociale » des neurosciences qui correspond à la diffusion et la transposition dans les sociétés contemporaines des savoirs et pratiques des neurosciences et de leur appropriation ou réappropriation par les individus ou les mouvements sociaux. Aujourd'hui, les neurosciences occupent une place croissante dans la société, bien au-delà des laboratoires et des domaines de la recherche et du soin, et imprègnent les représentations que nous nous forgeons de la réalité et de nous-mêmes, mais aussi orientent les politiques publiques et déterminent des logiques d'action. L'idée que le cerveau et son fonctionnement serait la clé de la compréhension de la nature humaine se diffuse largement et structure un discours naturaliste. Ces conceptions n'engagent pas seulement un certain mode de connaissance et de définition de l'homme, mais aussi des modalités d'action sur les individus. Ainsi, les neurosciences nous proposent aujourd'hui un ensemble d'interventions psychothérapeutiques, psychopharmacologiques, ou chirurgicales pour modifier ou stimuler le fonctionnement cérébral. Outre le soin, il s'agit aussi d'agir sur les conduites, d'augmenter les capacités, ou encore de caractériser et de modifier les identités, de repenser les liens entre biologie et subjectivité. Notre objectif est d'analyser : 1°) la diffusion des discours neuroscientifiques dans les médias ; 2°) les nouvelles formes d'interventions et conceptions du soin, notamment dans le cas des pathologies mentales ; 3°) le rôle des associations de patients dans la diffusion des représentations « cérébro-centrées » et la genèse du concept de neurodiversité.

Sébastien Lemerle,
Diffusion des discours neuroscientifiques dans les médias.

Baptiste Moutaud
Formes de vie et neurosciences. Ce que nous disent les nouvelles thérapies en santé mentale.

Emilie Massot
Réappropriation du discours des neurosciences par les associations de parents d'enfants autistes, en France. Illustration à partir de l'association Autisme Espoir Vers l'École (A.E.V.E.).

Brigitte Chamak
Genèse du concept de neurodiversité : rôle des mouvements associatifs dans la diffusion des représentations « cérébro-centrées ».

The Sociology of Public Health Crises

"The right thing to do": Canadian news coverage of H1N1 vaccine prioritization
Laena Maunula, University of Toronto
Co-Author(s) Alison Thompson

This study explores the ways in which Canadian print news media represented H1N1 vaccine prioritization.

During the 2009 outbreak of H1N1, Canadian newspapers reported the unfolding of controversial, value-laden issues that arose in preparing for and responding to the outbreak; Infection control measures which were put in place to reduce transmission and infection simultaneously posed numerous ethical challenges, including offering priority access to government funded health care and resources to some groups before others (e.g. vaccine prioritization strategies/rationing).

Drawing from a sample of Canadian print news media stories this paper presents a qualitative analysis of news coverage of vaccine prioritization during the H1N1 outbreak.

We argue that news representations of ethical issues related to vaccines cluster around three broad descriptive categories: acting in the midst of uncertainty, communicating with the public and setting vaccine priorities. News coverage of these three issues collectively paints a picture of multiple groups (individuals, families, public health authorities and government) deliberating over "the right thing to do" with respect to vaccines.

News media represented prioritization decision making as a struggle and dilemma due to a lack of clinical and epidemiological knowledge concerning H1N1 and the vaccine, implying the self-evidence of scientific expertise in directing prioritization decisions.

Access to ARV medication crisis in the Central African Republic: the dialectics of exception and abandonment.
Pierre-Marie DAVID, Université de Montréal

Analyze the social consequences of the presence or absence of antiretroviral drugs in Central African Republic.

In 2010 and 2011 major ARV stock outs have resulted in unexpected consequences: the renewal of social ties based on therapy, and also social resistance and defiance towards intervention.

Paradoxically, these life saving medications stock-outs brought up the question of a form of "killing" within a biopolitics of "making live". As I will argue the drug stock-outs I observed produced resistances, both biological and social, that would result in symbolic and material forms of killing. These stock-outs as "economies of abandonment" (Povinelli, 2011) may enlighten global initiatives' rationality, and their anthropological, as well as biopolitical, consequences. The Central African Republic, its distant state (Biershenk and de Sardan, 1997) and local micro sovereignties (Lombard, 2012), constitute a remarkable context to reveal and follow the networks of governance linked to the presence and absence of ARVs.

In 2010 and 2011 for respectively thre and two months I carried out in situ observations in Bangui AIDS clinics, ethnographic interviews with institution representatives, patients and health personnel, focus groups with members of community associations. The everyday practices that produce and reproduce the social world surrounding access to ARVs were my main theoretical objects (de Certeau, 1990).

ARV ruptures produced paradoxical effects. On the one hand, if infected people believed in a healthy future as "therapeutic citizens", this perspective changed for many with stock-outs. On the other hand, these ruptures reinforced traditional social ties of kinship. Different forms of subjectivities cohabit and scatter in Central African society, not mechanically depending on the presence of a therapeutic power, but according to its discontinuities and the negotiations of various forms of solidarity to cope with them.

On the other side of the coin, a less classical justification needs attention to be paid about exceptional intervention; the one in which social and biological resistances define the target population to "make live", as well as a threat to contain, with potentially new coercive technologies.

Two avenues for research could be reinforced: the first, streamlining the embodiment of biosocial resistance, and the second, describing the global health "scriptural practices" that build indicators as both the description of reality and the definition of needs, defining global interventions.

Governing the coordination of public health services in Québec
Viola Burau, McGill University
Co-Author(s)   Amélie Quesnel-Vallée

The aim of the paper is to test the capacity of governments to govern network coordination of health services by identifying the specific strategies through which this can occur. This is done based on a critical case study of public health services in Québec.

The paper draws on the literature on governance, where the strategies for governing the coordination of health services emerge from an interplay between two different mechanisms of coordination: hierarchy and networks. Interorganisational coordination of health services has many characteristics of network coordination, but coordination tends to be embedded in hierarchy and is often mandated rather than voluntary. Governing the coordination of health services can therefore be understood as different strategies of 'metagovernance' concerned with designing and managing the interorganisational

processes that occur in networks. The analysis uses the distinction between indirect and direct strategies to identify how governments can govern coordination of health services.

The analysis is based on two sets of data: first, a scoping study of the provincial/regional structures/policies of the public health system specifically; and second, a study of the indirect strategies of governing network coordination, at the level of the province and the regional board.

The paper presents very first findings. The hypothesis is that the province has a high capacity to govern, as the structures of the health system are highly integrated and policies have a strong focus on coordination. The results will be particularly robust, as the hypothesis is tested in relation to public health services, which pose particularly 'wicked problems' of coordination.

The expected contribution of the paper is two-fold: first, the paper specifies government capacity to govern health services coordination by identifying specific strategies; and second, the paper analyses how strategies perform under hard conditions of 'wicked problems' of coordination.

