STIGMA

Addressing Stigma

Towards a More Inclusive Health System

The Chief Public Health Officer's Report on the State of Public Health in Canada 2019

Canadä

Table of Contents

Message from the Chief Public Health Officer of Canada

By and large, we are a healthy nation. We can be proud of Canada's health and social systems that contribute to this status. From this position of strength, we have an even greater opportunity to lead the world in health status and to ensure all Canadians can achieve optimal health. This year, my annual report provides a snapshot of key public health trends and shines a light on one of the drivers of health inequities: stigma.

I am pleased to report on some important positive health trends this year like the lower incidence of certain chronic and other non-infectious diseases. Some social factors that lead to good health in Canada are also improving; more people are achieving post-secondary education, and poverty rates, especially childhood poverty, are decreasing.

I do continue to be concerned about worrying trends. With the dramatic rise in global measles cases this year, the risk of importation and domestic spread has increased. If we do not improve our vaccine coverage, we may lose our hard-earned measles elimination status. Sexually transmitted infections such as syphilis are also making a comeback with the additional challenge of

antibiotic-resistant bacteria causing gonorrhoea. Youth vaping rates are increasing and we do not fully understand the related harms, from potential impacts on the respiratory system to the incidence of youth cigarette smoking. The opioid crisis continues, and claimed more than 12 deaths per day in 2018. The harms may have been much greater if a range of preventive, harm reduction, and treatment measures had not been implemented.

All of these trends are reversible. We know what to do but need to re-engineer how we implement proven public health measures in today's context. This includes getting trusted, evidence-based information to Canadians in the age of misinformation and disinformation.

Although public health policies and programs should benefit all, persistent health inequities prevent many from being able to achieve their full potential. Often these differences can only be explained by how people are treated. That is why I focused this annual report on stigma and health.

Stigma affects us all. We are all vulnerable to the slow and insidious practice of dehumanizing others and we are all responsible for recognizing and stopping it.

This is what we know. Stigma is associated with poorer physical and mental health outcomes. Stigma and discrimination towards persons with health conditions, such as mental illness, substance use disorders, and HIV, cannot be understood or treated separately from stigma related to other characteristics such as race, gender, sexual orientation, age, and income.

These many forms of stigma, that intersect in complex ways, are very much present in our health system, driving those most in need from getting effective care and accessing services. It means that we, as health system leaders and practitioners, are contributing to negative health outcomes.

This report offers a way forward.

We can build on our Canadian multicultural and inclusive way of life, while at the same time openly recognize and name racism, homophobia, transphobia, and other stigmas related to social identities. We can stop using dehumanizing language, examine our own assumptions, and implement policies and education programs, while also measuring our progress towards stigma elimination across the health system. By understanding the common drivers, practices, and experiences of multiple stigmas, we may find more collaborative and effective interventions.

It is hard to face our vulnerabilities as individuals and organizations who set out to care for others but fall short on providing the safe, effective, and compassionate health system that puts people first. However, with a dose of humility and a deepened connection to people who experience stigma, we can deconstruct the "us versus them" narrative and develop the most inclusive health system in the world.

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.

"Greater attention needs to be paid to stigma as a social determinant of population health."[1]

About this Report

Every year, the Chief Public Health Officer writes a report on the state of public health in Canada. These reports raise the profile of public health issues and stimulate dialogue. They can also lead to action in improving and protecting the health of Canadians.

This year's report first provides a summary of the overall health of Canadians, including how different populations experience poorer health. The rest of the report focuses on stigma, one of the reasons for these differences.

Health of Canadians

Chapter One draws on indicators from the Chief Public Health Officer's Health Status Dashboard (Appendix A), as well as other national data on the health of Canadians. Some health inequalities are highlighted by the use of key examples. The dashboard provides a breakdown of national indicators by sex where possible. In the past year, some new data have been released and indicator values have been updated. In other areas, the indicator values from last year remain the same.

Stigma and Health

Chapter Two presents a stigma and health model that highlights the pathways from stigma to poor health outcomes and how different stigmas intersect. This new model illustrates how stigma drivers and practices, including those in the health system, can lead to health inequities. Chapter Three presents an action framework with a range of evidence-based actions that can be implemented simultaneously to reduce stigma across the health system. These sections examine a range of health-related stigmas as well as stigmas associated with social identities.

The information presented in the stigma chapters was synthesized from an evidence review conducted in social and health science databases.

When synthetizing the evidence, systematic reviews were prioritized and complemented by primary studies. The strongest evidence found through the review was prioritized. Where available, Canadian research has been highlighted. Emerging and promising practices were identified through the evidence review, environmental scan, and stakeholder engagement.

Throughout the stigma chapters, quotes have been included to reflect the lived experiences of stigma and broader input on solutions for developing an inclusive health system. These quotes were gathered during five discussion groups and eight interviews with a range of people with expertise in stigma across Canada. Participants included health professionals, representatives from community-based organizations, service providers, policymakers, researchers, individuals with lived and living experience, and others working to improve the health of their communities. The areas of focus included stigma experienced by First Nations, Inuit, and Métis peoples, African, Caribbean, and Black Canadians, seniors, and LGBTQ2+ people, and across health issues such as mental illness, substance use, tuberculosis, HIV, and obesity.

More information about the themes from the discussion groups and interviews can be found in the What We Heard report.

Describing the Health of Canadians

Introduction

Canadians are among the healthiest people in the world. In general, we live long lives in good health. Nevertheless, there are some concerning public health trends and health inequities.

The content of this chapter is based on indicator data derived from the Chief Public Health Officer's Health Status Dashboard (Appendix A), as well as other national data sources and scientific literature exploring the health of Canadians. Dashboard changes compared to the previous version that was published as part of the _Chief Public Health Officer's Report on the State of Public Health in Canada 2018: Preventing Problematic Substance Use in Youth_, include indicator value updates and breakdowns per sex, where available. In the event that no new indicator results were available, last year's published results are used. It is important to note, however, that national-level data can mask the health status of some groups in Canada. This chapter offers some examples of these persistent health inequities.

Health Trend Highlights

Life Expectancy is Changing

In 2017,[i] life expectancy at birth for women was 84 years, while for men it was 80 years.[2] Life expectancy is affected by both the number of deaths in a population, as well as the age at which those deaths occur.

For years, life expectancy at birth has steadily increased in Canada for both sexes, but recent data suggest this may be starting to change. From 2016 to 2017, for the first time in four decades, there was no year-to-year increase in life expectancy at birth for either males or females.[2]

Despite this, some encouraging trends in life expectancy have been observed. Over the course of the previous three decades, male life expectancy at birth has increasingly approached the life expectancy of females, so the gap between the sexes has decreased.[2] Life expectancy at birth has been positively influenced by fewer deaths or later deaths related to cancer or circulatory diseases from 2016 to 2017.[2]

Life expectancy is changing across age groups. Older people benefitted from improved mortality rates in 2017, meaning that they are dying at a slower rate than in 2016. However, gains in life expectancy at birth, due to these improved mortality rates for older Canadians, are being largely offset by increased mortality rates among younger adults. This is especially true for males (Figure 1).[2]

---

i   Respective life expectancy data is based on reference period 2015–2017.

Health Inequalities and Inequities in Context

Health inequalities reflect differences in health outcomes. When these differences are related to unfair conditions, they are called health inequities. When reporting on populations that experience a disproportionate burden of poor health outcomes, it is critical to understand the context of these data.

For instance, First Nations, Inuit, and Métis peoples have had to overcome stigmatizing and catastrophic experiences throughout history, such as colonization, the loss of traditional lands and political institutions, and attempts at cultural assimilation. Poor health outcomes related to substance use and mental health are examples of the lasting impacts of intergenerational trauma (i.e., passing on the negative effects from one generation to the next) that have influenced the health of Indigenous peoples in Canada.

Unique contexts also exist for other populations, which need to be contextualized within historical, political, social, and economic conditions. Not all of these situations may be referred to in this chapter due to data and space limitations. To further explore differences in health outcomes, please refer to the report Key Health Inequalities in Canada.

FIGURE 1: **Contribution of Age-specific Mortality Rates to the Change in Life Expectancy at Birth (by Sex, 2016 to 2017, Canada)**
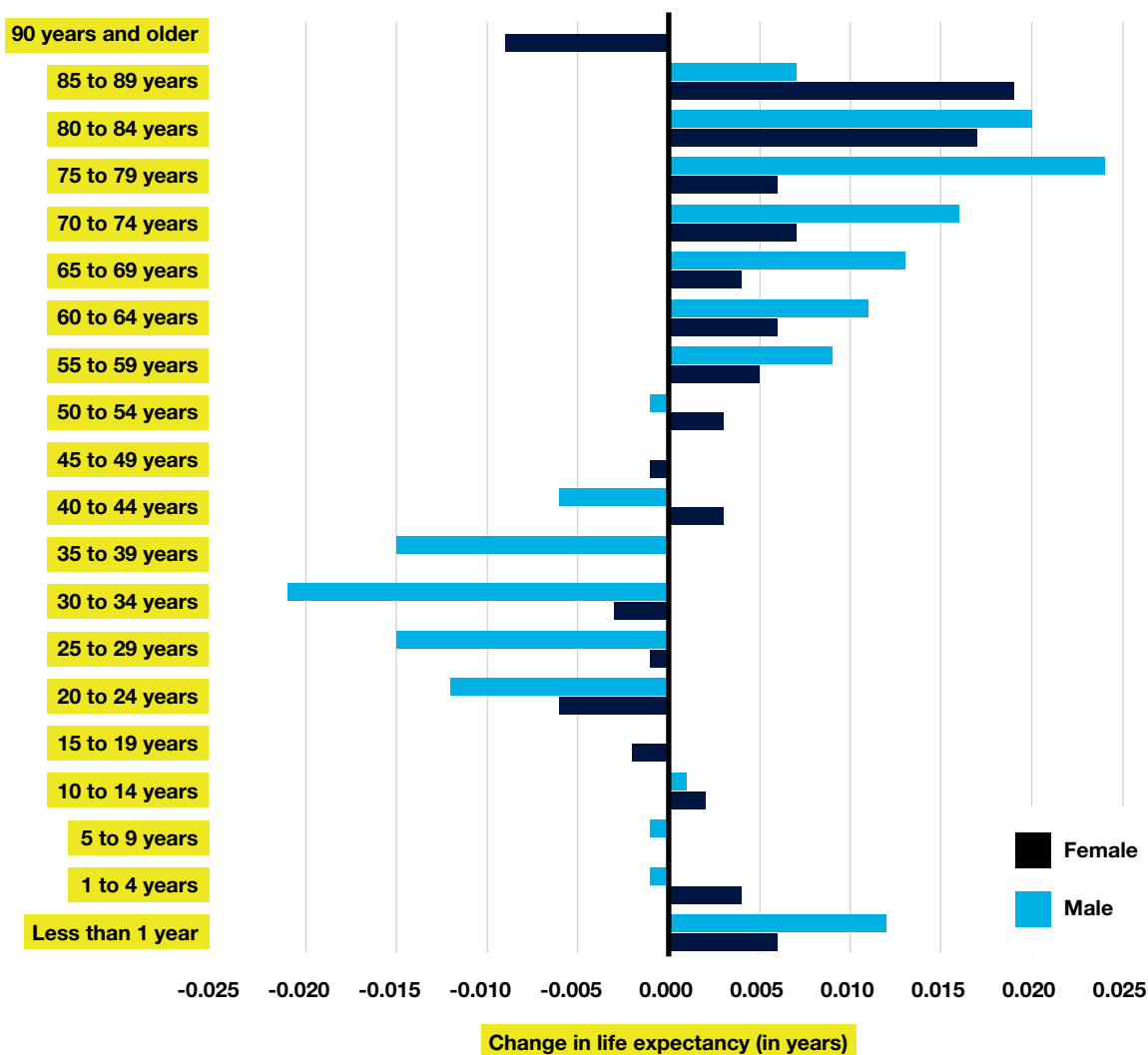
Source: Statistics Canada. Changes in life expectancy by selected causes of death, 2017.

