What We Heard

The Chief Public Health Officer's Report on
the State of Public Health in Canada 2019
Addressing Stigma:
Towards a More Inclusive Health System

Canada

Table of Contents

Message from the Chief Public Health Officer of Canada

Every year, the Chief Public Health Officer of Canada writes a report on the state of public health in Canada. This year my annual report provides a snapshot of key public health trends in Canada and shines a light on a driver of health inequities; stigma. With a topic as complex and personal as stigma, it was important to me to hear from Canadians impacted by stigma.

This report summarizes themes from five discussion groups and eight key informant interviews, with a range of people across Canada who have expertise in, and experience of, stigma in the health system. Participants included people working in the health system and those who experience different kinds of stigma, such as health-related stigmas, racism, sexual stigma, and gender identity stigma.

I would like to thank those who shared their experiences of stigma and resilience, and vision for how we might collectively mobilize to address stigma in the health system. Your stories and perspectives give life to the report and grounds the data in reality. This input amplifies the need for all Canadians to work toward building a more inclusive health system.

Dr. Theresa Tam
Chief Public Health Officer of Canada

We would like to respectfully acknowledge that the land on which we developed this report is in traditional First Nations, Inuit, and Métis territory, and we acknowledge their diverse histories and cultures. We strive for respectful partnerships with Indigenous peoples as we search for collective healing and true reconciliation.

We would also like to acknowledge the territories in which we conducted discussion groups that contributed to this report:

- We acknowledge that the discussion group in Ottawa took place on the traditional unceded territory of the Algonquin people.
- We acknowledge that the discussion group in Toronto took place on the traditional territory of the Wendat, the Anishnaabeg, Haudenosaunee, Métis, and the Mississaugas of the New Credit First Nation.
- We acknowledge that the discussion group in Montréal took place on the traditional unceded territory of the Mohawk people.
- We acknowledge that the discussion group in Vancouver took place on the traditional unceded territory of the Coast Salish peoples, including the territories of the Musqueam, Squamish, Stó:lō, and Tsleil-Waututh Nations.

Executive Summary

The Public Health Agency of Canada (PHAC) launched an engagement process in April 2019 to gather perspectives and insights from people with expertise in stigma. The purpose was to understand how individuals experience stigma and potential ways to address stigma in the health system. A range of stakeholders provided their input, including those representing First Nations, Inuit, and Métis peoples, African, Caribbean, and Black Canadians, LGBTQ2+ people, and people who experience multiple stigmas, such as those related to health conditions, language, and age. This input informed the *Chief Public Health Officer's Report on the State of Public Health in Canada 2019: Addressing Stigma – Towards a More Inclusive Health System*.

The engagement process included a series of five in-person discussion groups and eight key informant interviews. In total, 100 stakeholders participated in this process, including health professionals, representatives from community-based organizations, service providers, policymakers, researchers, individuals with lived experience, and others working to help improve the health of their communities.

This report summarizes the ideas shared by these stakeholders.

Key Themes of What We Heard

1. What holds stigma in place? (Stigma drivers and practices)

- **Cultural injustice in Canada:** Experiences with stigma often reflect Canada's history of colonization and cultural assimilation. The lack of recognition and appreciation for other cultures and histories has resulted in many people not having access to culturally appropriate care and mistreatment by health providers and systems.
- **Invisibility of structural discrimination:** Many people experience stigma in their everyday lives, as discrimination pervades structures and systems in society. However, this is largely unknown to, and overlooked by, most Canadians.
- **Outdated policies and laws:** Stigma is embedded in, and shaped by, existing policies and laws that enforce dominant cultural values and disproportionally affect certain groups of people.
- **Biases and stereotypes:** Stigma is often driven by attitudes and beliefs that reflect entrenched biases and prejudices, as many people cannot relate to or are fearful of those who are different from them. As a result, their behaviours and actions are often based on false assumptions.
- **Power imbalances and lack of engagement and representation:** Many patients/clients who experience stigma are not being meaningfully engaged in the health system – their voices are not being heard and they are not well represented. Additionally, there are power imbalances between providers and patients/clients that serve as a barrier for a more inclusive health system.
- **Stigma and social determinants of health intersect to affect health:** Socioeconomic factors, particularly education, poverty, and employment, intersect lead to poorer health outcomes and shape people's experiences of stigma. There is not enough understanding in the health system of these circumstances.
- **Limitations of current knowledge practices:** The lack of high-quality data perpetuates stigma, as there is not sufficient information on the experiences and health outcomes of certain groups to inform the development of programs, services, and policies.