**La prévention du VIH/sida à l'ère des antirétroviraux : entre médicalisation et
« evidence-based activism » ?**
Girard Gabriel, Université Concordia

La contribution a pour objectifs de :

- proposer une analyse empirique la médicalisation de la prévention du VIH/sida chez les hommes gais

- proposer une comparaison entre les contextes français et québécois dans le cadre du développement d'un essai biomédical à Paris et Montréal (IPERGAY)

Depuis le début des années 2000, la prévention du VIH/sida parmi les gais a connu de profondes inflexions. La promotion du préservatif, pierre angulaire de la prévention depuis les années 1980, est en effet remise en question. D'une part car son usage régulier s'avère problématique pour un nombre non négligeable d'hommes gais. D'autre part car de nouvelles approches, alternatives au préservatif, émergent, sous le vocable de la « réduction des risques sexuels », puis de la médicalisation des réponses préventives. De ce fait, les nouvelles technologies préventives sont au cœur des débats de santé publique dans ces pays, non sans désaccords entre les associations, les pouvoirs publics et les chercheurs. Les débats portent notamment sur l'efficacité de ces approches, et sur leur capacité à réduire effectivement la transmission à l'échelle collective et individuelle.

La présente contribution s'intéressera à ces enjeux en analysant plus particulièrement la construction problématique d'un essai biomédical de prophylaxie pré-exposition « IPERGAY », développé en France et au Québec depuis 2009. La proposition s'appuie sur une sociologie de la prévention du VIH/sida menée à Paris et à Montréal, qui combine l'analyse des articles de presse, les entretiens avec des acteurs clés et des observations lors de réunions et de débats.

Cette contribution vise à éclairer sous un nouveau jour les transformations récentes du paysage de la prévention gaie en France et au Québec. On est passé progressivement de recommandations centrés sur l'usage du préservatif, à des messages complexes. Dans ce cadre, les traitements anti-rétroviraux occupent une large place. Le traitement comme prévention tend à devenir le nouveau paradigme de la "gestion du risque" VIH. Comment comprendre cette évolution ? Et quel est le rôle des différents acteurs de la prévention (associations, médecins, santé publique) dans ce processus, d'un côté et de l'autre de l'Atlantique ? L'analyse de ces tensions entre les normes collectives et individuelles de prévention du sida constituera le fil conducteur de cette contribution. L'usage des données scientifiques dans les controverses fait l'objet d'une analyse spécifique.

L'intervention retracera l'émergence en France et au Québec d'un militantisme fondé sur les preuves (« evidence based activism ») dans le domaine de la prévention du VIH/sida.

Socio-demographic determinants of early marriage in Bangladesh: Issues on reproductive health and rights

Mohammad Mainul Islam, McGill University
Co-Author(s) Anita J. Gagnon, Professor, Ingram School of Nursing, McGill University, Canada

The objective of this study is to examine the socio-demographic determinants and effects of early marriage on women below 18 years in Bangladesh. There is a need to better understanding the existing policies in this regard.

The right not to engage in sexual relations and the right to exercise control over reproduction may both be violated by early marriage. While the age of marriage is on the rise globally, marriage below 18 years is still widely practiced in developing countries such as Bangladesh.

We analyzed the most recent Bangladesh Demographic Health Survey (BDHS) 2011 data to examine the relationships with age at marriage (cohabitation) below 18 years of 17,842 ever-married women aged 13-49 at the time of the survey. Cross tabulations, logistic and liner regression were used to compare characteristics and contextual factors among women married before age 18, to those married between 18-49, and to identify factors associated with selected marital outcomes. Literature was reviewed for policy documents related to age at marriage. Dates of policies implementations were compared against age at marriage and tested for trends.

Of all women responding to BDHS 2011, 77.7% were first married before 18 years of age. Although the percentage steadily declined over time, still nearly one fifth (17.2%) of the respondents (15-19 year olds) reported being married at age 15. Wealth index, religion, currently working, residence and schooling years are the socioeconomic determinants having significant effects whereas marrying below 18 years has impacts on the demographic determinants- age at first birth, total number of children ever born, and number of living children. Although some successes of reducing early marriage have been evidenced the proportion of women age 15, who have begun childbearing, remains the same even after two decades. The presence of a large proportion of early marriages, lower performances of policies show weaken association between international legal human rights framework applied to sexual and reproductive health rights.

Use of current law and policies as a means of regulating early marriage is in no way sufficient, the government of Bangladesh should be encouraged to create a policy environment that supports marriage at a mature age. Targeted policies should be focused on poorest women, Muslim religion, employment opportunity, rural residence, promoting education, later marriage and birth, etc. through legal reform, providing reproductive health education and services.

They make me happy and they are always there for me
Mary Clare Kennedy, University of Victoria

Co-Author(s)   Cecilia Benoit, Mikael Jansson, Doug Magnuson & Nadia Ouellet

The purpose of this study is to examine how peer, familial and institutional support are perceived by street-involved youth and to analyze how perceived differences are related to their emotional health.

Street-involved youth are often understood from a problem-oriented perspective, focusing primarily on their past and present experiences of victimization, poor health, and problem behaviours. These youth are also described as lacking social support in their daily lives due to severed or weakened ties to family members and mainstream school- and community-based social networks. Nevertheless, the relatively large body of literature on street-involved youth also includes some evidence of their heterogeneity and their varying level of personal strengths, resources and vulnerabilities, as well as a diversity in their level of connectedness with family and other potential providers of social support.

Our data are drawn from a recently completed longitudinal mixed-methods study of 210 street-involved youth in the capital metropolitan area of Victoria, B.C. For this paper, we present descriptive data on participants' social support networks and analyze qualitative and quantitative data on the characteristics of those who provide support, including emotional support. Thematic analysis of semi-structured interview data was employed to gain a nuanced understanding of the perceived availability of social support among participants.

Important social relationships of street-involved youth are sometimes a continuation of kinship and friendship ties formed prior to street-involvement, while others locate themselves primarily within new street-based relationships. Only a small minority of youth in our study did not identify a social network or close relationships with other people. Approximately half of our participants reported being emotionally supported by those in their social networks, describing close, intimate relationships characterized by compassion and trust. Most often participants who mentioned receiving emotional support indicated that this kind of support was provided by their peers. However, parents and siblings or service providers are also named by many youth as important sources of emotional support.

Our descriptive findings suggest that most street-involved youth are embedded in meaningful social relationships. These relationships are very important determinants of their mental, including emotional, health.

Santé, comportements de santé et violence parmi les immigrants et rôle des facteurs socioéconomiques chez les adolescents
Kénora CHAU, Université de Lorraine
Coauteur: Michèle BAUMANN (présentatrice); Nearkasen CHAU

Etudier les problèmes relatifs à la santé (usage de substances, état de santé, symptômes dépressifs, violence physique/verbale et abus sexuel subis, et implication dans la violence) des immigrés européens et non-européens et le rôle des difficultés socioéconomiques, relationnelles et scolaires.