The increase in deaths in young adults has been primarily attributed to the increase in opioid-related overdose deaths, particularly among young and middle-aged men. Opioid-related deaths have had a serious impact on life expectancy for both sexes, but more so for males in British Columbia and Alberta, contributing to decreases in life expectancy in both provinces from 2016 to 2017.[2]

When examining different groups in Canada, life expectancy is consistently lower among First Nations, Inuit, and Métis peoples. Other differences in life expectancies are consistent with what is known on the social determinants of health, like those living with lower income have a lower life expectancy than the general population. There are also populations for which we have very limited data. For example, life expectancy data for some populations, like other racial groups or LGBTQ2+ people, is not known.[3]

As seen in Figure 2, with respect to Indigenous peoples, Inuit were estimated to have a shorter life expectancy at birth, up to 14 years shorter for males, and up to 11 years shorter for females, compared to the overall Canadian population.[4] It is important to see these data in context; the lasting legacy of colonization and intergenerational trauma have led to systemic health inequities for First Nations, Inuit, and Métis peoples.[5]

FIGURE 2:   **Life Expectancy at Birth by Indigenous Identity and Sex (Canada, 2009–2011)**
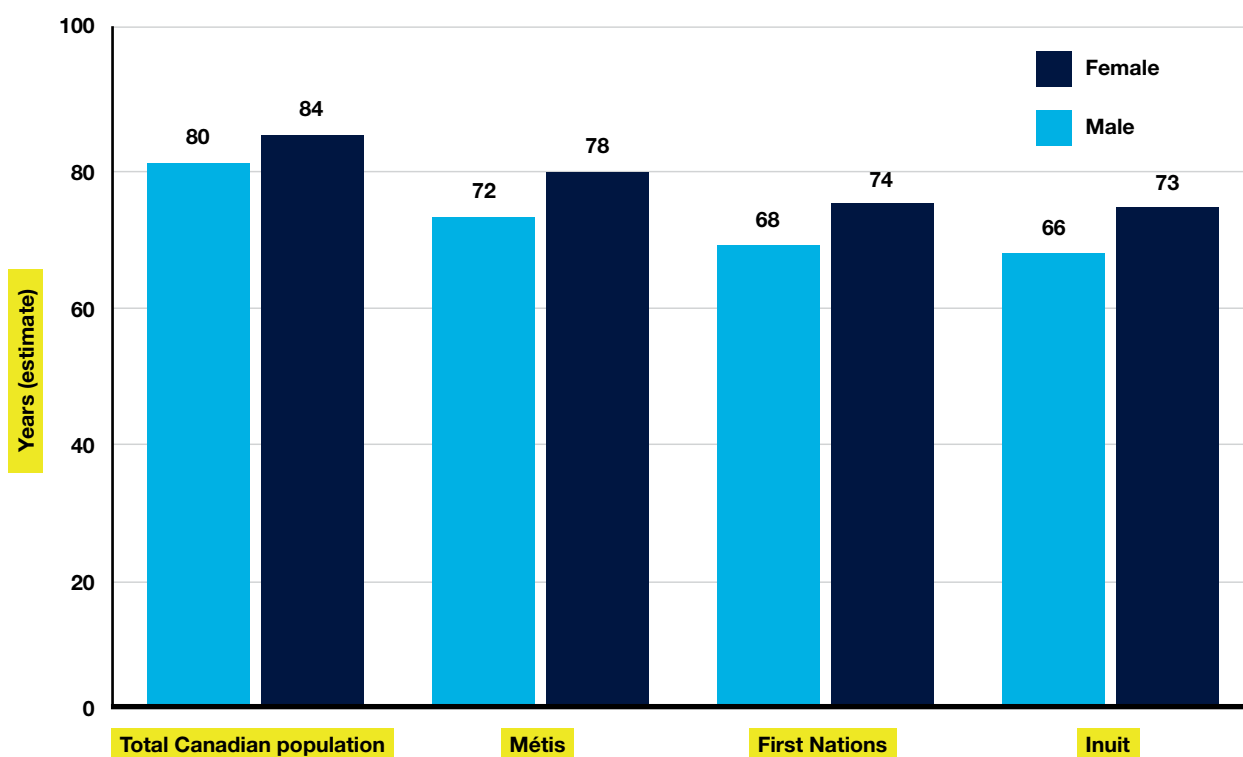
Source: Pan-Canadian Health Inequalities Data Tool, 2017 Edition.

FIGURE 3: Prevalence Rates of Common Chronic Conditions

The prevalence[ii] rates of the most common chronic conditions[iii] are:

Hypertension (age 20+)
26%

Osteoarthritis (age 20+)
14%

Osteoporosis (age 40+)
12%

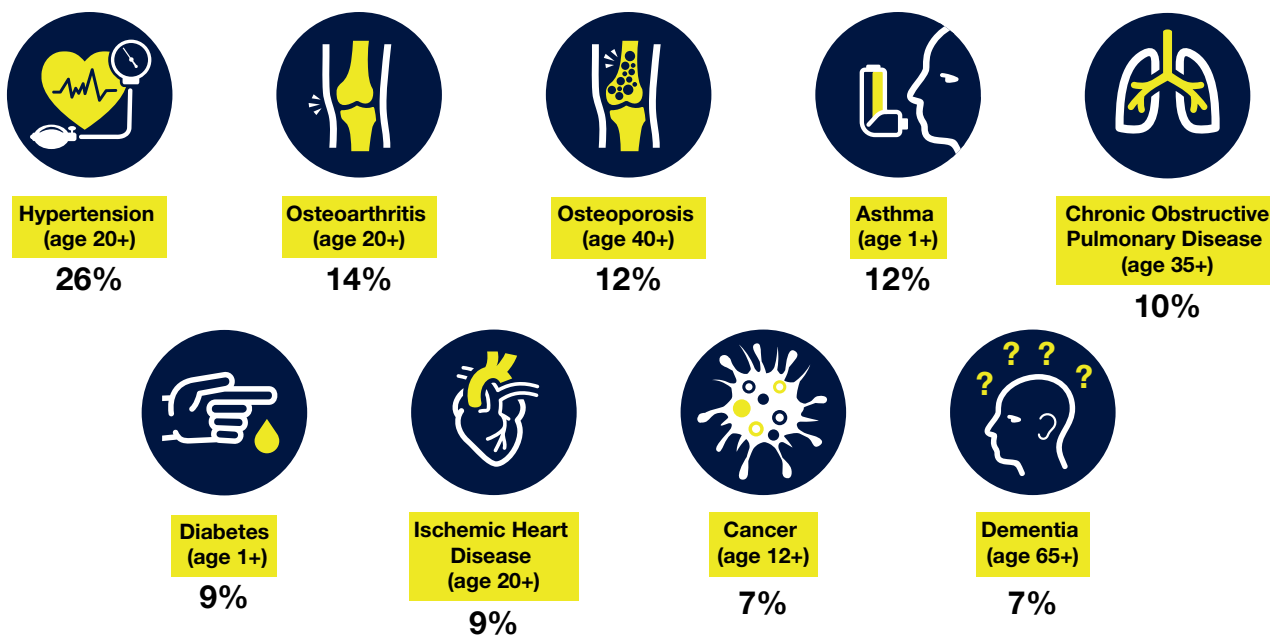**Asthma (age 1+)**
12%

Chronic Obstructive Pulmonary Disease (age 35+)
10%

Diabetes (age 1+)
9%

Ischemic Heart Disease (age 20+)
9%

Cancer (age 12+)
7%

Dementia (age 65+)
7%

Note that although mood disorders are among the most common chronic conditions, they are described separately in a subsequent section.

Source: Public Health Agency of Canada. Canadian Chronic Disease Indicators, Quick Stats, 2018 Edition.

Chronic Diseases Continue to be the Major Disease Burden

Chronic disease continues to be the biggest cause of disease burden in Canada. Close to half of Canadian adults over the age of 20 years report that they are living with at least one of ten common chronic diseases or conditions (Figure 3).[7]

On a positive note, recent data suggest declining incidence[iv] rates for a number of chronic diseases in Canada (Figure 4).[7] A report analyzing national data over the period of 1999 to 2012 from the Canadian Chronic Disease Surveillance System (CCDSS)

identified decreasing overall incidence trends for diagnosed asthma, chronic obstructive pulmonary disease, hypertension, ischemic heart disease, and stroke.[6] More recent data from CCDSS reiterates the continuation of these trends between 2003 and 2016 for all described chronic diseases and points to a declining incidence rate for diabetes starting in 2006.[7, 8] The observed decrease in chronic disease incidence rates may be influenced by factors such as varying strategies used to diagnose, manage, and report chronic diseases across the country. Further investigations are needed to fully understand these observations.

---

ii   The term "prevalence" is used when referring to the number of people living with an existing medical condition in a given time period.

iii   Many chronic conditions are influenced by modifiable risk factors which were not addressed in this report. Please refer to the CPHO 2018 annual report.

iv   The term "incidence" is used when referring to the number of people newly diagnosed with a medical condition in a given year.

FIGURE 4: **Age-standardized Chronic Disease Incidence Estimates (2003–2016, Canada)**

Legend: Stroke · Diabetes · Asthma · Chronic obstructive pulmonary disease · Ischemic heart disease · Hypertension

Y-axis: Incidence (per 100,000 population) — 0, 500, 1,000, 1,500, 2,000, 2,500, 3,000, 3,500

X-axis: Years — 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016
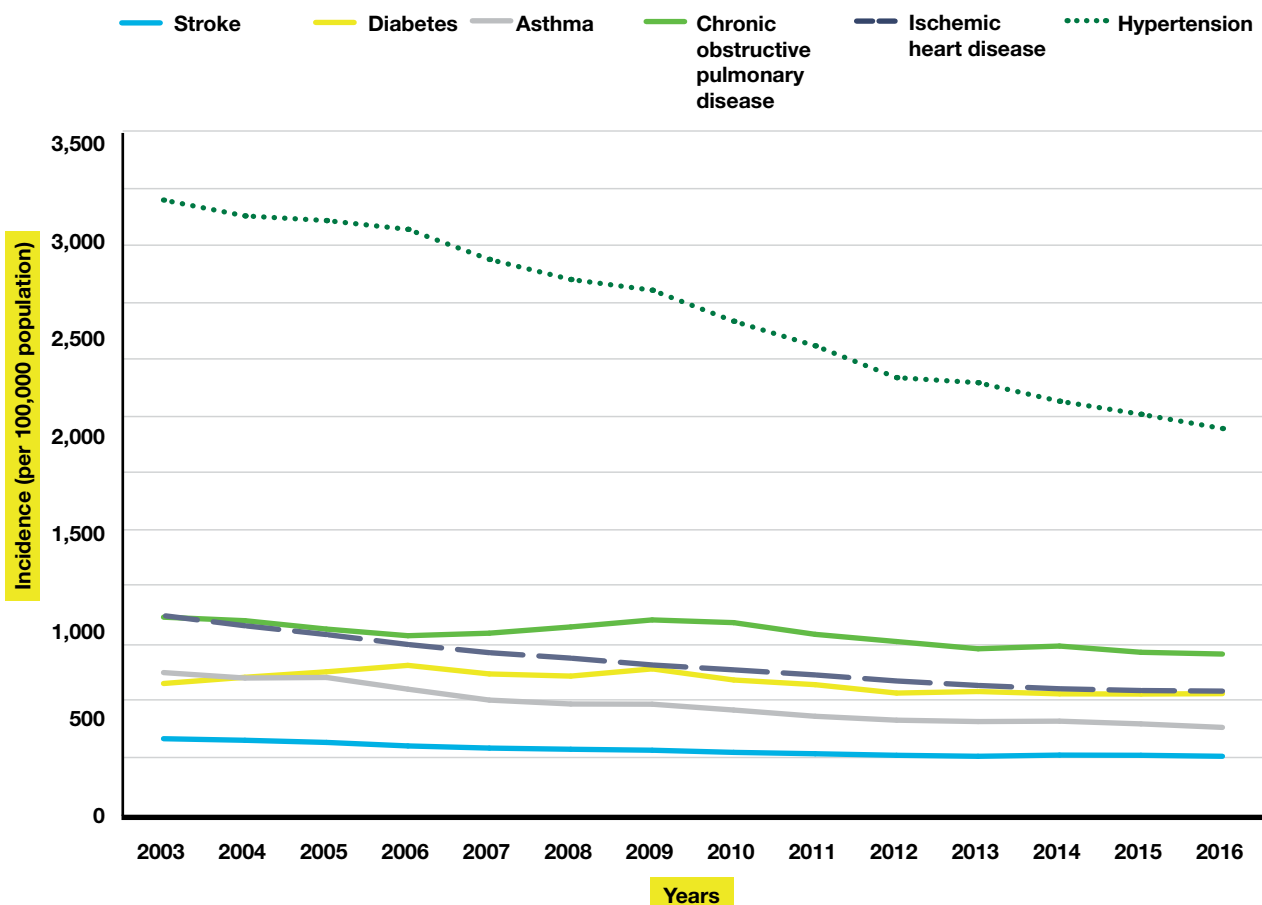
Source: Canadian Chronic Disease Surveillance System data files (as of August 2019).[7]