2. What can be done to address stigma in the health system? (Interventions and promising initiatives)

- **Make visible and address systemic stigma:** There needs to be broad, fundamental recognition of the systemic and historical issues – particularly the legacy of colonization and the ongoing effects of colonialism – underpinning many individuals' experiences with stigma, not only in health but across Canadian society more generally.

- **Counteract stigma from a social determinants perspective:** To properly address stigma, more holistic approaches are needed to target the social determinants of health, such as education and employment.

- **Meaningfully engage people with lived experience:** Health providers and organizations need to reach out to, engage, and learn from those who experience stigma. This will help build greater awareness of their realities and could be used to inform planning and decision-making related to health services and individual care.

- **Greater diversity and inclusion in the health system:** The health system workforce needs to be more diverse and represent people from a variety of backgrounds. This will require more efforts to engage youth, ensure equitable hiring and advancement practices, and re-think what skills are needed and valued, particularly in leadership positions.

- **Offer ongoing training to health providers to be aware and inclusive of difference:** Health providers need relevant, meaningful cultural competency training, which will help them develop greater self-awareness of their biases and build the skills needed to deliver quality care for all patients. This training needs to be provided early on and throughout their careers.

- **Create more positive public health messaging:** A positive approach could help address stigma in the health system by focusing on hope and empowerment and sharing stories of recovery and success, rather than relying on "scare tactics".

- **Increase funding and resources for community-based work:** There is a need for more funding and resources, particularly for smaller, community-based organizations that address stigma through prevention programs, training and capacity building, and targeted research and evaluation.

- **Improve knowledge generation practices:** Data collection and research on stigma needs to be improved to help build greater understanding of how people experience stigma and how it impacts their health. This includes valuing other forms of knowledge and ways of knowing.

Introduction

In April 2019, the Public Health Agency of Canada (PHAC) launched an engagement process to gather insights from a wide range of health leaders and stakeholders on stigma and health, with a focus on the health system. The data collected through this process has been used to inform this year's report on the state of public health in Canada prepared by the Chief Public Health Officer (CPHO), Dr. Theresa Tam. This annual report helps to raise the profile of public health issues, stimulate dialogue, and catalyze action to improve and protect the health of Canadians.

With this year's focus on stigma, the CPHO and colleagues engaged Canadians with expertise in stigma, including health professionals, representatives from community-based organizations, service providers, policymakers, researchers, individuals with lived experience, and others working to help improve the health of their communities. Through a series of in-person discussions and key informant interviews, various dimensions of stigma were explored, including definitions and concepts, stigma drivers and practices, and interventions. Additionally, there was a focus on certain groups who experience multiple layers of stigma, specifically First Nations, Inuit, and Métis peoples, LGBTQ2+ people, and African, Caribbean, and Black Canadians. The discussion groups and interviews also addressed health-related stigmas (e.g., mental illness stigma, substance use stigma, tuberculosis stigma, obesity stigma).

This *What We Heard* report summarizes the key findings from this process, with a focus on synthesizing common ideas shared by stakeholders across the in-person discussion groups and key informant interviews. The goal of this report is to represent the voices of all participants who provided their time and energy to meaningfully contribute to the annual report. However, all of the data gathered through this process has been subject to analysis and interpretation.

Process Overview

In-person Discussion Groups

To engage a diversity of stakeholders, PHAC held a series of five in-person discussion groups between April and June 2019. Each session had a slightly different focus in terms of participants and communities served, including health professionals, African, Caribbean, and Black Canadians, LGBTQ2+ people, and First Nations, Inuit, and Métis peoples. These sessions also included people who experience multiples stigmas including those related to health conditions, language, and age. Discussion groups took place as follows:

1. **April 4 in Ottawa**
   (part of the CPHO Health Professional Forum)
2. **April 29 in Ottawa**
   (Canadian Public Health Association pre-conference session)
3. **May 23 in Montréal**
   (hosted by DESTA Black Youth Network)
4. **May 29 in Toronto**
   (held at the YWCA)
5. **June 7 in Vancouver**
   (held at the First Nations House of Learning)