Les problèmes relatifs à la santé sont plus fréquents chez les immigrés européens et non-européens que les français. Ils sont fortement expliqués par les difficultés socioéconomiques, relationnelles et scolaires.

Cette enquête transversale a été réalisée sur 1559 adolescents des collèges dans le nord-est de la France. Elle est basée sur un auto-questionnaire, rempli en classe sous la surveillance de l'équipe de recherche, concernant le sexe, l'âge, la nationalité, les caractéristiques socioéconomiques (structure familiale, faible éducation parentale (èles de régression logistiques

Les problèmes sont fréquents : usage d'alcool (35,2%), tabac (11,2%), cannabis (5,6)%, drogues dures (2,8%), mauvais état de santé (25,8%), symptômes dépressifs (13,3%), être victime de violence physique/verbale (16,2%) ou d'abus sexuel (3,7%) et implication dans la violence (14,6%). Comparés aux français, les immigrés ont un risque accru pour : usage de tabac (odds ratio ajusté sur le sexe et l'âge 2,04), cannabis (2,33), drogues dures (4,18), mauvais état de santé (1,89), violence subie (1,84) et implication dans la violence (1,77). Les situations socioéconomiques expliquaient respectivement 25%, 9%, 13%, 30%, 12% et 39% de ces risques. L'ajout de relations sociales et de la performance scolaire expliquait respectivement 43%, 20%, 29%, 53%, 24% et 61% des risques. Ces problèmes et les contributions des cofacteurs diffèrent beaucoup entre les immigrés européens et non-européens.

Les problèmes relatifs à la santé sont plus fréquents chez les immigrés européens et non-européens que les français. Ils sont fortement expliqués par les difficultés socioéconomiques, relationnelles et scolaires. La prévention pour leur intégration sociale devrait traiter ces problèmes.

La prise en charge de l'enfant diabétique par les familles, étude de quelqies cas à Oran, Algérie
Ouassila Salemi, Université d'Oran

L'étude a pour objectif principal de comprendre et d'analyser la façon dont les familles conçoivent la prise en charge de leur enfant atteint de diabète, en nous appuyant principalement sur les représentations et les pratiques socio-sanitaires des mères.

En Algérie, le diabète constitue l'un des problèmes majeurs de santé publique. Il est le deuxième état morbide le plus fréquent (8.78%) après l'hypertension artérielle (16,23). Il touche 12,21% d'algériens dont une prédominance féminine de 12, 54 contre 11, 93 pour les hommes (TAHINA, 2007). Affectant les couches les plus jeunes de la société (Kourta, 2006), sur une population estimée à 32 millions d'habitants, et selon la fédération algérienne des associations des diabétiques, le nombre de diabétiques a atteint le chiffre de 2 millions dont 21% d'insulinodépendants. La part d'enfants est estimée à 20%. Il nous a semblé pertinent d'investir la clinique pédiatrique C, structure relevant du CHU d'Oran et spécialisée dans la suivi et la prise en charge des enfants atteints de diabète.

Travaillant sur le sens que les gens donnent à leurs actions, notre posture méthodologique est de type qualitatif. Elle est basée sur 20 entretiens individuels, approfondis, répétés et de longue durée (entre une heure et demi et deux heures environ) avec les mères d'enfants diabétiques et l'observation fine et détaillée des différents espaces investis (espaces domestiques et clinique pédiatrique spécialisée).

Il en ressort la forte charge émotionnelle et physique du diabète sur la famille et qui pèse particulièrement sur les mères. L'annonce du diagnostic apparait comme un choc important, causant un ébranlement dans l'entourage de l'enfant diabétique. L'injection de l'insuline représente un acte de violence symbolique et révèle la complexité de gérer les dosages. La charge de travail est telle qu'elle impose à la mère une surveillance continue de son enfant malade et est suivie d'un épuisement physique et moral.Le modèle fusionnel qui caractérise la relation mère-enfant révèle le sacrifice de la mère et le don de soi. Il apparait aussi que la clinique et les regroupements sont un lieu de socialisation importante où se font l'acceptation et la normalisation de la maladie aussi bien pour les mères que pour les enfants diabétiques.

Ainsi prendre soin de son enfant diabétique ne relève pas uniquement de gestes techniques standardisés,mais d'une véritable pratique de soins, sans cesse renouvelée et interrogée.Une logique de soins dans laquelle les mères, sont les véritables actrices de la prise en charge de leur enfant.

Access to primary health care services in French-speaking immigrants in minority situation in Canada
Ricardo Batista, University of Ottawa

This research project sought to provide further evidence in understanding how social determinants of health are contributing to shape inequalities in access and use of primary health services among francophone immigrant minorities in Canada.

Despite actions and some progress made aimed to improve the health conditions of all Canadians, inequalities in access to health services remains. Vulnerable populations such as immigrants and language minorities, face significant barriers to access and use different social services, including health care services. These barriers are even more challenging for French-speaking immigrants, living outside Quebec.

Research in the field on health conditions among official language minorities in Canada, has highlighted the existence of social and health inequalities and suggest that it can be attributed to their minority situation. Similarly, studies in Canada have repeatedly showed the obstacles for immigrants and refugees in accessing and using health care services. Contact and use of health care services signifies a real challenge for immigrants and it is an important factor for then during

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Although self-perceived health status is similar among French and English-speaking immigrants to Canada, the access and use of health care services reflect some differences. Preliminary results from the analysis of 2009-2010 survey data, shows that only 57% of French-speaking immigrants in all Canada report having a regular medical doctor, while that proportion is significantly higher for English-speaking immigrants (88%). Also, a lower proportion of francophone immigrants have a place to go when they are sick or need health advice (71%) compared to Anglophone counterparts (78%). Similarly the use of health services reflects important differences. Consultations with family doctors or general practitioners are also lower among French-speaking immigrants (56%) than other language groups (80% or higher). However a higher proportion of francophone newcomers (15%) reported consultations with

Despite actions and some progress made aimed to improve the health conditions of all Canadians, disparities in access to health services remains. French-speaking immigrants are among the most vulnerable sub-populations and actions to overcome those inequalities are required.

Comparing Approaches to Integrating Refugee and Asylum-Seeking Healthcare Professionals in Canada and the UK
Yvonne Leblanc, McMaster University

In this paper, we examine barriers to the integration of refugee doctors and nurses in Canada and the United Kingdom. Key obstacles impeding the integration of internationally trained health professionals are well documented, but less attention has been paid to the integration of refugee health professionals, particularly in Canada. Based on documentary analysis and semi-structured interviews with 46 Canadians and 34 UK Stakeholders, our research shows that there are no simple solutions to mitigating the core obstacles that prohibit the professional integration of refugee doctors and nurses into host countries. The targeted approach adopted in parts of the UK does provide some promising practices for Canada, which has yet to develop policies and initiatives specific to health professional refugees. This study is intended to contribute to our understanding of how immigration and health human resources policies have shaped the economic integration of refugee healthc are professionals in the UK and Canada in distinct ways.