Canadian data also suggest a possible decline in the incidence rates of newly diagnosed cases of dementia, including Alzheimer's disease (Appendix A).[9, 10] A recent Lancet commission examined lifestyle factors which might influence an individual's risk of developing dementia. Evidence shows that healthy living and higher education levels may contribute to preventing or delaying dementia.[11] While the incidence rate may be decreasing in Canada, the burden of Alzheimer's disease and dementia is expected to continue to increase, due to factors such as a growing and aging population, and possibly improved survival. Accordingly, between 2005 and 2016, the age-standardized prevalence rate of dementia increased by 12%.[7]

There are health inequalities across chronic diseases. For example, South Asian as well as African, Caribbean, and Black Canadian adults are more than twice as likely to live with diabetes than White adults.[3] Evidence suggests that dementia rates are rising more rapidly among First Nations populations compared to the general Canadian population, including earlier disease onset.[10, 12]

Poor Mental Health Continues to Impact Canadians

The good news is that 69% of Canadians aged 12 years and older reported their mental health status as very good or excellent in 2018. At the same time, the percentage of Canadians aged 12 years and older who indicated that they have been diagnosed by a health professional as having a mood disorder, such as depression, bipolar disorder, mania, or dysthymia (i.e., persistent depressive disorder) was 9% in 2018.[13]

Mental health varies considerably among Canadians, with some sub-populations being much more likely to report low self-rated mental health. For example, for the period of 2010 to 2013, adults who identified as bisexual were close to three times more likely, and adults who identified as gay or lesbian, were approximately twice more likely, to report low self-rated mental health than adults who identified as heterosexual. These higher rates could be linked to internalized stress related to gender expectations and experienced discrimination.[3]

In Canada, suicide rates remained stable from 2000 to 2017. On average, 11 Canadians die by suicide every day.[14] In 2017, the suicide rate among males was three times higher than the rate among females. Suicide rates were highest among middle-aged males.[14] Some Indigenous communities are disproportionally affected. Areas with a relatively high Inuit population had a 6.5 times higher suicide rate than areas with a low concentration of Indigenous peoples.[3] Suicide rates in areas primarily inhabited by First Nations and Métis peoples were also significantly higher (four and three times, respectively) than in areas with a non-Indigenous peoples majority.[3] The impacts of intergenerational trauma can ultimately manifest in poor mental health and practices that may place individuals at risk for suicide. However, it is important to note that not all Indigenous communities experience high suicide rates. For example, over 60% of First Nations bands had a suicide rate of zero.[15] Protective factors can include opportunities to speak and learn one's traditional language, cultural identity, and connection to the land.[16, 17]

Substance Use

Substance use and its related harms remain a concerning public health issue and a national priority. Street drugs contaminated with highly toxic fentanyl and fentanyl analogues continue to drive the current epidemic of opioid related deaths.[18] In addition, reducing or preventing alcohol-related harm is a persistent challenge, alongside addressing emerging concerns such as tobacco use and nicotine vaping among youth.

High Rates of Opioid-related Deaths Continue

Nationally, more than 12 apparent opioid-related deaths occurred on average every day in 2018.[18] In early 2019, 82% of accidental opioid-related deaths involved fentanyl or fentanyl analogues.[19] Regional variations continue to be observed and some provinces and territories (British Columbia and Alberta, in particular) have been impacted more than others. Data for 2018 show that overall, men accounted for three quarters of accidental apparent opioid-related deaths in Canada.[18] Likewise, in 2018, young and middle-aged adults accounted for the most accidental apparent opioid-related deaths overall, with 27% of deaths reported among those aged 30 to 39 years, followed by 22% in those aged 40 to 49 years, 21% aged 50 to 59 years, and 20% aged 20 to 29 years.[18] Although complete national information on opioid-related harms in Indigenous peoples is lacking, available data suggest higher opioid use and associated harms, including higher rates of hospitalization, accidents, and death in some but not all Indigenous communities, compared to the general Canadian population.[20] In this context, it is important to note that First Nations, Inuit, and Métis peoples have experienced intergenerational trauma, abuse and systemic racism, which directly or indirectly contribute to elevated levels of substance use rates.[21, 22]

Vaping Increases Among Youth

Vaping is the inhaling of a vapour created by an electronic cigarette (e-cigarette) or other vaping device. In 2017, the use of e-cigarettes as a cessation aid in the past two years was reported by 32% of current or former smokers.[23] Among the 3% of Canadians aged 15 years and older who used a vaping product in the past 30 days in 2017, 65% were current smokers, 20% were former smokers, and 15% reported having never smoked cigarettes.[23]

The increased use of vaping products by youth represents an emerging and serious health trend. Vaping can increase the risk of nicotine addiction and could alter brain development in youth.[24] The long-term effect of exposure to a range of harmful chemicals such as formaldehyde, acrolein, metals, and other contaminants through vaping remains unknown. Emerging evidence points to increased risk of respiratory disease in vaping device users, highlighting the need for further studies.[25, 26] In 2017, approximately 15% of Canadians aged 15 years and older had ever tried a vaping product, with the greatest likelihood among youth aged 15 to 19 years (23%) and young adults aged 20 to 24 years (29%).[23] A recent meta-analysis indicates that adolescents and young adults who had ever used e-cigarettes had close to four times higher odds of initiating cigarette smoking than those who had never used e-cigarettes.[27] Accordingly, from 2017 to 2018, the percentage of Canadian youth aged 16 to 19 years who reported vaping in the last month increased substantially by 74%.[28] More research is required to better understand the association between vaping and smoking behaviour in Canada, and the related health impacts.

Cannabis Use Rises in Adults 25+

In 2017, the prevalence of past-year cannabis use was 15%, a 3% increase compared to 2015.[23] Frequent cannabis use did not change between 2015 and 2017, with approximately 3% of Canadians aged 15 years and older reporting daily or almost daily cannabis use in the previous three months. It is important to note that most of the available data on cannabis consumption pre-dates cannabis legalization in Canada in 2018.[29] Consequently, cannabis use reporting was strengthened with

the implementation of the *Cannabis Stats Hub* in 2018, which now monitors cannabis use every three months.[30]

Cannabis use varies by age. In 2017, past-year use of cannabis was highest among youth aged 15 to 19 years (19%) and young adults aged 20 to 24 years (33%) compared to adults aged 25 years and older (13%). Compared to 2017, past-year cannabis use among adults aged 25 years and older increased from 10% in 2015, though there were no changes reported for other age groups.[23] National and regional studies identified differences in cannabis use by race in youth, with Indigenous youth being the most likely group reporting lifetime and recent cannabis use.[31, 32]

By the end of 2018, the cannabis sources accessed by users largely depended on their reasons for using it. Eighty-six percent of medical users with documentation acquired cannabis from legally authorized retailers or licensed online producers, in contrast to 26% of non-medical users.[33] Forty-two percent of non-medical users declared obtaining cannabis from illegal sources and 54% from friends or family.[33]

One important contributor for harms related to cannabis use is the increased risk of motor vehicle collisions when driving under the influence of cannabis.[34] Among cannabis users with a valid driver's licence, 14% admitted to driving within two hours of using cannabis. This practice was nearly twice as common in males compared to females.[35]

Heavy Drinking Rates Remain Harmfully High

Alcohol continues to be the most used psychoactive substance amongst adults and youth. In 2017, 78% of the population over 15 years of age reported drinking alcohol in the last year.[23] In 2017, past-year alcohol use among youth aged 15 to 19 years was 57%.[23] These figures were all unchanged from 2015.

Heavy drinking rates remained stable from 2017 to 2018, with 19% of Canadians aged 12 years and older reporting heavy drinking in 2018.[13] Heavy drinking means having five or more standard drinks for men or four or more standard drinks for women, on one occasion, at least once a month in the past year.[36]

FIGURE 5: **Percentage Change in Reported Rates of Selected STBBI in Canada (2007–2016)**
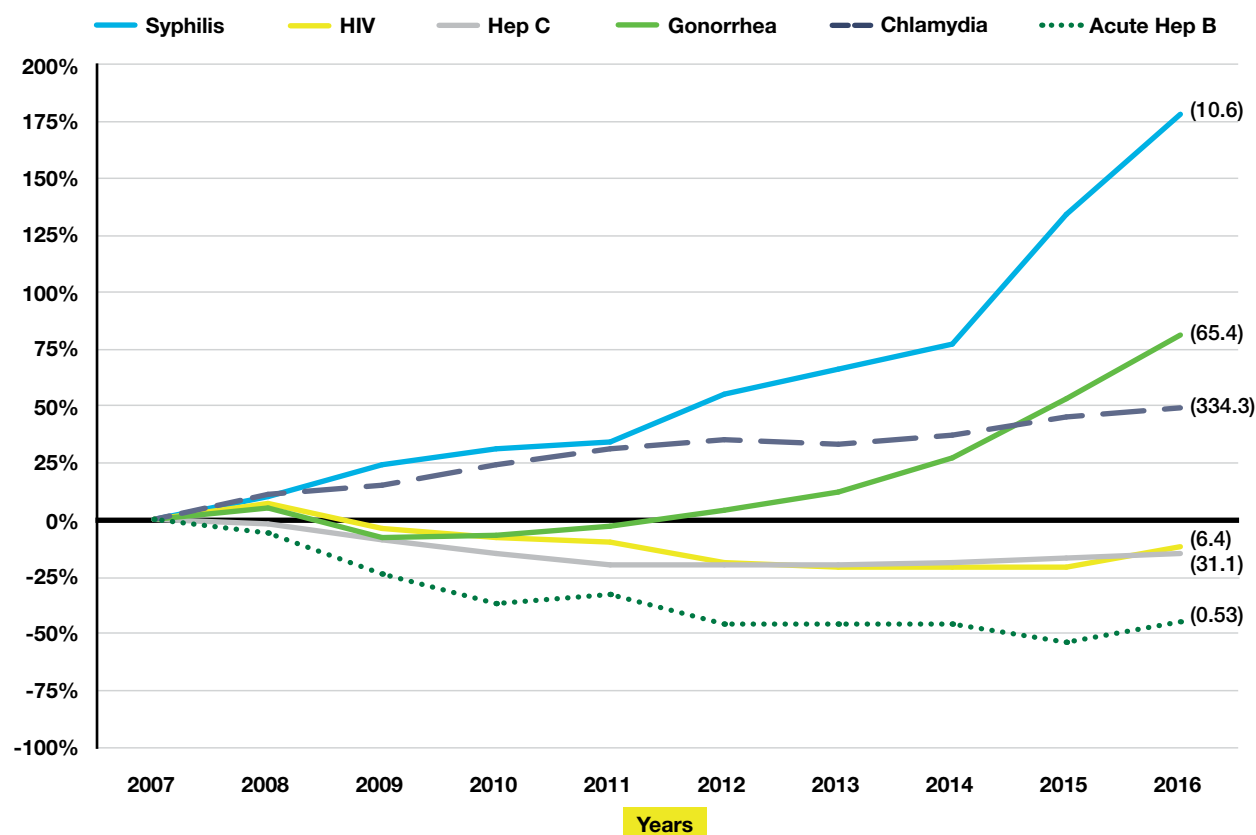
The percentages on the left represent the percent change relative to the reference year of 2007. The values in brackets represent the 2016 infection rates per 100,000 population.