The purpose of the sessions was to gather stakeholders' input on the following key areas:

1. **What holds stigma in place?**
   (Stigma drivers and practices)
2. **How do we address stigma in the health system?**
   (Interventions and promising initiatives)

Each discussion session was 3.5 hours in length and included a mix of presentations, small group discussion, and plenary dialogue. Each session was hosted by the CPHO or her delegate with members of the Office of the CPHO's Reports Unit and PHAC regional offices supporting the event (as well as the CPHO Health Professional Forum Secretariat). PHAC engaged an outside consultant, *Hill and Knowlton Strategies* to support facilitation and note-taking for session's #2-5.

In total, 92 stakeholders participated in these discussion groups. Please see Appendix A for the list of participating organizations.

Key Informant Interviews

In addition to the in-person discussion groups, eight key informant interviews were conducted by *Hill and Knowlton Strategies* in June and July 2019. The purpose of the interviews was to further engage stakeholders representing critical perspectives and expertise on stigma in health, particularly those who could not attend the in-person sessions. The interview questions followed similar lines of inquiry as the discussion groups, with a focus on stigma drivers and interventions. Each interview was approximately 45 to 60 minutes in length and conducted by an independent facilitator and note-taker. Please see Appendix A for the list of organizations/perspectives represented.

Data Collection, Analysis, and Reporting

Qualitative data was collected via detailed notes taken by a note-taker during all of the in-person discussion groups and key informant interviews. Worksheets were completed by participants and used for reporting on their table discussions. Notes and worksheets were analyzed to inform summary reports for each session, which included a synthesis of key ideas.

To develop this *What We Heard* report, session summary reports, session notes, and interview notes were reviewed and analyzed to identify overarching themes from stakeholders across all forums. The focus was on highlighting the most common themes (i.e., most frequently discussed). Non-attributed participant quotes are highlighted throughout this report to help illustrate participants' perspectives pertaining to each of the themes.

Key Findings

This section provides a synthesis of the key findings from both the in-person discussion groups and key informant interviews. Findings are presented by discussion question and theme.

What Holds Stigma in Place?

Biases and stereotypes

Cultural injustice in Canada

Invisibility of systemic discrimination

Outdated policies and laws

Power imbalances and lack of engagement and representation

Stigma and social determinants of health intersect to affect health

Limitations of current knowledge practices

Cultural injustice in Canada: As one of the top themes, participants across all sessions highlighted how stigma experienced in the health system often reflects Canada's history of colonization and cultural assimilation, in which people from certain groups continue to face injustice and trauma. As a result of the disruptive and ongoing impact of colonialism, First Nations, Inuit, and Métis peoples have a long history of being mistreated by health providers and not having access to care in their language or reflecting their culture. Participants described a lack of recognition of First Nations, Inuit, and Métis culture and knowledge (including holistic concepts of health such as including spirituality, one's role and contribution to their community), the impact of historical traumas like residential schools and missing and murdered Indigenous women, and differences between and within different Indigenous groups. One participant discussed how children in their community have been misdiagnosed and have died from serious but treatable conditions like strep throat, and how some patients are not given sufficient information about their drugs/treatment.

Similarly, some participants described the need to raise awareness of Canada's history with the transatlantic slave trade and build appreciation for the contribution of African, Caribbean, and Black Canadians. Some discussed how others do not fully recognize the agency and capacity of people belonging to groups that have historically been stigmatized, such as African, Caribbean, and Black Canadians and First Nations, Inuit, and Métis peoples.

Invisibility of systemic discrimination: For many participants, systemic discrimination pervades structures and systems, not only in health, but also in education, employment, justice, and housing systems. While this stigma is felt deeply by many individuals, it is largely unknown to and overlooked by most Canadians. For example, one participant described the experience of "living while Black": "There isn't a moment where we are not calculating what does this mean, how will this be seen, how are they going to react, how am I going to react. It takes a lot of energy."