La recherche sur les barrières linguistiques et culturelles en santé
Louise Bouchard, University of Ottawa
Co-Author(s)   Solange van Kemenade, Mobolaji Laflamme-Lagoke

L'objectif de cette communication est de rendre compte de la productivité scientifique sur l'impact des barrières linguistiques et culturelles sur l'accès aux services de santé et sur l'état de santé de minorités.

Une importante tranche de la population canadienne doit composer avec des barrières linguistiques et culturelles plus ou moins importantes lorsqu'il s'agit d'accéder aux services sociaux et de santé. En effet, trois populations, aux effectifs démographiques en croissance, auraient des difficultés à s'exprimer ou à comprendre l'une ou les deux langues officielles : les immigrants et réfugiés (250 000 nouveaux arrivants chaque année) et dont le quart ne parle aucune de deux langues officielles, les locuteurs d'une des langues officielles en situation minoritaire (2 millions) et les communautés Autochtones (1 million). Les enjeux de communication avec les professionnels de la santé, dans le contexte de la spécialisation de l'information médicale et sanitaire et celui de la pluralité culturelle, sont nombreux et ont des repercussions importantes sur l'accès et utilisation des services.

Une base de références sera constituée à partir du moteur de recherche de Web of Science. Nous établirons une stratégie de recherche de manière à capturer la production scientifique sur le thème au fil du temps. L'information sera traitée d'une part par une analyse bibliométrique (volume d'articles et d'auteurs, structure conceptuelle, disciplines, institutions, distribution géographique, citations) et une analyse de contenu des articles les plus cités.

Cette étude permettra d'identifier les théories qui prévalent dans le domaine de recherche, les explications et compréhensions du problème, les approches méthodologiques, les populations les plus vulnérables, les situations médicales pour lesquelles la communication est cruciale et enfin les interventions et modèles culturellement appropriés pour réduire les inégalités de santé qui affectent plus particulièrement les minorités.

La présentation soulignera des pratiques exemplaires en matière d'intervention culturellement appropriée pour réduire les barrières linguistiques et culturelles et améliorer la santé des minorités.

Mortality and life expectancy of official language minorities in Canada – a 15 year longitudinal follow-up study
Erika Silva, University of Ottawa
Co-authors: Bouchard, Louise; Makvandi Ewa

The main objective of this study is to identify disparities in mortality rates, all-cause mortality, and life expectancy of the official language minority communities in Canada aged 25 and older in relation to the language majority population.

Francophones minorities in Canada represent approximately one million people leaving outside the province of Quebec. Fifty one percent of them live in the province of Ontario followed by twenty two percent in New Brunswick. In Ontario the Francophone population represents 4.5% of the total population, whereas in New Brunswick represents 32.7%. In the remaining provinces the francophone population accounts for less than 4% of the population. Studies on a number of determinants have shown that the health status of Francophones minority is generally poorer than that of their fellow Anglophones citizens in any given province. They also are more likely to declare poorer health condition and that this condition is attributed to circumstances of life in situation of minority. Little is known on the characteristics and distribution of the mortality of Francophones outside QC.

This is a longitudinal follow-up study covering the period of 1991 to 2006 of a cohort of individuals based on the 1991 Census. Age standardized mortality rates, life expectencies at age 25, and survival to age 75 were calculated for key socioeconomic factors such as education, income, and occupation levels for men and women separately. Rate ratios were used to determine significant differences in mortality between minority and majority populations.Hazard ratios by socioeconomic variables were obtained through Cox proportional hazard model.

Francophone minority was older than the Anglophone majority and more likely to belong to the lower socioeconomic groups. Male Francophones in the lowest socioeconomic groups had higher mortality rates and lower life expectancy than their Anglophone counterparts. In all socioeconomic categories studied, the Quebec Anglophones had a higher life expectancy and lower mortality rates than the

Francophones. We also showed that in both Anglophone and Francophone populations, death occurred more frequently for those who were less educated, unemployed, and situated in the lowest quintile of income. In both language groups, the probability of dying was much higher, while life expectancy and survival to age 75 was much lower among the members of the cohort with the lowest socioeconomic status.

Language minorities, especially in the lower socioeconomic groups, have higher mortality rates and lower life expectancies. Francophone minority is in a worse situation than the Anglophone minority. This study provides evidence that living in situation of minority is an important health determinant

Retour vers *Les figures urbaines de la santé publique*.
***Enquête sur les [nouvelles] expériences locales* menées par les métropoles :**
Toulouse, Bordeaux, Lille…

1. Présentation de l'action publique de santé menée à Toulouse (France)
Jean-Charles BASSON, Politiste, Maître de conférences, Université de Toulouse (France), Laboratoire *Sports, Organisations, Identités* (SOI), EA 4561 ; *Laboratoire des Sciences Sociales du Politique* (LaSSP), EA 4175 ; *Institut Fédératif d'Etudes et de Recherches Interdisciplinaires Santé et Société* (IFERISS), FR 4142

2. Présentation de l'action publique de santé menée à Bordeaux (France)
Marina HONTA, Sociologue, Professeure des universités, Université de Bordeaux (France), *Laboratoire Cultures, Education et Sociétés* (LACES), EA 4140

3. Présentation de l'action publique de santé menée à Lille (France)
Loïc SALLE, Sociologue, Maître de conférences, Université de Lille (France), *Equipe de Recherche Septentrionale Sport et Société* (ER3S), EA 4110

Description de la session
Dressant le portrait, en 1998, des *Figures urbaines de la santé publique*, Didier Fassin compte Toulouse parmi les *expériences locales* soumises à l'*enquête* (Fassin, 1998). Croisant « politique des corps et gouvernement des villes », l'auteur voit dans « la rencontre de la santé publique et de l'espace local […] un analyseur fécond des transformations en cours dans les sociétés contemporaines, et singulièrement dans le monde urbain » (Fassin, 1998, 7).
Quinze ans après la publication de cet ouvrage pionnier, l'action publique municipale de lutte contre les inégalités sociales de santé nouvellement développée à Toulouse est, en effet, l'occasion de s'interroger sur la prégnance de cette qualité prêtée alors à la ville (Basson, Haschar-Noé, Honta, 2013 ; Basson, Haschar-Noé, Theis, 2013). Une analyse cognitive de la construction du sens de l'action publique sanitaire toulousaine permet, alors, de confirmer les thèses du tenant d'une anthropologie politique et morale de la santé et, ainsi, de relever que le processus de légitimation de la santé à l'échelle locale emprunte les formes suivantes. D'une part, la requalification de la santé en objet légitime de politique publique voit cette dernière érigée au rang de bien commun. D'autre part, l'action publique municipale met résolument l'accent sur l'éducation pour la santé et travaille à valoriser l'expertise sociale émanant des expériences associatives et des compétences des habitants eux-mêmes. Enfin, elle en appelle à la mobilisation citoyenne et solidaire afin que se développe une démocratie sanitaire susceptible de lutter efficacement contre les inégalités sociales de santé.
Cette « opération de traduction du social dans le langage sanitaire » (Fassin, 1998, 15) n'est pas le propre des acteurs publics toulousains. L'élargissement de l'investigation empirique à deux nouvelles métropoles (Bordeaux et Lille) offre, en effet, l'occasion de mesurer les diverses modalités du processus urbain de « sanitarisation du social » (Fassin, 1998, 42) actuellement à l'œuvre dans les grandes villes françaises (Honta, Basson, Sallé, 2013)[1]. Cette