Source: Adapted from *Accelerating our Response: Government of Canada Five-year Action Plan on Sexually Transmitted and Blood-borne Infections*.[38]

The rate of alcohol-related hospitalizations has increased faster for women than for men. More than 25,000 women had alcohol-related hospitalizations, representing a 3% increase from 2015–16 to 2016–17. In contrast, the increase for men was 0.6%.[37] Differences in heavy drinking behaviour exist across populations. For instance, close to 22% of White adults reported heavy drinking between 2010 and 2012, which is greater than the approximate 7% of heavy drinking among African, Caribbean, and Black, Asian, and Arab adults. Bisexual women and lesbians were almost twice as likely to declare high alcohol consumption as heterosexual women.[3]

Sexually Transmitted and Blood-borne Infections are on the Rise

Concerning increases for some sexually transmitted and blood-borne infections (STBBI) have been observed in Canada. From 2007 to 2016, the reported rates for chlamydia, gonorrhea, and syphilis increased by 49%, 81% and 178%, respectively (Figure 5).[38] Moreover, six cases of congenital syphilis were reported in Canada in 2015, reversing the previous downward trend observed from 2011 to 2014.[39] This result is disquieting as it coincides with a rise in syphilis cases in women of childbearing age. There are numerous factors that may contribute to some extent to the

observed trends, other than a true rise in incidence, such as improved diagnostic tools, contact tracing, and case detection.[40]

While the number of newly diagnosed HIV infections remained relatively stable in Canada, 14% of people living with HIV were estimated to be unaware of their status in 2016.[41] Similarly, as of 2016, national Hepatitis C infection rates remained stable over the course of previous years.[42] An estimated 44% of Canadians living with Hepatitis C are thought to be unaware of their status.[43]

Some communities are disproportionally affected. For example, gay, bisexual and other men who have sex with men accounted for more than 50% of new HIV infections in 2016, although they represented approximately 3% of the male population in Canada. Indigenous peoples accounted for 11% of new HIV infections in 2016, but represented only 5% of the general population.[41]

Certain sub-populations are at high risk for Hepatitis C infections, such as people who inject drugs and people who are incarcerated.[43]

Current Vaccination Rates are Not Reaching National Targets

For many decades, vaccines have helped prevent and control the spread of serious infectious diseases in Canada and abroad. However, effective vaccine protection at the population level requires establishing and maintaining high vaccination rates across the country. Since 2011, little progress has been made towards reaching national childhood vaccination targets for several vaccine preventable diseases, such as measles and polio (Appendix A).[44]

In the case of measles, for example, the disease was declared eliminated from Canada in 1998. This was shortly after introducing a routine second dose of the measles vaccine to the childhood immunization schedule, prior to school entry.[45] In spite of this success, the national estimated measles vaccine coverage rate among two-year-olds was

only 90% in 2017, which is below the minimum 95% vaccination coverage needed at the population level to maintain measles elimination.[46] Over the past two decades, measles cases and outbreaks have occurred intermittently in Canada, ranging from a few secondary cases to over 680 cases per outbreak (Figure 6).[47–51] They have been linked to individuals who acquired measles during international travel.

Antimicrobial Resistance and Unnecessary Antibiotic Use is an Emerging Threat

Antimicrobial resistance (AMR) describes the capability of disease-causing microorganisms to withstand antimicrobial treatments such as antibiotics, thereby limiting available treatment options. AMR has been identified by the World Health Organization as one of the ten most significant threats to global health. Globalization, travel, and medical tourism mean that Canada shares this threat.[52, 53] If left unchecked, it is estimated that AMR could cause 10 million deaths a year worldwide by 2050.[54]

Concerning national AMR trends were observed for several infectious diseases. For example, rates of community-acquired methicillin-resistant *Staphylococcus aureus* (MRSA) infections increased by 62% between 2012 and 2017; *Neisseria gonorrhoeae* infections resistant to azithromycin increased by 50% from 2015 to 2016.[53] While infection rates of some of the most resistant organisms, carbapenem-resistant Enterobactericeae (CRE), have been stable, a very worrisome trend can be found in the five-fold increase, between 2014 and 2017, in the number of people who are carriers of these bacteria.[55] However, some progress has been made in Canada to reduce AMR, primarily in hospital settings. For example, healthcare-associated *Clostridioides difficile* and healthcare-associated MRSA infections decreased respectively by 36% and 6% from 2012 to 2017.[55]

Threats from AMR are not restricted to those coming from bacterial infections. For example, multidrug-resistant fungal infections caused by *Candida auris* are also a concern. Initially reported in Japan in 2009, the first imported case described in Canada was in 2017.[56] As of July 2019, there have been 20 cases of *C. auris* reported in Canada.[8]

Antibiotics are used widely in both human and veterinary medicine as well as in the agricultural industry. The prevalence of AMR is strongly associated with antibiotic use, and lowering antibiotic use can reduce the development of AMR.[57] In Canada, 92% of all antibiotics dedicated to human health care are prescribed in the community, primarily by general practitioners (65%), followed by dentists, nurses, and pharmacists (22%), as well as other specialists (13%).[58]

Greater efforts are required to reduce the unnecessary use of antibiotics.[59] In many cases, antibiotics are prescribed for indications where they are ineffective, such as for viral infections.[57, 60] Not only does this accelerate the development of AMR, it puts the patient at risk of side effects without offering them benefit. In some studies, it is estimated that 30–50% of all antibiotic prescriptions in outpatient settings are inappropriate.[61, 62]

FIGURE 6: **Annual Number of Confirmed Measles Cases (1998–2019, Canada)[v]**

---
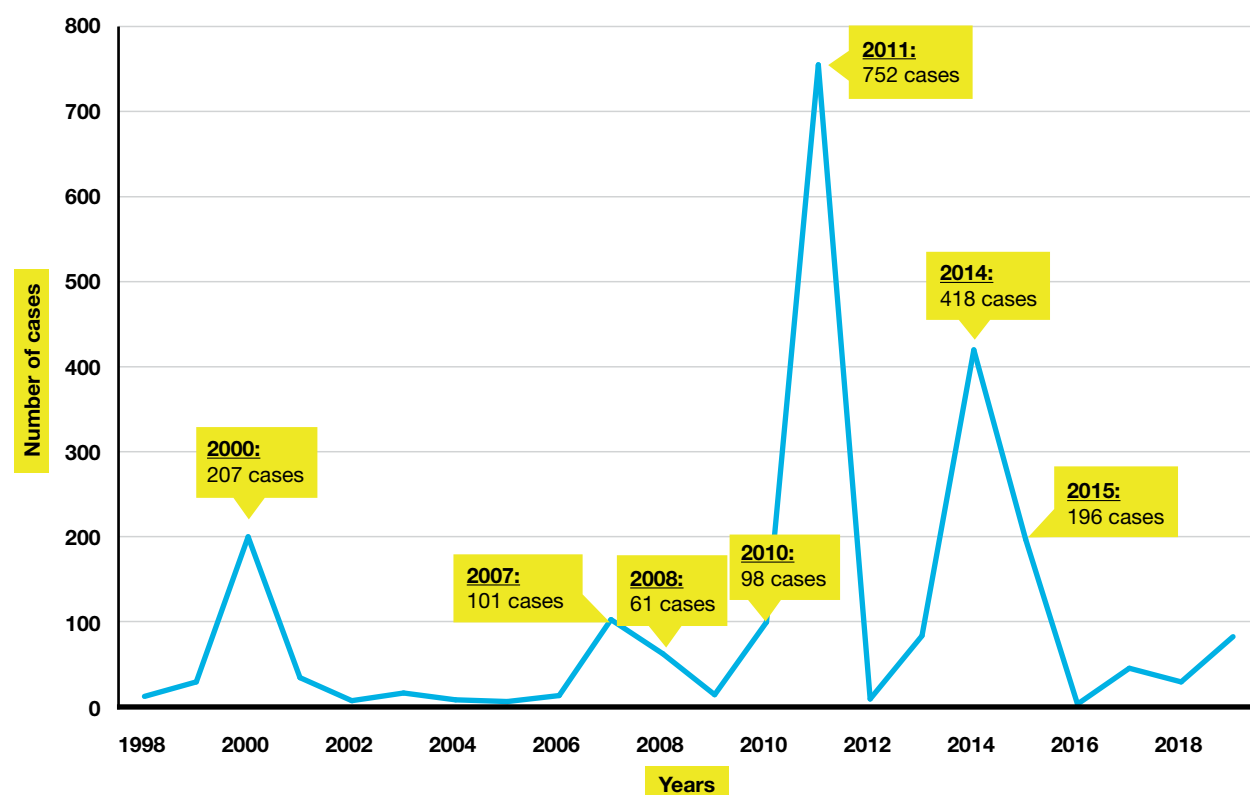
v   75% or more of all confirmed annual measles cases were linked to one single outbreak that occurred the same year.

Climate Change is Impacting Health and Well-being

Our climate is changing. Canada is warming at about double the global rate, and northern Canada has already warmed to almost three times the global rate.[63–65] *Canada's Top Climate Change Risks* report (2019) has identified health and well-being as one of the key areas of climate change risk facing Canada, while pointing out that such risks can be meaningfully reduced through adaptation measures that lessen vulnerability and/or exposure.[66]

Climate change is having an impact on health and well-being both directly and indirectly. Extreme weather events such as flooding, wildland fires, and heatwaves can result in death, injury, and illness. For example, more than 90 people in Quebec died as a result of the July 2018 heatwave.[67] Changes in precipitation and temperature have also influenced the spread of climate-driven infectious diseases.

Social determinants of health such as housing, working conditions, and food security will be affected by climate change. Extreme weather events not only increase the risk of direct negative health impacts, but also pose challenges to health systems and health care facilities with consequences for patient care, safety, and healthcare costs.[65]

The impacts of climate change on health and well-being will also vary by region. In northern Canada, the consequences of climate change are significant and widespread. For example, loss of sea ice is associated with food insecurity and mental health impacts for populations that rely on ice to access hunting grounds and traditional sites, and to bring food and supplies from the South.[65] In Rigolet, Nunatsiavut community members have reported feelings of displacement due to the disruption of hunting, fishing, foraging, trapping, and travelling from climate change impacts.[68]

Climate-driven Infectious Diseases

Changes in precipitation and temperature can increase the spread of climate-driven infectious diseases, specifically, zoonoses (i.e., diseases that can spread between animals and people), vector-, food- and water-borne diseases:

- Changing climate has facilitated the spread of the tick responsible for Lyme disease, contributing in part to an increase in cases from 144 in 2009 to 2025 in 2017.[69, 70] Other tick-borne diseases have also started to emerge in Canada including, for example, anaplasmosis and Powassan virus.[69]

- Four out of the five bacteria that account for over 90% of foodborne illness in Canada are influenced by climate change.[71]

- Over the last 20 years, the incidence rates of endemic mosquito-borne diseases, such as West Nile virus and Californian serogroup virus, have increased in Canada.[72]

Highlights of Other Factors Impacting Health

The health of individuals and populations is determined by a number of personal, social, economic, and environmental factors. These factors influence someone's place and position of power in society, and the access they have to the building blocks of good health. Examining key trends in the determinants of health is important to our understanding of public health and health inequities.