Participants expressed strong concerns with the lack of support or willingness to change the structures that perpetuate stigma: "People are complacent with the status quo… There is a 'don't talk about it' attitude." Many Canadians do not recognize that they are "implicated in racist systems" – they often do not know these issues exist or choose to ignore them. For example, some believe that racism can only occur through "extreme" behavior, rather than through prevailing cultural privilege or a narrative that benefits some but not others. Additionally, some health professional participants acknowledged that there is complacency in their work settings and/or profession to make necessary changes.

A major challenge is achieving broad recognition that the legacy of historical and cultural injustices continues to re-enforce stigma and perpetuate health inequities. Many participants discussed how it is difficult to advance the dialogue with the broader public in this area, as many Canadians do not want to acknowledge their conscious and/or unconscious biases. Participants described examples including the controversial legacy of certain historical sites or undermining the level of violence committed against missing and murdered Indigenous women.

DISCUSSION GROUP QUOTES

"It goes back to the incapacity of white people to understand that other people who are not white have the capacity to inform and transform their environment."

– Montréal participant

[As a Black physician] "A doctor wanted me to do a consult for one of his patients with a thick Caribbean accent. He had depicted her as a "gypsy" and indicated that he was afraid of them. In reality, the challenge was that he couldn't understand her accent."

– Discussion group participant

Similar feedback was provided from the perspective of linguistic minorities, who often feel discriminated against and forced to communicate in the language of the majority to access health services. For example, participants described patients from both English- and French-speaking minority populations being criticized and nearly refused services by health providers. In one participant's perspective, this reflects often unspoken expectations for assimilation between English- and French-speaking Canadians.

Outdated policies and laws: Several participants discussed how stigma is embedded in and shaped by existing policies and laws, can be outdated and disproportionately discriminate against First Nations, Inuit, and Métis peoples, African, Caribbean, and Black Canadians and LGBTQ2+ people. Some emphasized that policies and laws are not written by or for people from these communities. In the health sector, some examples include those related to HIV non-disclosure, blood donor eligibility criteria, and partner notification of sexually transmitted infections (STIs). Additionally, some participants discussed how the *Indian Act* enforced significant changes to First Nations culture and tradition. For example, enforcing colonial values on First Nations communities by taking respect and "power away from the matriarch." As a result, many participants called for updating policies and laws to incorporate new research/evidence and reflect lived experiences of stigma.

Biases and stereotypes: Similar to previous themes, some participants discussed how stigma is driven by attitudes and perspectives that reflect entrenched prejudice and biases. In many cases, these embody a "fear of difference" or "fear of the unknown" among many Canadians. For example, one participant suggested that many people "believe that drug users put themselves in those positions through their own decisions." Within the health system, some participants shared how they have been treated differently as a result of their ethnic or cultural background, even though they have the same health needs as other patients. Some

> *"Racism that has been written into policy is hard to see. You can't see that the policies are written by people with a certain lens – white, elite, male, etc. Everyone has a bias."*
>
> **– Key informant interview participant**

> *"People make assumptions of Inuit capacity if they don't speak proper English… They look at our population as "less" rather than "in need of support."*
>
> **– Key informant interview participant**

> *"There is an assumption that you can't possibly be as bright as they are, and invariably someone thinks I'm there to wash their bloody floor… Before any conversation, I always have to introduce myself as a doctor."*
>
> **– Montréal participant**

suggested that this could be the result of false assumptions or narratives, such as African, Caribbean, and Black Canadians having a higher pain tolerance or being more likely to get pregnant. In the context of the health system, several participants talked about their own experiences with racism and discrimination. As a patient, this includes receiving care based on false assumptions, being blamed for their health issues and experiencing barriers to care for their children and family members. Over time, these negative experiences have caused many people to be reluctant to seek out and receive care. From an Indigenous and linguistic minority perspective, some participants discussed not having access to services in their first language. In some cases, this leads health providers to make assumptions about the capacity of a patient when there is actually language barrier.

Similar experiences of both patient and health professional biases and stereotypes were also shared from the perspective of health providers. For example, both First Nations, Inuit, and Métis and African, Caribbean and Black Canadian participants who are service providers described experiences of patients refusing care from them, being questioned about their level of education and profession, and being ostracized by their colleagues.