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[1] L'étude comparée des situations bordelaise, toulousaine et lilloise est menée sous la responsabilité de Marina HONTA, pour le compte du Conseil Régional d'Aquitaine, dans le cadre de la recherche *Activité physique, alimentation et territoires. Une analyse comparée des modes de régionalisation des programmes de prévention et d'éducation à la santé (Aquitaine, Midi-Pyrénées et Nord-Pas-de-Calais)*.

municipalisation de l'action publique de santé opère prioritairement en matière de prévention et d'éducation via les compétences exercées par les villes : sports, hygiène publique, restauration collective, transports, environnement, développement durable et, plus particulièrement, au titre de la politique de la ville par le truchement des ateliers santé-ville.

Eléments bibliographiques

Basson, J.-C., N. Haschar-Noé et M. Honta. 2013, « Toulouse, une *figure urbaine de la santé publique*. A propos de l'action publique municipale de lutte contre les inégalités sociales de santé ». *Revue d'Epidémiologie et de Santé Publique*, 61S2, 81-88.

Basson, J.-C., N. Haschar-Noé et Y. Theis. 2013, « La traduction territoriale du programme national nutrition santé (PNNS) en Midi-Pyrénées, France ». *Healthcare Policy*, vol 9, Special Issue, 26-37.

Fassin, D. (dir.), 1998, *Les figures urbaines de la santé publique. Enquête sur des expériences locales,* La Découverte, Paris.

Honta, M., J.-C. Basson et L. Sallé. 2013, « La démocratie sanitaire à l'épreuve de l'action locale : le cas des villes de Bordeaux, Toulouse et Lille ». Congrès International ADELF-SFSP, *Revue d'Epidémiologie et de Santé Publique*, 61S, 226.

Social scientists and humanities scholars working in Canadian faculties of medicine: Trying to turn apples into oranges?

Mathieu Albert, University of Toronto
Co-Author(s) Ayelet Kuper, Elise Paradis

This paper explores social scientists' and humanities scholars' integration within the medical research environment. Specifically, how do they navigate their career within a culture and reward system that may be inconsistent with their own research practices and views on academic excellence.

Interdisciplinarity has had strong advocates in Canadian health research. In 2000 the Gov. of Canada replaced the MRC by the CIHR to promote interdisciplinary research on a wide range of determinants of health, broadening the understanding of disease as merely biological. Faculties of medicine have also become fervent promoters. Most of them have firmly committed themselves to interdisciplinarity. This call for interdisciplinarity is grounded in the assumption that using multiple lenses to the study of a problem will generate "better" research and that researchers from all disciplines will equally contribute to the research enterprise. We focus on social scientists and humanities scholars to show how interdisciplinarity has mostly resulted in these scholars' adaptation to the rules of the medical research field, rather than led to a transformation of the field.

We conducted semi-structured interviews with 29 social scientists and humanities scholars working in 11 faculties of medicine across Canada. Participants had to hold a doctoral degree from a social science or humanities department or program (e.g., Anthropology, Sociology, Education, History) and have held a primary academic appointment in a faculty of medicine for at least two years. Participants were selected through purposeful and snowball sampling. To capture participants' professional experiences the interview script addressed several aspects of participants' work experience.

Interview data showed that the strategy for success internalized by social scientists and humanities scholars in their home discipline is out of phase with the research culture of the medical field. Several participants reported that they had to modify aspects of their research practice (e.g., selection of research questions, writing style, publication patterns, division of labor with colleagues and graduate students) and adapt their view on academic excellence to the prevailing standards in medicine. Further, several among those who were unable to engage in such adaptation faced discouragement and disillusion with the game of science. The structural and cultural constraints they are confronted to are discordant with the lavishness of the discourse about the collaborative and the spirit of openness inherent to interdisciplinarity.

If funding agencies and faculties of medicine are serious about fostering interdisciplinarity they need to make room for different research practices. Otherwise, interdisciplinarity may end up being an empty mantra with the real effect of subordinating social scientists to the rules of the powerful.

Should more support be given to interdisciplinarity in health research? The perspective of biomedical scientists, clinical scientists and social scientists

Suzanne Laberge, Université de Montréal
Co-Author: Brian D. Hodges

The aim of this study was to investigate how three different groups of health research scientists (biomedical, clinical and social) perceive (1) the value added by interdisciplinary research and (2) the increasing support of interdisciplinary research by funding agencies.

Interdisciplinarity seems to be a new priority of research institutions and funding agencies in the health domain. Many of the funding agencies (e.g. NIH, CIHR) have undergone restructuring and program development specifically to intensify interdisciplinary inquiry. Moreover, several universities in Canada launched new interdisciplinary health programs as well as interdisciplinary research and professional training. Despite this growing interest, little is known about scientists' standpoints regarding the principle that working across disciplines adds value to health research. Given that scientists are central actors in the design and conduct of research studies, their perspectives cannot be ignored. This study is part of a larger project on the issues raised by the integration of the social sciences in the health research domain.

We conducted semi-structured interviews with 31 biomedical scientists, 30 clinical scientists, and 33 social scientists. The scientists were selected from the 2000–2006 membership lists of peer-review committees of the CIHR. The data were analyzed by thematic content analysis. We examined respondents' perspectives on the assumption that collaboration across disciplines adds value to health research. We also investigated their perspectives on funding agencies' growing support of interdisciplinary research.

The 94 respondents expressed a wide variety of perspectives on the value of interdisciplinary health research (IHR), ranging from full agreement to complete disagreement. Many presented qualified viewpoints. A substantial majority (2/3) felt that the funding agencies' increasing level of support of IHR was in some way unwarranted. This unfavourable perception was predominant among all groups but still more among biomedical and social scientists. Arguments included the belief that current support leads to the creation of artificial teams and that a top-down process of imposing interdisciplinary on research teams constrains scientists' freedom. On both issues we found contrasting trends between the three groups. The similarities and divergences observed will be discussed in light of current institutional and organizational transformations and stakes in the health research domain.

If the support to IHR is to be maintained or increased, efforts should be made to provide evidence of its added value for tackling complex health problems. The valuation of IHR should be sensitive to the unique context of research problems and avoid the undesired effects of funder-driven IHR.