Strong Sense of Community Belonging

Community belonging has an important role in shaping mental health and a number of indicators related to community connectedness are included in the Public Health Agency of Canada's *Positive Mental Health Surveillance Framework*.[73] In 2018, 68% of the population aged 12 years and older reported a somewhat strong or very strong sense of belonging to the local community.[13] Some Indigenous peoples rate their sense of community belonging much higher than the national average. For example, close to 81% of First Nations peoples declared a somewhat strong or very strong sense of belonging to their local community in 2015–2016.[74] A strong sense of community belonging can be an asset for fostering resilience and mitigating the impact of societal inequities.

Higher Education Attainment and Less Poverty

Income and education are two key social determinants of health exerting an influence on many important health measures such as overall life expectancy. In the period from 2009 to 2011, Canadians living in the lowest-income neighbourhoods had a life expectancy at birth that was

approximately four years lower than those living in the highest income neighbourhoods. Similarly, Canadians living in areas with the highest proportion of people having less than a high school education had close to three years lower life expectancy at birth compared to those living in areas with the highest proportion of university graduates.[4]

This year, important and encouraging trends are being reported for income and education.

The proportion of Canadians aged 25 to 54 years[vi] without a certificate, diploma or degree has decreased by 51%, from 14% in 2003 to 7% in 2018.[75] This trend may be influenced by a generational shift in the likelihood of completing postsecondary education.

There have also been considerable decreases in the proportion of Canadians living below Canada's Official Poverty Line, which is a measure of low income (based on the Market Basket Measure[vii]). In 2017, 10% of Canadians were living below the poverty line compared to 16% in 2006.[76] This represents a decrease of 39%. The change was even more pronounced among children living below the poverty line, with a decrease of 53% from 19% in 2006 to 9% in 2017.[76] Despite this encouraging trend, childhood poverty remains a concern in some populations. For example, in 2015, high childhood poverty rates were reported for Indigenous children, ranging from an average of 47% for First Nations children to 25% and 22% for Inuit and Métis children, respectively. Moreover, data on non-Indigenous children indicate that recent immigrant and non-Caucasian children had poverty rates of 35% and 22% respectively, compared to 12% for all children in the remaining group.[77]

---

vi   Note that the CPHO Health Status Dashboard reports on educational certification for persons 25 years old and older. A narrower age range was chosen here to minimize the risk of possible misleading effects from including older Canadians in analysis.

vii   The Market Basket Measure (MBM) is a measure of low income based on the cost of a specified basket of goods and services representing a modest, basic standard of living.

Stigma is a Public Health Issue

Some Canadians experience worse social and health outcomes than others. The evidence tells us this is, in part, due to how we treat each other. When we stigmatize people, we affect their chances for a long and healthy life.

Stigma affects health through stress and other physical pathways. Many people are exposed to multiple stigmas, preventing them from attaining the resources they need to achieve optimal health such as education, employment, housing, and health services.

These stigma chapters will focus on the health system, which includes health care, public health, and other allied health services. Stigma in the health system can be particularly harmful, as people are prevented from accessing the health information services and resources they need, creating mistrust and further exclusion.

The Experience of Stigma

Here we introduce you to Charles and Cynthia, fictional people who experience multiple and intersecting stigmas. They face stigma in society and the health system, which affects their well-being and health. We revisit Charles and Cynthia in the next chapter, to see how things could have worked out differently.[viii]

Charles

Charles recently moved to a mid-sized town in Ontario. He feels people staring at him and has even seen people crossing to the other side of the street when he walks by. He wonders whether this is because he is Black. Charles has been with his partner David for most of his adult life. During the AIDS epidemic of the 1980's, he contracted HIV. Thanks to current treatments, the virus is undetectable in his body. However, recently he has been experiencing some symptoms that he thinks may have something to do with cardiovascular disease, just like his parents had. He knows that he needs to go see his new doctor and get this checked out, but he is hesitant because he had been treated with disrespect before by healthcare providers.

Charles attends an appointment with his new doctor to discuss his symptoms; however, she seems dismissive of his concerns. She instead asks Charles several questions about his HIV status and whether he is practising safe sex. At the end of the appointment, she only suggests that Charles change his diet, and she does not refer him for any further testing. Charles leaves feeling frustrated and ignored. He does not seek further care as he is worried that

---

viii   We recognize that these stories may be disconcerting. The purpose is to use these fictional characters to highlight how stereotypes and stigma are often attached to individuals and communities because of their racial or sexual identity background.

he will not be taken seriously again. Several months later, Charles suffers a heart attack and is rushed to the hospital. While recovering, Charles feels the hospital staff are apprehensive to touch him and he notices that they put on gloves to perform routine tests, such as taking his blood pressure, which they do not do with other patients. Charles overhears two nurses whispering about his HIV status. Charles feels unsettled about the care he received and is worried about his future health.

Cynthia

Cynthia is a Cree woman living in Saskatchewan with her two young children and is pregnant with her third baby. She is connected with members of her First Nations community and has been receiving health care in a First Nations health centre. She has just learned that she will need to be admitted to a large hospital to receive treatment for complications related to her pregnancy. She is afraid of going into the hospital because during her first pregnancy, her non-Indigenous doctor kept asking her questions about drug and alcohol use and insinuating that she may not be capable of providing for her child. She has delayed going to the hospital because she does not want to face those kinds of questions or risk losing her children. The stress of worrying is causing her to not sleep or eat properly.

Due to her previous negative experiences, Cynthia avoids going to the hospital for treatment. Cynthia experiences severe complications during the seventh month of her pregnancy, and is rushed to the hospital, where she has an emergency C-section. Her baby is born with an extremely low birth weight and will need to stay in the neo-natal intensive care unit for at least one month. As she is recovering, the doctors and nurses repeatedly ask Cynthia why she did not get treatment to avoid these complications. Cynthia feels that they are implying she is a bad mother, and they are blaming her for the outcome of the pregnancy. Cynthia feels alone and is worried about the next steps for herself and her new baby. She is unsure how she can visit her new baby at the hospital without adequate childcare for her other children. Despite voicing her concerns, the hospital staff tell Cynthia these are "normal" emotions after having a baby, and they do not refer her to a hospital social worker or provide her with additional resources for support. Cynthia leaves the hospital feeling helpless and stressed, which adds to her existing eating and sleeping problems.

INTERVIEW QUOTE

"There are so, so many ways stigma stops people from reaching their full potential. And we as a society are poorer for that."

The Pathways of Stigma to Health Outcomes

Stigma begins with the labeling of differences and negative stereotyping of people, creating a separation between "us" and "them." Those who are stigmatized are devalued and subjected to discrimination, which is unjust treatment. This can lead to disadvantage and inequitable social and health outcomes.[ix] Stigma happens in institutions (e.g., healthcare organizations), at a population level (e.g., norms and values), through interpersonal relationships (e.g., mistreatment), and internally (e.g., self-worth and value).

Stigma can be seen as both a cause and effect; it continues to justify the devaluing of people through stereotypes and exclusion.[78] Unless this cycle is actively stopped, the separation into "us" and "them" is reinforced by unequal power dynamics in society. People and institutions with resources and power, including health organizations, shape laws and social norms that can influence what is considered to be "normal" and "acceptable." In the health system, this power dynamic also exists between healthcare providers and patients.

Stigma can target different identities, characteristics, behaviours, practices, or health conditions.[79] For example, stigma can be based on race, gender and gender identity, sexual orientation, language, age, substance use, ability, and social class. Stigma related to health conditions can include obesity, substance use disorders, mental illness, dementia, tuberculosis, and HIV infection. When stigmas intersect, they can exacerbate negative health outcomes.

Stigma includes discrimination, as "enacted" stigma.[81, 82] While there is little data measuring stigma in Canada, discrimination is more commonly measured. The following section summarizes available self-reported discrimination data for some key populations. It is important to note that there is still limited data in this area and that experiences of discrimination may be underreported.

> ## Stigma can benefit those in power in several ways:[80]
>
> **By keeping people "in"**, that is, by enforcing preferred social norms and values
>
> **By keeping people "down"**, which maintains one's group advantage in society
>
> **By keeping people "away"**, in order to avoid disease or a perceived threat

Discrimination in Canada

Over one in four Canadians have reported experiencing at least one form of discrimination in their lifetime.[83] Many Canadians experience discrimination based on race, religion, ethnic origin, gender, or sexual orientation. The most common type of discrimination reported by Canadians is racial discrimination.[83] African, Caribbean, and Black Canadians are the most likely to report discrimination in Canada, followed by Indigenous peoples.[84] Alarmingly, hate crimes, one of the most extreme forms of discrimination, have been on the rise in Canada, primarily against people who are part of Arab, Muslim, Jewish, and Black communities.[85]

---

ix   Stigma definition adapted from Bruce G. Link and Jo C. Phelan, 2001.[81]

New analyses of the 2013 Canadian Community Health Survey Rapid Response Discrimination Module, the only national discrimination survey in Canada, support these findings. Lesbian, gay, bisexual (LGB) participants (note that transgender identities were not included in the survey), African, Caribbean, and Black Canadians and Indigenous peoples in Canada were more likely to report being unfairly treated than the general population. More specifically, LGB community members were almost three times more likely, and African, Caribbean, and Black Canadians and Indigenous peoples were twice as likely, to report having faced discrimination than their general population counterparts.[8]

In a national Canadian survey, the majority of youth who identified as transgender (ages 19 to 25 years) reported having experienced discrimination in the last year based on their gender identity (70%), sex (63%), physical appearance (60%) or sexual orientation (59%).[86]

In 2012, 20% of Canadians with a mental health illness reported being affected by negative opinions or unfair treatment due to their poor mental health.[87] In 2014, 10% of Canadians with mental health disabilities[x] reported violent victimization in the 12 months prior to the survey, which was more than double the general population.[88]

In an online Canadian survey in 2016, 49% of people currently in recovery from addiction reported experiencing stigma or discrimination during their active addiction.[89]

DISCUSSION GROUP QUOTE

"I think there are actually two groups that are impacted by stigma, those groups who are negatively impacted… [and] another group that we don't think about very often, and that's the group that benefits from stigma, and benefits from the perpetuation of those mainstream ideologies that continue to maintain that settlers, people with European background, as being better."