Participants also discussed how patients are categorized and pathologized based on their health conditions. Rather than being seen as a whole person and assessed in the context of the wide variety of life experiences that can impact health (including social determinants of health), people can be "singled out" and "slotted into a group or labelled" as, for example, someone who uses substances, has HIV, or has a mental illness. These categories often have stereotypes and stigma attached to them, which can lead providers to make false assumptions about the person and their needs. Stigma is further perpetuated when patients are treated in a transactional manner, rather than a person-centred and compassionate approach.

> *"We've been good at creating silos. Everything is organized around one thing… But what are my needs as a person? I'm not just a patient or client. That's too transactional."*
>
> **– CPHO Health Professional Forum participant**

Power imbalances and lack of engagement and representation:
Many participants highlighted that patients, particularly those from groups who experience stigma, are not being engaged in the health system – whether through meaningful conversations around their own care or being included in decision-making processes related to making improvements to the health system. Their voices are not being valued if health providers and organizations do not actively reach out and listen to their stories. Some felt that better engagement is critical in ensuring that health providers understand upstream factors impacting a person's health and so that patients are treated more as unique individuals rather than "treating them like their illness." Some participants discussed how, for First Nations, Inuit, and Métis peoples, meaningful engagement means working collaboratively to build customized person-centered approaches that incorporate Indigenous knowledge. Without this person-centered approach, these patients may not seek the care they need, leading to further stigmatization and poorer health outcomes.

Additionally, some participants shared their concerns about power imbalances between health providers and patients. One participant stressed that these power imbalances are the reason why stigma can have a real impact on health outcomes. For example, providers are typically "middle class or highly privileged people" who may not be able to communicate effectively with or relate to their patients. There is often a "provider knows best" mentality, in which their preferred methods are prioritized over a patient's individual needs, which may not be sufficiently considered in care planning discussions.

One participant suggested that some providers are not always aware of the power and privilege they hold over patients. This influences patient/provider interactions, especially among patients who are highly stigmatized. For example, some patients are reluctant to request services in their language of choice because they worry that it will create problems with their provider.

"[As an Indigenous person] often I find people don't hear, listen to or see me."

– Vancouver participant

"[The patient] is afraid of being judged if they don't stay quiet and accept the services."

– Key informant interview participant

"Living in an impoverished community increases their [African, Caribbean, and Black Canadians] likelihood to get into criminal activities because it's available to them. That then reinforces stigma that Black people are more likely to be involved in crime."

– Key informant interview participant

Stigma and social determinants of health intersect to affect health: Several participants described how other factors, like income, education, and geography, intersect and shape their experiences of stigma. For example, some emphasized barriers due to low income, not only for accessing health services but also for broader participation in society in terms of education, employment, housing, and justice systems. Additionally, greater income inequality can create more divisions and make people "less accepting of differences": "When [income inequality] gets bigger, you get bigger social problems that breaks societies." Some participants explained how poverty can lead to race-based stigma and discrimination towards, for example, African, Caribbean, and Black Canadians.

Participants provided similar feedback on the impact of low levels of education (e.g., less employment prospects) and geographical isolation (e.g., limited access to services in communities) on health outcomes.

Additionally, participants discussed how experiences with exclusion and discrimination can be amplified for individuals who face multiple layers of stigma, such as being racialized and gay, or homeless and experiencing mental health or substance abuse issues. In these cases, these individuals are often blamed for making "bad life choices."

Some participants emphasized that understanding the impact of multiple and intersecting stigmas remains challenging, as it is currently not a well-researched area and is difficult to study when multiple factors are involved.

Limitations of current knowledge practices: Participants discussed challenges around what and how knowledge is valued and used to make decisions that impact health. Some participants discussed the lack of high-quality data available to health providers and policy makers, especially pertaining to African, Caribbean, and Black Canadians, First Nations, Inuit, and Métis peoples, and LGBTQ2+ people. There is a need for expanded health data collection and administration to better represent underserved groups. For example, one participant highlighted: "If you are trans you are not counted in a lot of data collection, so you don't exist within the system." Additionally, some participants discussed how data categorization practices (e.g., epidemiological categories) and the incorrect interpretation of data contributes to stigma in health. Participants also challenged how Eurocentric knowledge systems are valued over other ways of knowing. For example, Indigenous knowledge and traditions such as powwows and drums are linked to health, though these ways of knowing are not "written down as actual evidence or science."