How "gendered" is cancer?: An exploration of online cancer narratives
Lyndsay Gray, Carleton University

The objective of this paper is to present a portion of my PhD dissertation, which takes as its central focus, the 'gendered' nature of cancer specifically, and the 'gendered' nature of illness more generally. It is my primary goal is to better understand how gender is performed in illness narratives

In light of the increasing contemporary analyses of gender and health in medical sociological literature, this paper, through an empirical exploration of the subjective experiences of cancer narratives, seeks to better understand and explore the ways in which subjective experiences of cancer shape, and are shaped by, broader socio-cultural and public health understandings of illness. Furthermore, this exploration suggests that while contemporary theoretical and methodological approaches to gender and health have most certainly drawn our attention to the disparities of health outcomes and institutional inequalities based on gender, my data suggests that `it has unfortunately re-enforced a perspective that is highly dichotomized, and therefore underplays the fluidity of the variety of gendered experiences of illness.

The methodological approach utilized in this paper combines the insights and tools of Adele Clarke's "Situational Analysis" (2005) and Arthur Frank's "Socio-Narratology". The data for this paper was collected from the website "Blog for a Cure" and consists of a "gendered spectrum" of cancer sites (breast, prostate and colorectal).

Although I have just begun examining and interpreting my data, it has been revealed that presently, even though 'gender' discourse is rife

in socio-cultural and public health policy understandings of illness (and cancer in this specific case), it is perhaps less dominant and dichotomized in narrative accounts of illness, especially when considered in-light of contemporary health and illness literature whose central investigative lens is gender. Through the examination of "gendered" cancer narratives online, this paper suggests that a theoretical and methodological approach to gender and illness would greatly benefit from an approach that collects, examines and interprets raw, unsolicited data, such as online blogs, to garner a more 'un-guided' and nuanced understanding of the subjective experiences of illness and the role that gender occupies in these experiences.

Overall, this paper is situated as an exploration of the ways in which broader socio-cultural and public health policy constructions of gender often obscure the lived reality of men and women who suffer from illness.

Institutional and Financial Hurdles to Interdisciplinarity in Canadian Health Research
Elise Paradis, University of Toronto
Co-Author: Mathieu Albert

The assumption that interdisciplinary research in health increases collaboration and leads to higher-quality research is unproven. This paper discusses the policies and pre-existing power relationships that shape interdisciplinarity in faculties of medicine in Canada, and limit true collaboration.

The recent push for interdisciplinarity in Canadian health research is manifested in the recent incorporation of the social sciences and humanities (SSH) within the purview of the Canadian Institutes of Health Research (CIHR). In 2000, the Medical Research Council of Canada was replaced by CIHR, whose mandate was interpreted as encompassing the social sciences and humanities. By 2009, the Social Sciences and Humanities Research Council of Canada (SSHRCC) had stopped funding SSH research. This move had broad implications for the funding of SSH scholars' scientific production, as SSH scholars are a clear minority in the broader field of health sciences research. We sought to investigate the different institutional consequences of this transformation of the health research domain in Canada on SSH scholars, using the concept of decoupling from neo-institutional theory (cf Meyer & Rowan 1977)

To investigate the institutional and financial consequences of the transformation of the health research domain on Canadian health researchers from the SSH disciplines, we performed a document and policy analysis of a wide array of documents produced by the Canadian Institutes of Health Research. To investigate the financial consequences of this change we also collected data about average grant award and health-research-related expenses.

We found substantial institutional and financial hurdles to interdisciplinarity that affect SSH scholars. With a budget close to one billion dollars for 2012-2013, CIHR is the largest funding agency for health research in Canada. Therefore, decisions made by leadership committees regarding issues such as research priorities, strategic development and budget allocation have a significant impact on health research in Canada. We found that the leadership space at CIHR is almost entirely populated by scholars with biomedical backgrounds, such that the interests of SSH scholars are not represented. We also found that the ratio of the average grant size in the SSH versus biomedical sciences is in the 1:2.6 to 1:5 range, putting SSH scholars at a clear disadvantage when it comes to paying publication fees, attending conferences, and retaining graduate students.

The Canadian health research domain has not accommodated the new SSH scholars in its midst. The under-representation of SSH scholars and their financial ostracization work to reproduce previous hierarchies that give them low legitimacy and undermine their academic success.

Session: Déconstruction des Souffrances Sociales et processus Cumulatif

Déconstruction du processus cumulatif et d'amplification des souffrances :les effets d'une dérive…
Michèle BAUMANN, Université du Luxembourg
Coauteur: Claire CHABOT, Senad KARAVDIC

A partir du discours de professionnels de proximité qui côtoient au quotidien les souffrances psychiques de leurs clients, nos objectifs ont été d'analyser les principaux problèmes de santé mentale et les facteurs psychosociaux qui contribuent à l'émergence des souffrances, et participent à leur maintien ou leur développement, et de déterminer leurs besoins et les actions qui pourraient être entreprises pour y répondre.

Notre problématique s'inscrit une compréhension des processus présents dans la construction et la reconstruction des souffrances des clients des services sociaux et de santé. Comme aucune information n'existe sur l'accès aux soins en milieu rural, notre étude a tenté d'aborder les mécanismes de la souffrance décrits par les professionnels de proximité. Notre approche a été guidée par les questions suivantes: si la souffrance résulte d'une vision de l'individu sur sa propre existence, quelles valeurs entrent en jeu ? Si la souffrance est appréhendée comme la résultante d'une conduite particulière, dans quelle mesure est-elle aussi un produit social ? Quelles sont les interventions qui couvriraient les besoins de cette clientèle ? Quelles sont les actions qui les amèneraient à acquérir des capacités personnelles et des capabilités sociales pour s'opposer aux effets des souffrances ? Comment lorsque les souffrances interagissent de concert dans des contextes qui leur sont propices, mènent-elles les personnes aux dérives d'un état psychique qui se détériore ?

La liste des professionnels de première ligne travaillant auprès de personnes âgées de 18 à 65 ans issues des communes rurales a été établie avec l'aide du comité de pilotage du RE.SO.NORD (REseau du centre SOcial de la région du NORD).

Un entretien semi-structuré d'une durée de plus d'une heure a été mené en face à face. A partir des retranscriptions des discours des professionnels, une analyse de contenu a été menée.

Les professionnels de proximité ayant participé à l'enquête (sept médecins généralistes, trois psychiatres, neuf assistants sociaux, trois psychologues et sept travailleurs sociaux ; moyenne d'âge 42 ans, dont les femmes sont légèrement plus nombreuses) décrivent les effets d'une dérive en montrant comment les mécanismes en jeu produisent des processus d'amplification des problèmes neuropsychiatriques et d'accumulation des facteurs psychosociaux, et comment ces souffrances peuvent aboutir à des états de santé mentale critiques. Dans cette logique de gradation, les problèmes de santé mentale viennent s'agréger à un ensemble de comportements délétères. Cette gradation illustre un état que les clients atteignent lorsque les sphères intime et sociale se dégradent de concert. Elle représente cet état au cours duquel les personnes semblent avoir comme perdu face à leurs

souffrances et ne parviennent plus à s'en relever. Car la di fficulté majeure rencontrée par leurs clients ne réside pas tant dans l'existence avérée d'une souffrance, mais dans l'incapacité à la surmonter.