The Costs of Stigma

Stigma imposes significant costs on society, although quantifying the direct economic cost of stigma remains a challenge. Researchers have examined productivity loss and the consumption of resources from experiencing stigma.[90] On an individual level, stigma is a significant barrier to housing, employment, income improvement, and health care.[91–94] By reducing the accessibility and quality of health care, stigma can drive avoidance or delay of health care and non-disclosure of health conditions. This can increase the severity of symptoms and result in higher rates of hospitalization, emergency room visits, and healthcare-related costs.[92, 95–97] As an example of stigma's economic impact, mental health stigma increases absenteeism and productivity loss in the workplace.[98, 99] It also discourages affected people from seeking health care and treatment, which increases costs to the healthcare system.[95, 99]
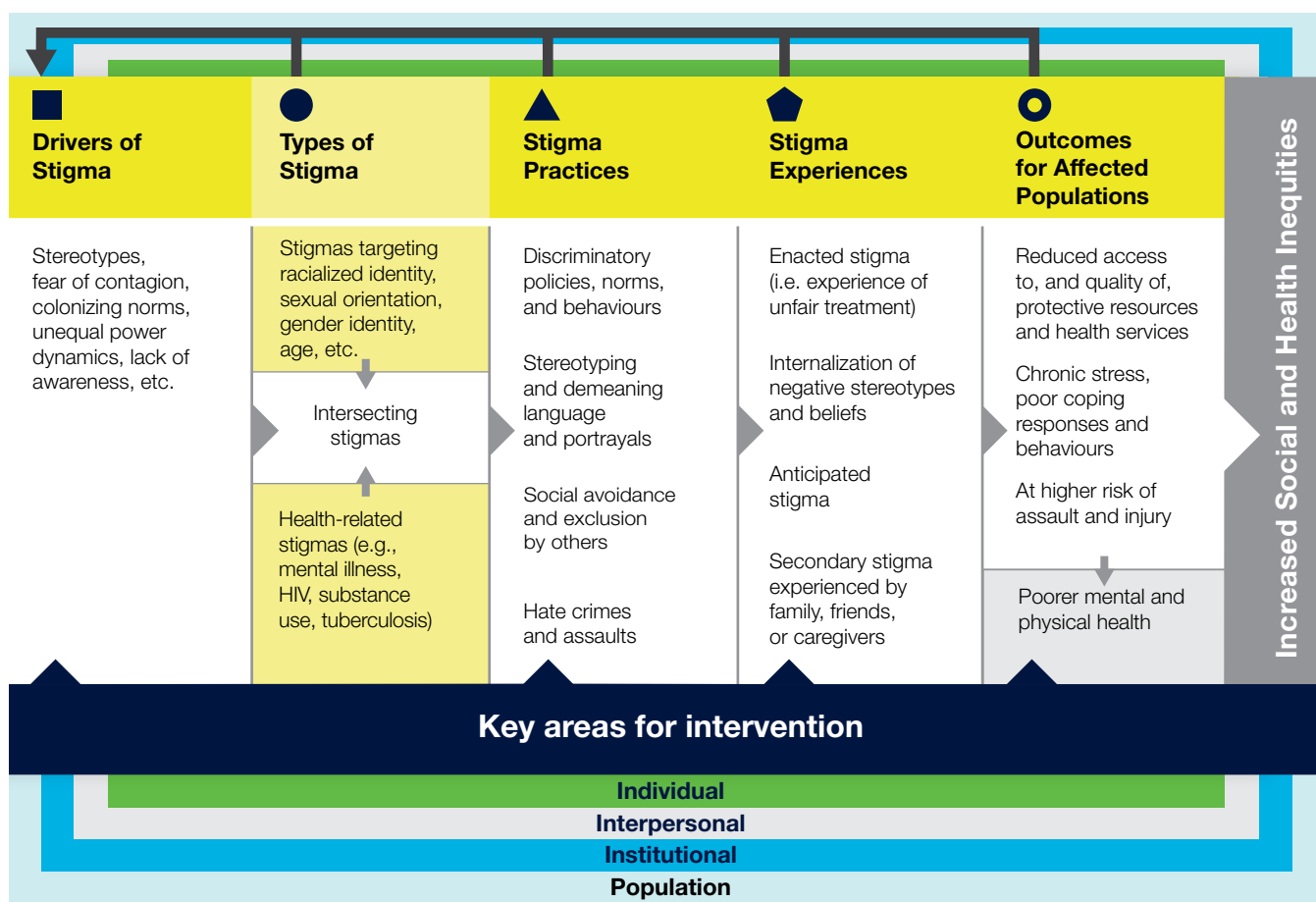
---

x   A mental health disability refers to conditions that limit daily activities, including anxiety, depression, bipolar disorder, anorexia, and substance use disorders.

Why a New Stigma Model is Needed

The following Stigma Pathways to Health Outcomes Model (Stigma Model) provides a new way to think about stigma and how it undermines health for individuals and contributes to population health inequities (Figure 7).[xi] It builds on recent efforts to understand the full impact and significance of stigma on health, including the experience of multiple and intersecting stigmas that many people experience.[82, 100–102]

Although stigma has been studied in social and health sciences for decades, the research is generally focused on isolated health conditions or social identities.[82] This Stigma Model can be used to understand individual stigmas while also considering how different stigmas inevitably intersect to create worse outcomes for some people. The Stigma Model also offers the opportunity to understand the impact of stigma on different health outcomes simultaneously.

FIGURE 7: **Stigma Pathways to Health Outcomes Model**

Drivers of Stigma	Types of Stigma	Stigma Practices	Stigma Experiences	Outcomes for Affected Populations
Stereotypes, fear of contagion, colonizing norms, unequal power dynamics, lack of awareness, etc.	Stigmas targeting racialized identity, sexual orientation, gender identity, age, etc.	Discriminatory policies, norms, and behaviours	Enacted stigma (i.e. experience of unfair treatment)	Reduced access to, and quality of, protective resources and health services
	Intersecting stigmas	Stereotyping and demeaning language and portrayals	Internalization of negative stereotypes and beliefs	Chronic stress, poor coping responses and behaviours
	Health-related stigmas (e.g., mental illness, HIV, substance use, tuberculosis)	Social avoidance and exclusion by others	Anticipated stigma	At higher risk of assault and injury
		Hate crimes and assaults	Secondary stigma experienced by family, friends, or caregivers	Poorer mental and physical health

Increased Social and Health Inequities

Key areas for intervention

Individual
Interpersonal
Institutional
Population

---

xi   This model has been adapted from the novel *Health Stigma and Discrimination Framework* recently commissioned by the National Institutes of Health.[100]

Stigmas Intersect Differently to Affect Health

Different types of stigma can intersect and work interactively to affect health.[103] Researchers use the term "intersectionality" to understand the complex connections, outcomes, and opportunities that can arise when people are subjected to multiple forms of stigma.[104] For example, the discrimination experienced by a racialized gay man living with HIV could produce poorer health outcomes because of the stigmas that arise from being racialized, identifying as gay, and living with HIV. Poorer outcomes might also result for an Indigenous, two-spirited person living with a mental illness. The reality is that many Canadians live with multiple stigmas. A key benefit of an intersectional approach is that it embeds an understanding of this complexity in our understanding of stigma's impact on health, and can therefore lead to a more complete and impactful response in addressing health consequences.

Importantly, the Stigma Model can be used by policy leaders, researchers, practitioners, and service providers to identify drivers of stigma and stigma practices in the health system that cut across areas of stigma. Interventions to address these broader issues are explored in Chapter Three and through the proposed Action Framework for Building an Inclusive Health System.

The Stigma Model works from left to right, but the components also influence one another. Applying the model to a particular stigma offers a way to understand how certain drivers lead to the "marking" and labelling of targeted groups. Once marked, people are then vulnerable to a variety of stigmatizing practices and discriminatory actions from other people, institutions, and society in general. Experiencing stigma can then lead to adverse health outcomes for individuals and increased inequities for populations.[100]

Practical Application of the Model

To illustrate how the model can be used to explore stigma pathways in detail and identify both cross-cutting and unique issues for different stigmas, seven examples are presented below (Table 1):

1. **Racism as experienced by First Nations, Inuit, and Métis peoples**

2. **Racism as experienced by African, Caribbean, and Black Canadians**

3. **Stigmas as experienced by LGBTQ2+ people (sexual stigma and gender identity stigma)**

4. **Mental illness stigma**

5. **Substance use stigma**

6. **HIV stigma**

7. **Obesity stigma**

Although the content for these examples has been drawn from the evidence, this is not a full examination of all possible pathways or the varied experiences within stigmas. Rather, the examples offer some areas for intervention across the health system. The Stigma Model can be used to further explore these stigmas as well as examine additional stigmas related to racial identities, religion, age, disability, and other characteristics or behaviours.

A detailed list of references for each stigma topic in Table 1 will be available on the 2019 CPHO annual report web page.

TABLE 1: Examples of How the Stigma Pathways to Health Outcomes Model Can be Applied to Different Stigmas

■ Drivers of Stigma	● Intersecting Stigmas	▲ Stigma Practices	⬟ Experiences of Stigma	◉ Outcomes and Impacts for Affected Populations
Racialized identities: First Nations, Inuit, and Métis peoples (Racism)				
Unequal racial power dynamics created by colonization and reinforced by ongoing colonialism; forced removal from traditional lands and creation of reservation system; the residential school system; historical and current disproportionate rates of apprehension by child welfare agencies (e.g., Sixties Scoop); race-based stereotypes	Other social identity stigmas (e.g., sexual stigma, gender identity stigma, ageism) and health-related stigmas (e.g., mental illness stigma, substance use stigma, HIV stigma)	Abolishing or not recognizing traditional language and culture; social avoidance and exclusion by others; hate crimes and assaults; negative media portrayals; demeaning language (e.g., racial slurs); discrimination in employment, education, criminal justice, and housing sectors creating health vulnerabilities Health system: Discriminatory interpersonal behaviour of health professionals; Eurocentric health professional training (e.g., rejection of traditional knowledge, medicine, and healing practices)	Enacted stigma (the experience of unfair treatment); internalized stigma (e.g., shame and embarrassment for LGBTQ2+ people, people who use substances, and people living with HIV, mental illness or obesity); anticipated stigma; secondary stigma for family, friends, and/or caregivers	Overcrowded or inadequate housing; barriers to accessing post-secondary education; reduced economic resources due to employment barriers; increased risk of food insecurity; disconnection from family, community and culture; exposure to violence, particularly against Indigenous women and girls; reduced seeking, or avoidance of healthcare services and poorer quality of services received Chronic stress leading to health harming coping strategies (e.g., smoking, alcohol and substance use) Health outcomes: Increased risk of adverse physical health (e.g., lower life expectancy, tuberculosis) and mental health outcomes (e.g., intergenerational trauma, post-traumatic stress disorder, suicide and suicide attempts)
Racialized identities: African, Caribbean, and Black Canadians (Racism)				
Unequal racial power dynamics from slavery and colonization; forced removal from traditional lands; social, educational, residential, and occupational segregation; race-based stereotypes	Other social identity stigmas (e.g., sexual stigma, gender identity stigma, ageism) and health-related stigmas (e.g., mental illness stigma, substance use stigma, HIV stigma)	Social avoidance and exclusion by others; hate crimes and assaults; negative media portrayals; demeaning language (e.g., racial slurs); discrimination in employment, education, criminal justice, and housing sectors creating health vulnerabilities Health system: Discriminatory interpersonal behaviour of health professionals; Eurocentric health professional training	Enacted stigma (the experience of unfair treatment); internalized stigma (e.g., shame and embarrassment for LGBTQ2+ people, people who use substances, and people living with HIV, mental illness or obesity); anticipated stigma; secondary stigma for family, friends, and/or caregivers	Barriers to accessing post-secondary education; overcrowded or inadequate housing; reduced economic resources due to employment barriers; increased risk of food insecurity; exposure to violence; reduced seeking, or avoidance of healthcare services and poorer quality of services received Chronic stress leading to health harming coping strategies (e.g., smoking, alcohol and substance use) Health outcomes: Increased risk of adverse physical health (e.g., hypertension, diabetes) and mental health outcomes (e.g., intergenerational trauma, depression and anxiety)