> *"People who are homeless are often viewed as unwelcome, frequent flyers [in the health system], who are coming in with issues that aren't viewed as legitimate or real problems."*
>
> **– Key informant interview participant**

How Should We Address Stigma in the Health System?

Counteract stigma from a social determinants perspective

Meaningfully engage people with lived experience

Greater diversity, inclusion, and leadership in the health system

Create more positive public health messaging

Increase funding and resources for community-based work

Improve knowledge generation practices

Offer ongoing training to health providers to be aware and inclusive of difference

Make visible and address systemic stigma

Make visible and address systemic stigma: For many participants, addressing stigma requires a broad, fundamental acknowledgment of the systemic and historical issues underpinning many people's experiences, not only in the health system but society more generally. In particular, the legacy and ongoing effects of colonialism need to be recognized and addressed, as they reinforce discriminatory perspectives and attitudes towards First Nations, Inuit, and Métis peoples and African, Caribbean, and Black

> *"Anybody who is part of racialized work would tell you that Canada is deeply racist and [only] changing health services doesn't change that."*
>
> **– Key informant interview participant**

> *[On systemic issues] "You can smack people in the face with evidence and they will refuse to believe it… The everyday Canadians that are taught this behavior need to acknowledge and change it."*
>
> **– Vancouver participant**

Canadians, while also creating divisions between different groups in society. Some participants stressed that actions to reduce stigma cannot be limited to the health system – they should be extended more broadly across all structures in society. To help recognize and build greater awareness of the factors underpinning stigma in Canadian society, participants suggested developing public campaigns that could, for example, teach children about various cultures and histories. Additionally, participants noted that this issue is complex as there is need for change at both a systemic and individual level.

Counteract stigma from a social determinants perspective: Participants discussed the need for more holistic approaches that include prevention and actions to address the social determinants of health. This could include addressing the lack of education and employment opportunities for African, Caribbean, and Black Canadians through mentorship and education programs. Among Indigenous participants, there was discussion about how, in Indigenous contexts, the concept of health should not be separate from the concept of wellness, unlike in Western medicine.

Many participants shared the realities of working within the confines of existing systems that do not recognize the broad needs of patients and clients. For example, a community organization that receives funding for arts programs that, in reality, is supporting mental health work but does not have the resources to hire trained mental health professionals. More "flexible, sustainable funding" models could help community organizations address these issues, as the current models are "too rigid."

Meaningfully engage people with lived experience: Participants across all sessions emphasized the importance of engaging people who have experienced stigma. This involves reaching out and learning from people's realities in order to build greater awareness among health providers and the health system more broadly. Additionally, engagement could focus on health system redesign to improve patient navigation.

> *"You can't divorce the social from the health."*
>
> **– Montréal participant**

> *"Actually listen to patients on what their lived experience is... They will come up with solutions that will meet their needs better than what we can come up with."*
>
> **– CPHO Health Professional Forum participant**

Participants suggested that meaningful engagement could be achieved in a variety of ways. Many will require changes in how organizations operate. These include:

- Using a flexible, adaptable, person-centred approach, recognizing that people can experience stigma in many different ways.
- Deploying a multitude of engagement methods to help encourage individuals to tell their own stories to inform health system change in a variety of ways, such as through Photovoice – a participatory research methodology that has been used in different contexts.
- Providing opportunities for those with lived experience to be leaders of – not just participate in – important discussions, for example, to shape training and inform decision-making.
- Bringing together individuals with lived experience and health system actors at all levels (e.g., health care administrators, physicians, nurses, educators) to share experiences and discuss collective goals.
- Adapting culturally safe frameworks and developing meaningful partnerships to facilitate authentic engagement and help minimize tokenism, such as through Indigenous Advisory Circles (IACs). An example of a current culturally safe partnership is Tungasuvvingat Inuit's regional cancer program gatherings held in partnership with the Canadian Partnership Against Cancer (CPAC).