La souffrance dite « émotionnelle » désigne le caractère privé de l'existence et concerne les aspects tels que les comportements liés à l'addiction, aux troubles neuropsychiatriques et psychologiques, aux anxiétés existentielles profondes, et aux conséquences que ces problèmes engendrent sur le bien-être mental via les maladies mentales, font ici sens au regard d'une souffrance, à tout le moins personnelle. La détresse d'ordre psychique agit alors comme le révélateur de la souffrance vécue lorsque la sphère intime de leur existence se dégrade.

Quant à a souffrance dite « sociale » est le résultat de l'angoisse perçue quant à la dégradation de leur qualité de vie. Elle se réfère aux conditions psychologiques de vie ainsi qu'aux conditions matérielles de l'e xistence telles que le travail, le logement, le revenu, autant de facteurs qui, lorsque leur pérennité devient incertaine, et affecte la satisfaction à l'égard de la vie des personnes et de son entourage.

La mise en avant d'une interaction résultant du choc des sphères émotionnelle et sociale montre qu'un problème survient rarement seul. La question qui demeure, est celle de comprendre si la présence simultanée de divers problèmes découle d'un effet en cascade, du glissement d'un problème vers un autre ou de la présence de facteurs de risque communs à l'apparition de cette souffrance.

Dans la mesure où les souffrances sont multiples et s'interpénètrent, les observations des professionnels ont tenté de mettre au jour l'attention particulière qu'il est nécessaire de porter au développement conjoint des diverses trajectoires problématiques, et de leurs comorbidités. Les pistes d'action vers lesquels aboutissent nos résultats s'inscrivent dans les objectifs majeurs du Plan d'Action Global de Santé Mentale (2013-2020) auquel le Grand-duché adhère.

The 'Ancestral Health' Solution? An Analysis of the Construction and Practice of an Emergent Health Knowledge/Regime
Amanda Peters, McMaster University

A proposed case study of the Ancestral Health perspective aims to enhance theoretical understandings of the relationship between emergent health knowledge/regimes and social change, situating the actor as change-agent in the ongoing construction of health/illness within a political-cultural context.

Ancestral Health (AH) advances an evolutionary view of disease; while 2.5 million years of evolution lies behind us, today's bodies are sick, suffering from cancers and metabolic syndrome that only a "return to simplicity" can fix. Public engagement with AH is notable as it both exhibits qualities common within neoliberal healthism, and challenges key institutions of modernity. Health/illness scholarship highlights the role of systemic change in informing health beliefs and behaviour, especially in terms of medicine as an authoritative, state-sponsored institution. While structural approaches emphasize actors' weak

position in affecting change, illness experience and social movement scholars emphasize agents' change capacities. Wading in the murky waters of a dialectical relation, a critical constructionist-interpretivist frame highlights the tensions and opportunities that AH engenders.

To achieve sufficient depth and breadth of data while developing a representation of the phenomenon as accurate to individual experience as possible, this study employs multiple data sources and collection methods, including internet based methods. A content analysis of popular media (books) aids in identifying AH's origins and purpose, a content analysis of online-journaling (blogs), as well as semi-structured interviews and focus groups with supporters of the perspective, provide the key data sources for this study.

While in its early stages, the proposed investigation provides a valuable addition to existing theories of health and social change, broadening our understanding of tensions that arise as individuals engage in and construct innovative frames for being and doing the 'healthy body'. AH organizes everyday practice in a way that illuminates and configures ones' relationship with food, the environment, institutions and others. The ancestral body construct arises as an achievable ideal based on a science-informed understanding of human history, and importantly, it allows for individual engagement in important, health-related activities in post-industrial life: the conscious consumption of mass produced food and pharmaceuticals; building social relationships and developing shared identities; participating in the process of the democratization of science and knowledge; and producing social change.

Perspectives like AH raise awareness of and questions about issues related to health, the environment and sustainable living, offering an opportunity to better understand how health knowledge/regimes emerge, and how actors are situated in and contribute to processes of broader social change.

Session: Chronic Illness Paid Employment and Social Location

Tracing the Re-Emergence of Immunotherapy for Food Allergies
Stephanie Nairn, McGill University

The objectives of my research are to situate the study of food allergy and food allergy therapeutics on the sociological research agenda. In this presentation I will review the literature on the emergence of immunotherapy for food allergy (IT).

There has been limited sociological research on food allergy or food allergy therapeutics. Thus, in this presentation I will review the literature on the emergence of immunotherapy for food allergy (IT). The treatment involves administering increasing dosages of the foodstuff to which individuals are allergic in order to induce tolerance/de-sensitization to the foods to which they are allergic. This 'novel' therapeutic approach has been in practice in clinical allergy and immunology since the beginning of the twentieth century (Jackson 2005), but has not been the focus of sociological investigation. It is unclear, after reviewing medical literatures, why the therapy for food allergy did not 'catch on' like other IT therapies for hay fever and other aeroallergens.

I performed systematic review of medical/clinical databases for information about food allergy IT and have drawn on sociological conceptual theoretical frameworks to understand the emergence of this contested therapeutic approach.

Ultimately, I will demonstrate that this new therapeutic class offers insight into the ways that the molecularization of biology (Landecker 2011) and shifts to epigenetics in scientific research are realized in clinical studies of IT for food allergy. I hypothesize that whilst IT treatment for food allergy remains in clinical equipoise for the management or treatment of food allergy, the possibilities it offers to advance clinical and scientific understanding of epigenetic interactions, bolsters its appeal and legitimacy within the scientific community and further contributes to the enhancement of 'molecular imaginations'(Landecker 2011), particularly for patients.

I conclude with a call for more empirical studies and work on the emergence of food allergy as a social problem and 'epidemic' for both developed and developing nations via an exploration of the 'science' of food allergy therapeutics.

Common Education Standard for Ontario's Personal Support Workers: Implications for Independent Living Attendant Services

Chrissy Kelly, University of Ottawa

The goal of this paper is to consider the implications of the developing educational standard for Ontario Personal Support Workers for people with disabilities using Independent Living attendant services.

Scholars and community groups note variable content among Personal Support Worker (PSW) training and significantly, highly variable skills, responsibilities and knowledge among working PSWs. In 2013 the Ontario government announced a plan to develop a common educational standard for PSW training programs in order to establish core competencies, define the scope of practice and improve health outcomes.

Independent Living is a social movement, network of non-profit organizations, and philosophy that undergirds service provision. In brief, Independent Living strives to put services designed for people with disabilities into the hands of the users, and the philosophy emphasizes that people with disabilities are the experts in their own care needs. There are potential conflicts between the move to standardize PSW education and the goals of Independent Living attendant services.

This study included a literature review and analysis of public domain materials related to PSWs, including consultation submissions from community organizations, reaction to the preceding announcement of a personal support worker registry, news stories, and press releases.