■ Drivers of Stigma	● Intersecting Stigmas	▲ Stigma Practices	⬟ Experiences of Stigma	◉ Outcomes and Impacts for Affected Populations
LGBTQ2+ (sexual stigma and gender identity stigma)				
Heteronormativity (expected sexual orientation is heterosexual); historical criminalization of same-sex relationships and sexual practices; societal expectation that gender identity matches biological sex at birth; gender bias that values men over women; historical medical diagnosis of alternative sexual orientation or gender identity as disordered; stereotypes based on sexual orientation	Other social identity stigmas (e.g., racism, sexual stigma, gender identity stigma, ageism) and health-related stigmas (e.g., mental illness stigma, substance use stigma, HIV stigma)	Assumptions of an individual's sexual orientation or gender identity; rejection and exclusion from family, peers, and/or community; lack of alternative gender identities on identification documents; hate crimes and assaults; negative media portrayals; demeaning language Health system: Discriminatory interpersonal behaviour of health professionals (e.g., incorrect use of gender pronouns); insufficient training of health professionals pertaining to LGBTQ2+ health; inappropriate practices such as conversion therapy; insufficient tailored health information, resources, and services	Enacted stigma (the experience of unfair treatment); internalized stigma (e.g., shame and embarrassment for LGBTQ2+ people, people who use substances, and people living with HIV, mental illness or obesity); anticipated stigma; secondary stigma for family, friends, and/or caregivers	Decreased social participation; concealment or denial of identity; increased risk of homelessness; reduced employment and income opportunities; exposure to violence; reduced seeking, or avoidance of healthcare services and poorer quality of services received Chronic stress leading to health harming coping strategies (e.g., self-harm, disordered eating, smoking, alcohol and substance use) Health outcomes: Increased risk of adverse physical health (e.g., sexually transmitted and blood-borne infections) and mental health outcomes (e.g., depression, anxiety and suicide ideation and attempts)
Mental illness stigma				
Beliefs that mental illness is caused by "bad genes," behavioural problems, or social skills deficits; divergent perceptions and understanding about the meaning of [mental] health; beliefs that people with mental illness are dangerous; negative perceptions about prognosis of recovery	Social identity stigmas (e.g., racism, sexual stigma, gender identity stigma, ageism) and other health-related stigmas (e.g., substance use stigma, HIV stigma, obesity stigma)	Low investment in research and education; negative media portrayals; demeaning language; violence and assault; distrust and avoidance of people living with mental illness; failure to accommodate employees with mental illness Health system: Limited training of health professionals to meet the needs of people with mental illness; using labels instead of person-first language (e.g., "schizophrenic" instead of "person living with schizophrenia"); low investment in mental health services	Enacted stigma (the experience of unfair treatment); internalized stigma (e.g., shame and embarrassment for LGBTQ2+ people, people who use substances, and people living with HIV, mental illness or obesity); anticipated stigma; secondary stigma for family, friends, and/or caregivers	Decreased social participation; concealment of illness; limited access to and loss of work or advancement opportunities; decreased use of health and social services and poorer quality of services received Health harming coping strategies (e.g., denial, self-isolation, substance use) Health outcomes: Increased risks of poorer physical health, quality of life, and psychological outcomes (e.g., lower self-efficacy, self-esteem and hopeless); decreased patient safety when stigma prevents health professionals from seeking care for their own mental health problems

■ Drivers of Stigma	● Intersecting Stigmas	▲ Stigma Practices	⬠ Experiences of Stigma	◎ Outcomes and Impacts for Affected Populations

Substance use stigma[xii]

Belief that substance use is a reflection of poor willpower or moral failure, and that people are to blame for their condition; belief that people who use substances are dangerous and reckless; belief that substance use is not a real illness and people "could choose to stop"	Social identity stigmas (e.g., racism, sexual stigma, gender identity stigma, ageism) and other health-related stigmas (e.g., mental illness stigma, HIV stigma)	Negative media portrayals; social avoidance and exclusion by others; discrimination in housing (e.g., denial of applications, eviction), failure to accommodate employees with substance use disorders Health system: Use of demeaning or inappropriate language; reduced empathy from professionals and less motivation to meet the needs of people who use substances; lack of training in harm reduction	Enacted stigma (the experience of unfair treatment); internalized stigma (e.g., shame and embarrassment for LGBTQ2+ people, people who use substances, and people living with HIV, mental illness or obesity); anticipated stigma; secondary stigma for family, friends, and/or caregivers	Decreased use of health and social services and poorer quality of services received; concealment of substance use disorder; loss of work and limited access to leadership positions; increased risk of homelessness Health harming coping strategies (e.g., isolation, social withdrawal and avoidance, further substance use) and behaviours (e.g., needle sharing) Health outcomes: Increased risks of poorer physical health, quality of life and psychological outcomes (e.g., lower self-efficacy, self-esteem and hopelessness); limited uptake of opioid agonist therapy; poorer outcomes for substance use disorder treatment

HIV stigma

Fear of infection or contagion; misinformation about transmission of HIV; incorrect assumptions about prognosis and treatment	Social identity stigmas (e.g., racism, ageism) and other health-related stigmas (e.g., mental illness stigma, substance use stigma)	Criminalization of non-disclosure; forced disclosure; social distancing and avoidance; negative media portrayals Health system: Taking unnecessary precautions when interacting with people living with HIV; compartmentalized care (focus on HIV and not seeing the whole person); restrictions on blood and organ donations from gay, bisexual, and other men who have sex with men	Enacted stigma (the experience of unfair treatment); internalized stigma (e.g., shame and embarrassment for LGBTQ2+ people, people who use substances, and people living with HIV, mental illness or obesity); anticipated stigma; secondary stigma for family, friends, and/or caregivers	Delayed or decreased use of health and social services and poorer quality of services received; concealment of HIV status; self isolation; limited access to employment Health harming coping strategies (e.g., social withdrawal, substance use, denial, non-adherence to medications) Health outcomes: Increased risks of poorer physical health, quality of life, and psychological outcomes (e.g., depression, loneliness, suicidal ideation); lower self-rated health

---

xii   The extent to which substance use is stigmatized varies by the particular substance and context of use. Much of the literature on substance use stigma focuses on substance use-related health conditions (e.g., substance use disorders) or use of substances in ways that might be harmful (e.g., drinking alcohol during pregnancy), though other contexts of substance use are also subject to stigma.

Drivers of Stigma	Intersecting Stigmas	Stigma Practices	Experiences of Stigma	Outcomes and Impacts for Affected Populations
■	●	▲	⬟	◉

Obesity stigma

Belief that individuals are to blame for their weight due to lifestyle choices; stereotypes related to the behaviour or character of people living with obesity	Social identity stigmas (e.g., racism, sexual stigma, gender identity stigma, ageism) and other health-related stigmas (e.g., mental illness stigma, substance use stigma, HIV stigma)	Physical avoidance and exclusion by others; bullying; exclusion from the workforce; negative media portrayals **Health system:** Refusal of care, or low quality of care from service providers; healthcare environment not adapted to larger bodies; lack of empathy from health professionals; use of demeaning language	Enacted stigma (the experience of unfair treatment); internalized stigma (e.g., shame and embarrassment for LGBTQ2+ people, people who use substances, and people living with HIV, mental illness or obesity); anticipated stigma; secondary stigma for family, friends, and/or caregivers	Reduced seeking of care and use of health and social services and poorer quality of services received; decreased social participation; socioeconomic consequences (lower personal income) Health harming coping strategies (e.g., disordered eating) **Health outcomes:** Higher acute and chronic stress and related physiological responses; maintenance of excess weight, poorer mental and physical health outcomes (e.g., anxiety, depression, decreased motivation for physical activity)

Understanding Stigma Drivers and Practices in the Health System

Understanding how stigma drivers and practices manifest in everyday practices in the health system can inform the development of system-wide interventions. Below is a description of interrelated key drivers and practices that foster and sustain stigma in the health system.

The Language We Use

Language is a powerful tool that reflects and perpetuates biases in society. Words communicate assumptions, values, judgements, and stereotypes that create and reinforce negative portrayals of devalued groups. The way language is used in media, popular culture, health promotion initiatives, education, research, and policy shapes how people understand the world.

The use of outdated or incorrect language in the health system, such as an inaccurate pronoun or the negative labelling of a particular group, perpetuates stigma and can influence healthcare providers' perceptions of patients.[105, 106] For example, labelling people who use drugs as "addicts" or "junkies" marks them as less worthy of care and promotes fear.[107] In another example, describing the illness ahead of the person (e.g., using "schizophrenic" instead of "person living with schizophrenia") contributes to dismissive or demeaning behaviours by healthcare providers during treatment.[108] These types of labels also do not allow for other identities a person may have and suggest that everyone within that group has the same wants, needs, and challenges.

Implicit and Conscious Biases

Stigmatizing practices by health professionals may be a result of implicit or conscious bias.[22, 106, 109] Conscious bias occurs when an individual believes and reproduces negative stereotypes and myths about particular groups or individuals, resulting in discriminatory language or practices.[106, 109] For example, a health professional may use demeaning,

DISCUSSION GROUP QUOTE

"So in order to address that root cause of stigma, we absolutely need everybody to hold that mirror up and ask themselves that really important question, of how am I implicated in these systems and structures that discriminate, that stereotype, that hurt people. How can I be an agent of change, what can I do to arrest and disrupt those practices and policies that are so harmful to many of us?"

offensive, or incorrect language in reference to a patient's identity or condition, even after the patient has previously stated their preferred terminology.[106]

Implicit bias occurs when professionals are unaware that their actions or language is stigmatizing.[22, 106] Commonly held beliefs, stereotypes, and assumptions that pervade society make bias difficult to recognize. For example, many Canadians believe there are only two genders, and this assumption is widely reflected in everyday practices such as washroom signage, clothing labels, and healthcare intake forms. Assumptions are generally based on misperceptions or misinformation about certain groups, and may influence how a professional examines, treats, and assesses a patient. For example, patients with chronic pain may be denied medication on the assumption that they may be displaying "drug seeking" behaviour.[110, 111] Lack of training on appropriate care for health conditions or traditional cultural approaches to healing may contribute to the implicit bias of health professionals.[22, 106, 112–114] Although the avoidance of learning appropriate care is an example of conscious bias.

Lack of Respect and Understanding of People's Lives

Colonization and subsequent colonialism have been defining factors for Indigenous peoples and racialized populations. Colonialism has driven unjust attempts to erase cultural identity and practices, and has contributed to loss of language, exclusion from social and health institutions, and continued spatial segregation.[22, 109, 114, 116] The influence of colonialism is reflected in medical curricula that often do not incorporate or reflect the experiences of Indigenous peoples and other

DISCUSSION GROUP QUOTE

"We need to acknowledge that it [slavery] happened in Canada—if you don't ever acknowledge it, you leave us out there wondering if it even happened. You need to validate our reality."

The Death of Brian Sinclair

In 2009, Brian Sinclair, a 45-year old Indigenous man, died of preventable and treatable sepsis in an emergency room (ER). He was referred to the ER by a community physician for a bladder infection. Once he arrived, he did not get properly triaged and was told to wait in the waiting room. There he stayed for 34 hours before someone else let ER staff know that Brian did not seem to be breathing. The Winnipeg Regional Health Authority publicly apologized to his family for the preventable tragedy and has accepted all recommendations from a judicial inquest into this death. Recommendations include improving cultural safety for all staff at regional health authorities and recruitment of Elders for improved care in health centres. Indigenous leaders have asked the judicial inquest to seriously consider the ways in which Brian Sinclair's race, disability, and class led to his death.[22]

racialized populations, including diverse ways of knowing and under-standing health and well-being.[22, 113, 114, 118, 119] The exclusion of these perspectives and ways of knowing shapes health professionals' practices and leads to culturally inappropriate treatment or care, which leads to further exclusion from health settings.[106]

Relatedly, healthcare providers are traditionally trained to focus on individual agency and lifestyle factors, without acknowledging the other factors that impact a person's life (e.g., the social determinants of health).[121] Patients have reported a lack of empathy and compassion from healthcare providers, as they feel they are blamed for their circumstances while the systemic barriers that have contributed to these are ignored.[111, 122–124]

Fear of Danger and of Contagion

Fear is a significant driver of stigmas relating to infectious diseases.[125, 126] Quarantine-related policies, mandatory immigration screening, and notifiable disease frameworks can have unintended stigmatizing effects.[127, 128] For example, people with tuberculosis may be stigma-tized due to their perceived incurable and contagious state.[129] In a low-disease incidence country like Canada, specific population groups such as migrants can be portrayed as a public health threat and blamed for being carriers of infectious diseases such as HIV.[130, 131] Fear can also drive stigmatization of other health conditions, such as mental illness, where affected people may be seen as dangerous, unpredictable, or aggressive.[132]

Stigmatizing Organizational Cultures

Organizational cultures influence whether stigmatizing practices are acceptable and how health providers interact with patients.[108, 133–136] The above drivers and practices can become embedded in the culture of health organizations and reinforced by clinical and non-clinical staff (e.g., administrative, management and support staff). This can manifest in stigmatizing language, making assumptions, breaching confidentiality, using unnecessary precautions, and even, in some cases, denying care or access to treatment.[22, 106, 112, 113, 137] For example, transgender women have been denied access to women-only services for appearing too masculine[138] and "flagging" files to distinguish particular medical records may also promote stigmatization.[113] Burnout and compassion fatigue of providers can further contribute to these practices.[108]

Service providers may convey power and distance through the utilization of unnecessary protection, their way of delivering diagnoses, and their reactions to diagnoses.[108, 131, 139] This may also be seen through the imposing of rules and policies that shape treatment and recovery opportunities for individuals seeking help for conditions such as mental

DISCUSSION GROUP QUOTE

"You need education throughout your career. Not one day on cultural sensitivity, or mental health sensitivity."