Many participants identified the need to engage youth to help address stigma over the long term. For some participants, this means educating young Canadians about diversity and inclusion in ways that are relevant to them, such as through school-based programs. This could help minimize the drivers of stigma in the future. Similarly, health professionals discussed how healthcare facilities can meaningfully engage youth and involve them in shaping the patient experience. For example, the Children's Hospital of Eastern Ontario (CHEO) has a Youth Advisory Committee that is engaged on a regular basis by the hospital's administration and board, which has led to policy changes (e.g., clinic hours).

[On engaging Indigenous people] "If we listen to our families and go right to folks [impacted by] stigma… that means self-determination… People know what they need but we just don't listen to them."

– Vancouver participant

"Do what you did here today, but with children. Invest in our future generations to ensure stigma does not continue for years to come."

– Toronto participant

Greater diversity, inclusion, and leadership in the health system: Several participants discussed how barriers to employment – particularly for African, Caribbean, and Black Canadians and First Nations, Inuit and Métis peoples – helps drive stigma in the health system, both as patients, providers and co-workers on health teams. To address this, there needs to be greater workforce representation from a diversity of backgrounds across the health system, particularly in senior leadership and decision-making positions. This requires more equitable hiring, pay and advancement practices in the health sector, as well as more general "re-thinking" of what skills are valued in positions of leadership. Some participants also mentioned the importance of greater diversity and inclusion in institutions beyond health, such as in the education system and employment sector. Additionally, some highlighted the importance of supporting youth to pursue careers in the health sector: "Our kids need role models and supports." They discussed the importance of reducing barriers to post-secondary education, such as through scholarships and targeted recruitment programs (e.g., Dalhousie University's Promoting Leadership in Health for African Nova Scotians (PLANS) program).

Offer ongoing training to health providers to be aware and inclusive of difference: Many participants emphasized the importance of health providers receiving relevant, meaningful training early on and throughout their career. Health professionals need to develop greater self-awareness of their biases and should be required to complete cultural competency training to build the skills and competencies needed to deliver quality care for all, such as being more accepting, respectful, and culturally aware, and using non-stigmatizing language with their patients. They need to develop a greater understanding of the impact of the social determinants of health and barriers that some individuals may face. This could involve anti-racism, in addition to cultural competency, training for health providers to get "at the root of the issue": "White people are more comfortable talking about culture than race. We need to change the language."

Additionally, training needs to be ongoing – not just through "one-time events" – to help support the full, continuous changes in attitudes and behaviours needed to address stigma, as well as to help ensure accountability. Training could also involve more "field opportunities" to be exposed to, and learn about, communities.

> *"When you address stigma, you need to start at the top by setting an inclusive playing field as a standard."*
>
> **– Toronto participant**

> *"You need education throughout your career. Not one day on cultural sensitivity, or mental health sensitivity."*
>
> **– CPHO Health Professional Forum participant**

Create more positive public health messaging: Some participants underscored the value of using positive messaging in public health campaigns. This could include using messages that focuses more on hope and empowerment and sharing stories of recovery and success, as opposed to relying on "scare tactics", which can add to stigma already associated with some health conditions. Additionally, some participants discussed the need to learn from and leverage promising public health initiatives that take a strengths-based approach, rather than focusing on people's deficits. For example, the First Nations Health Authority uses a strengths-based approach to draw on collective and personal strengths for public health messaging and to treat people with complex trauma.

Increase funding and resources for community-based work: Several participants highlighted the impact of community-level actions in addressing stigma through the development of upstream prevention programs, building downstream capacity, and conducting more targeted research. Many community-based organizations and initiatives have been very successful in this area; one participant suggested that, in contrast to larger organizations, the community-based organizations have a better understanding of, and connection to, individuals who may face stigma. However, these community-based organizations need more sustainable funding and resources, especially if they are a smaller operation. Montréal participants highlighted how funding tends to be focused on supporting larger organizations, which "continues to keep [community-based organizations] in a position of third class."

To better support community-based organizations, participants discussed how more project- and program-based funding is needed to develop training programs and hire experts to conduct workshops to engage both health providers (including social workers) and community members. Long-term funding models also need to be less rigid and more flexible to support long-term sustainability for community-based organizations. Additionally, one participant discussed how funding applications need to be simplified to increase accessibility to resources for these organizations: "You practically need a PhD to apply for these grants."