A voice conspicuously absent from the educational standard consultation are adults with disabilities who use attendant services. A 2006 report exploring regulation of PSWs is careful to identify these issues as unique from other long-term care settings. Subsequent reports do not adequately address these issues and simply encourage attendant services users support both the registry and the educational standard. It is important to acknowledge the unique position of attendant services on the long-term care landscape.

Establishing an educational standard, and registry for that matter, must take seriously the perspective of Independent Living and adults with disabilities who have fought many policy, service and human rights battles to create and maintain the limited programs available to them.

Session: Public Policy to Promote Health & Safety in the Sex Industry: Canadian & international Perspectives

Sex workers' views on whether Canada's prostitution laws promote or inhibit their health and safety
Cecilia Benoit, University ofVictoria
Co-authors: Mikael Jansson, Mary Clare Kennedy & Nadia Ouellet

This presentation sheds light on sex workers' views of Canada's recently challenged prostitution laws in regard to their health and safety at work, and also what direction they would like any new legislation to take.

In December 2013, the Supreme Court of Canada unanimously decided that various sub-sections of the Criminal Code governing brothels, living on the avails of prostitution, and communicating in public for the purpose of selling sexual services, were unconstitutional. Chief Justice Beverly McLachlin wrote that "Parliament has the power to regulate against nuisances, but not at the cost of the health, safety and lives of prostitutes." The Supreme Court gave Parliament one year to devise new legislation, should it choose to do so. Shortly thereafter, Justice Minister Peter Mackay indicated that the Federal government plans to introduce new legislation ahead of the December 2014 deadline. While referring to the "Nordic model" (an approach that criminalizes purchasing, but not selling, a sexual service) as important for consideration, the Justice Minister also noted that the process of drafting new legislation will involve extensive consultations with experts, the pr ovincial and territorial governments, as well as members of the general public.

Our project, National Survey of People Working in the Canadian Sex Industry, which is one of the projects in a five-year CIHR team grant in progress, provides insights on this fundamental matter from currently-active sex workers who will experience new legislative changes first-hand. We interviewed 218 sex workers in Canada with diverse characteristics, including Aboriginal and other minorities, people from all genders and sexualities, as well as indoor, outdoor, and independent workers. We present descriptive data on participants' perceptions of and interactions with police and other regulatory authorities. Additionally, we conduct a thematic analysis of participants' responses to these open-ended questions: (1) What level and kind of interaction do you have with the police through your sex work? (2) What do you know about the laws surrounding sex work?

Preliminary findings suggest that one-quarter of participants have been arrested while working in the industry, and half state that local police do a poor job in treating sex workers fairly. Our qualitative date indicate that the majority of participants are in support of the recent Supreme Court ruling that the current prostitution laws inhibit rather than protect their health and safety.

The majority of participants would like sex workers to be treated like other adult service workers in Canada, which they maintain would help reduce the heavy stigma they face because of what they do for a living and make it easier for them to seek health services and police protection when needed.

Love the one you're with: How sex workers are supported by their partners.
Mikael Jansson, University of Victoria
Co-Authors: Cecilia Benoit, Mary Clare Kennedy & Nadia Ouellet

Illustrate the impact of the current Canadian criminal code on the relationship between sex workers and their partners based on interviews with currently active Canadian sex workers and their partners.

Laws and regulations governing sex work also affect the intimate partners of workers. The Canadian criminal code not only specifies in section 212(1)(j) that "[e]veryone who… lives wholly or in part on the avails of prostitution of another person, is guilty of an indictable offence" but also presumes in section 212(3) that anyone who is "habitually in the company of a prostitute" is guilty of this offence unless proven innocent. The Supreme Court of Canada unanimously ruled that this section threatened the health and safety of sex workers, therefore contravening the Charter of Rights and Freedoms. The Court chose to give the Federal Government until December 2014 to write new laws. The Federal Government has indicated that they will amend the criminal code based in part on consultations with experts, the provincial and territorial governments, as well as members of the general public.

In 2013 we interviewed 30 sex workers and their intimate partners in selected areas of Canada. During a 3-4 hour in-person meeting the two individuals were first interviewed separately and then as a couple. We asked a large number of closed and open-ended questions about social and demographic background, physical and mental health, work and career, romantic relationships, and laws and regulations affecting sex workers and third parties, including their intimate partners. This project was part of a larger team effort that collected data from sellers, buyers, managers, partners and regulators.

Preliminary findings suggest that while knowledge of laws and regulations is weak among partners of sex workers, fear of being charged with a crime is paramount. This fear is an important impediment to intimate partners' capacity to support their close companions, isolates intimate partners from family and friends, and negatively impacts their own health and safety.

Although there is limited understanding among partners of the laws and regulations governing sex work, they feel constrained in the level of support that they can provide to their partners who are sex workers. Stigma and low social support also impede support by partners.

An Exploration of Canadian Sex Industry Managers' Perspectives on Health, Violence, and the Law
Rachel Phillips, University of Victoria
Co-Authors: Dr. William McCarthy, Lauren Casey

This presentation examines sex work managers' views on Canada's prostitution laws and health and safety in the workplace. Our findings support the inclusion of managers in dialogue regarding legislative frameworks which support sex workers health and safety.

Managers in the sex industry are often understood through the archetypes of the "madame" or "pimp", and imagined within moralist frameworks that do not allow for a consideration of their roles within the organization of the Canadian sex industry. Academic research on the perspectives of managers has been scarce, however, recent Canadian research and information emerging from sex workers suggests that managers play a important role in the organization of some sex work environments. Sex work managers negotiate multiple sectors of the law from municipal zoning to federal statutes, and these varied legal environments have important implications for how they organize their work and enact health and safety measures in their workplaces. Managers in the sex industry also mediate, in varying ways, the encounters between sex workers and sex purchasers.

Mixed method (questionnaire and semi-structured) in person interviews (n=61) were conducted with male and female managers from a variety of sex industry venues where sexual services involving physical contact are sold. Interviews were conducted in medium and large Canadian cities. Managers included persons aged 19 and over who, for at least 6 months in the last 12, earned an income from providing instruction or direction to sex workers, including training, hiring, coordinating, monitoring, disciplining, and setting the workplace standards for sex workers in the performance of their duties

We report on the demographic and occupational backgrounds of managers and provide a qualitative analysis of managers' views on health and safety in the workplace. Managers employ a number of strategies to reduce conflict in the workplace and many report that their occupational settings are largely safe. However, they also note a number of risk factors which contribute to conflict and violence, both between workers and clients and among co-workers. Managers have mixed views on the current Canadian legislation, some preferring a hidden work environment due to avoid stigma and discrimination, while others would welcome public and regulated work environments. These views and their implications are described.

It is important to consider management in the sex industry when trying to understand factors that contribute to the health and safety of sex workers. Future research will include brining management, sex worker and sex purchaser perspectives together in a cross sample analysis.