Improve knowledge generation practices: Valuing different ways of knowing and improving research and data could help address stigma by building a greater understanding of people's experiences and, ultimately, informing the design of more inclusive policies, programs, and practices. Participants representing and/or working with First Nations, Inuit, and Métis communities emphasized the importance of incorporating Indigenous knowledge into healthcare approaches and beyond (e.g., K-12 education system). Additionally, one participant discussed their experience with a research project focused on suicide prevention in Vancouver's Downtown Eastside, which became more effective in reaching those in need of help with the inclusion of elders to work alongside physicians.

Efforts to improve knowledge generation could include collaboration with people and communities impacted by stigma to reduce biases in health data, conduct more targeted race-based research (e.g., mental health of African, Caribbean, and Black Canadians), and collect more stigma-related health data: "We need the numbers to be able to say this is where stigma and racism is coming from." Some participants also emphasized the importance of evaluation and knowledge sharing to help spread promising initiatives, foster collaboration across stakeholder networks, and hold health system leaders accountable.

Conclusion

By engaging with key leaders and stakeholders interested in stigma and health, the CPHO gained valuable insights to inform the 2019 CPHO Annual Report.

Participants generously gave their time to have open and honest conversations about the challenges facing many Canadians as they interact with the health system. The key findings throughout this report reiterate that fundamental change is needed across various systems and structures, not just in the health system, but more broadly across society.

APPENDIX A

Participants' Organizations

Chief Public Health Officer Health Professional Forum Discussion Group

- Centre for Addiction and Mental Health
- Canadian Public Health Association
- Association of Medical Microbiology and Infectious Diseases Canada
- Canadian Dental Association
- Canadian Indigenous Nurses Association
- Canadian Medical Association
- Canadian Nurses Association
- Canadian Paediatric Society
- Canadian Pharmacists Association
- College of Family Physicians of Canada
- Community Health Nurses of Canada
- HealthCareCAN
- Infection Prevention and Control Canada
- Royal College of Physicians and Surgeons of Canada
- Society of Obstetricians and Gynaecologists of Canada

Canadian Public Health Association Pre-conference Discussion Group

- Assembly of First Nations
- Canadian Centre on Substance Use and Addiction
- Canadian Coalition for Seniors Mental Health
- Canadian Institute for Health Information
- Canadian Public Health Association
- Community Addictions Peer Support Association
- Egale Seniors National Advisory Council
- Institut National de Santé Publique du Québec
- Mental Health Commission of Canada
- Métis National Council
- National Collaborating Centre for Indigenous Health
- National Collaborating Centre for Determinants of Health
- Ottawa Senior Pride Network
- Public Health Ontario
- Simon Fraser University
- St. Paul's University
- University of Ottawa
- University of Toronto
- Youth Services Bureau

Montréal Discussion Group

- Afrique au Féminin
- Arts, Racines & Thérapies
- Black Community Resource Centre
- CIUSSS du Centre-Sud-de-l’Île-de-Montréal
- Dalhousie University
- DESTA, The Black Youth Network (Little Burgundy)
- Général ACCÉSSS
- L’Association Médicale de Personnes de Race Noire du Québec
- Ligue des Noirs du Québec Maison d’Haïti
- McGill University, Lady Davis Institute for Medical Research

Toronto Discussion Group

- Africans in Partnership Against AIDS
- Black Health Alliance
- Hospital for Sick Children
- McMaster University
- National Collaborating Centre for Determinants of Health
- Rainbow Health Ontario
- Toronto Senior Pride Network
- Toronto Public Health
- Wilfrid Laurier University
- Li Ka Shing Knowledge Institute
- Wellesley Institute
- University of Toronto

Vancouver Discussion Group

- BC Ministry of Mental Health and Addictions
- BC Nurses Union
- First Nations Health Authority
- Métis Nation British Columbia
- Pacific AIDS Network
- Office of the Provincial Health Officer, British Columbia
- The Cedar Project
- University of British Columbia, School of Nursing
- Winnipeg Boldness Project
- YouthCo

Key Informant Interviews

- Centre for Urban Health Solutions, St. Michael’s Hospital
- Community Health and Social Services Network
- Faculty of Health, Dalhousie University
- Inuit Tapiriit Kanatami
- IWK Health Centre
- Quebec Black Medical Association
- Tungasuvvingat Inuit
- Wellesley Institute