DISCUSSION GROUP QUOTE

"People often struggle with the idea that people can be different than them."

DISCUSSION GROUP QUOTE

"When you challenge [cultural norms] in your practice, you can get boxed in…. For example, when I talk about race, religion, gender, there is a defense mechanism that kicks in."

health problems, substance use disorders, and HIV infection.[107, 140, 141] These practices include refusing mental health care to people who use drugs or restricting treatment for recurrent drug use, and denying access to treatment because of particular sexual practices or gender nonconformity.[107, 134, 138, 141–143]

Stigma in organizational cultures may also have an impact on the health and well-being of staff. Healthcare providers may be reluctant to acknowledge or disclose their own stigmatized conditions, such as mental illness, in workplaces where stigma is persistent. This may result in self-treatment and a lack of peer support.[108]

How Stigma Leads to Adverse Health Outcomes

The following more fully unpacks how the experience of stigma leads to poorer outcomes and impacts overall health. Emerging research indicates that stigma affects health in **three key ways**:[xiii]

1 **It reduces access to and quality of protective resources and health services**

2 **It increases the risk of chronic stress and poor coping responses**

3 **It puts stigmatized people at higher risk of assault and injury**

FIGURE 8: **How Stigma Affects an Individual's Health**
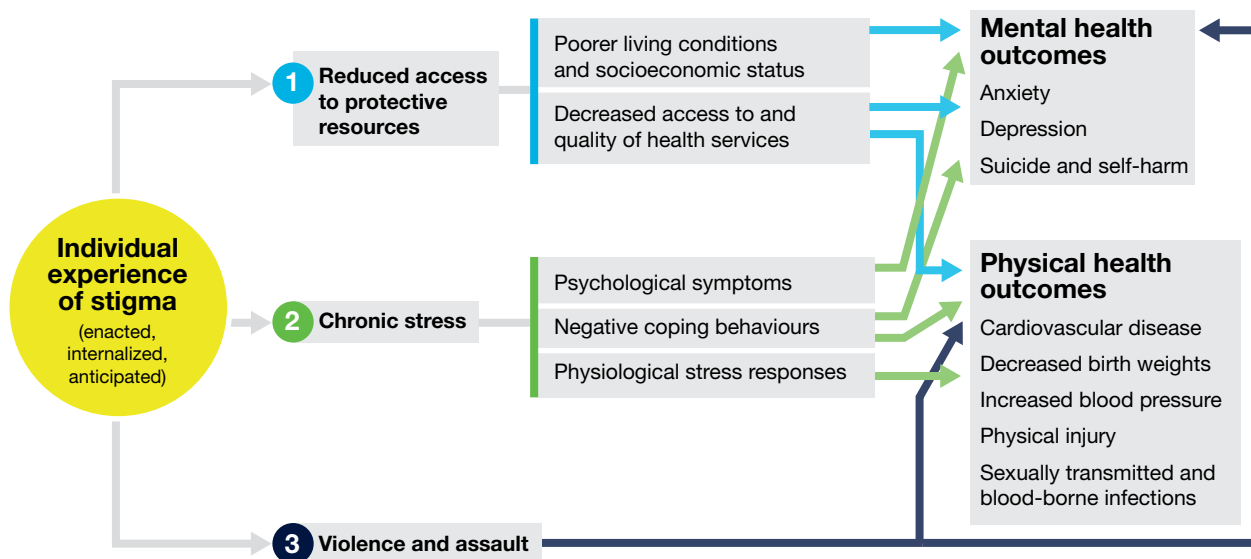
While this is not a comprehensive list of all possible outcomes or mechanisms, it does summarize many of the proposed associations.[144]

Source: Adapted from Paradies *et al*. 2013[155]

xiii   These data generally comes from self-reported experiences of stigma in relation to health outcomes. Additionally, many of these studies were conducted in the US. Caution should be taken regarding the generalizability of the findings.

1   *Stigma Reduces Access to and Quality of Protective Resources and Health Services*

Stigma can be a barrier to accessing essential resources and opportunities in life, such as housing, jobs, education, inter-personal relationships, and health care. These barriers may be the result of direct and active exclusion through discrimin-ation by gatekeepers (e.g., landlords, employers, teachers, and healthcare professionals) or may arise internally from one's anticipation of facing stigma and mistreatment based on previous exposure to negative environments or discriminatory practices.[22, 106, 109, 111, 112, 123, 145] When people are excluded from these opportunities in life, they are exposed to more health risk factors and fewer protective factors.[109, 145–148] Importantly, once accessed, the services may be culturally inappropriate or of poorer quality.[118, 146]

2   *Stigma Causes Chronic Stress and Poor Coping Responses and Behaviours*

Stigma is a major source of psychological stress, whether it is enacted, internalized or anticipated. Because of their stigma-tized status, people from stigmatized groups may experience shame, low self-worth, and blame, and are at increased risk of exposure to stressful and unfair conditions and situations.[106, 112, 152] Excessive and ongoing stress can affect the body in a negative way throughout the life course and can be particularly dam-aging for developing children.[153, 154] This repeated activation of stress responses can lead to an impaired immune system and interfere with the body's repair processes. It can also elevate blood pressure, heart rate, and stress hormones, which may have an effect on health over time.[120, 156, 157]

3   *Stigma Can Expose People to Violence and Assault*

Certain groups of people are feared or seen as less worthy of respect or dignity because of stigma. In combination with other social inequities, groups that are stigmatized are targets for explicit hatred and violence, including physical assault or abuse, sexual assault, bullying, harassment, and hate crimes. Verbal, physical and sexual violence against individuals or groups can occur at home, in school, in the workplace, in the community, or online.[106, 116, 149–151]

DISCUSSION GROUP QUOTE

"We're kind of scared, when I say "we're" I'm speaking as a Black woman, we fear not being understood, and most times ... I find it more manageable for me to just handle it on my own, or to maybe seek out a friend or family. Where really, I should feel comfortable to go and seek help in these facilities."

DISCUSSION GROUP QUOTE

"Well I think for people it [stigma] sort of affects their self-worth, their self-confidence, even though they might be skilled, or very educated, or informed, that it creates the self-doubt in them."

The effort required to deal with stigma reduces a person's psychological resources and resilience. It creates challenges in managing emotions and the ability to self-regulate, and an increased likelihood of having poor sleep habits, using substances, risky sexual behaviour, and unhealthy eating.[145, 158–161] These can place stigmatized people at even higher risk of acquiring further stigmatizing conditions (e.g., HIV infection, obesity). Although the outcomes may be harmful, these behaviours can be coping strategies and a way to survive challenging or even traumatizing events and experiences.[155] Through this lens, these responses can be understood as normal or expected responses to unjust and traumatic situations.

Through These Three Avenues, Stigma Can Lead to Adverse Mental and Physical Health Outcomes

Measuring the health impacts specifically due to stigma is methodologically difficult; however, research indicates that poor mental health is often associated with many types of stigma. Adverse outcomes include anxiety, depression and depressive symptoms, post-traumatic stress disorder (PTSD), suicidal ideation and behaviours, self-harm, and low self-esteem and self-worth.[100, 146] Poor cardiovascular health has also been linked to discrimination and chronic stress, and is a major cause of morbidity and mortality.[146,188] For example, recent research has focused on examining how systemic racism can have an impact on hypertension, cardiovascular health, and diabetes.[162, 163] In other research, experiencing stigma and discrimination while pregnant has been associated with pre-term birth, low birth weight, and higher rates of infant mortality.[164, 192] Discrimination has also been associated with increased rates of diabetes, cancer, tuberculosis, increased Body Mass Index and obesity, and increased risk of sexually transmitted and blood-borne infections.[112, 125, 146, 188]

DISCUSSION GROUP QUOTES

("Living while Black") "There isn't a moment when 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."

"Often I find people don't hear, listen to or see me."

DISCUSSION GROUP QUOTE

"When you kind of zoom out a little bit and realize that our social structures create situations in which people are silenced and can't get the resources they need to reach their full potential, then we see all kinds of poorer health outcomes."

Resisting the Impacts of Stigma

Building Resilience

Many people living with stigma resist devaluation and discrimination and build strength, resilience, and strategies to ward off stressors.[165, 166] These strategies can include invalidating the negative beliefs associated with stigma, attributing prejudices to ignorance and not to themselves, and drawing upon their identities (such as LGBTQ2+) or social roles for protection.[165, 166]

Others may disclose their stigmatized status and educate others on their health condition. Disclosure can lead to having more informal and formal support.[172, 233] Although disclosure can be empowering, not everyone may feel comfortable or safe to do so. Resilience can mean choosing not to disclose in order to feel safe.[167] In recent years, many people from stigmatized groups have come forward and publicly disclosed experiences of stigma and discrimination (for example, women who experienced violence and sexual assault).

When groups mobilize, there can be psychological and social benefits, such as social support, that buffer them from some negative health consequences.[165] For example, Black Canadian women are less likely to self-report poor mental health compared to White Canadian women.[168, 169] Research from the US demonstrates that African Americans may develop resiliency strategies, such as strong family and community ties, to cope with and challenge racism and discrimination.[170] These strategies and strengths may act as buffers and help prevent mental health issues.[169, 170] Although this has not yet been researched in a Canadian setting, similar dynamics may be at play.[168, 169]

Community Connection

Community culture and connection can play a protective role in supporting individuals who face stigma and discrimination. Among Indigenous peoples in Canada, cultural continuity has been associated with lower youth suicide rates.[171] Cultural continuity is measured in different ways, and can include factors such as self-government, community-level Indigenous language knowledge, and control over education, community, social or health services. As emphasized in the First Nations Mental Wellness Continuum Framework, culture—including values, sacred knowledge, language and cultural practices—is the foundation of health and wellness.[16]

DISCUSSION GROUP QUOTE

"…we have to get back to finding our kindness, and our humanness, and recognizing that if we were all the same it would be a very boring place to be and that the difference is what makes us strong and what keeps us going."

Collectively Changing the Health System

Populations subjected to stigma and oppression for generations have responded by engaging in collective responses and self-determination, and displaying profound group resilience. For example, despite a history of cultural genocide, assimilation, intergenerational trauma, and colonial policies, Indigenous peoples have survived and preserved their cultures and ways of being.[22] Learning about and incorporating traditional Indigenous health practices can build resilience and a sense of ownership over one's health.[22, 173, 174] First Nations, Inuit and Métis peoples in Canada have engaged in collective resistance to health system stigma by advocating for Indigenous education programs, promoting public education against negative stereotyping, and developing Indigenous-run governing health bodies and holistic approaches to health that respect and build on traditional ways of knowing.[22]

People living with HIV mobilized early in the AIDS epidemic to form a powerful social movement that helped to mitigate the stigma associated with HIV and AIDS and change the health system response by improving the patient-provider relationship, challenging stereotypes, and ensuring the meaningful participation of people living with HIV in research and health practices.[175, 176]

The call for meaningful representation has been echoed across other movements and communities, such as the disability movement that initiated the slogan "Nothing about us without us" as an act of resistance to the under-representation of people living with disabilities in research and in the media.[177] Similarly, Indigenous peoples have emphasized the importance of telling their own stories about Indigenous health and well-being, and leading the way forward through Indigenous-directed health and community services.[22]

The mental health movement in Canada contributed to normalizing mental health, the deinstitutionalization of mental health services and the shift towards having mental health and social supports available in the community, which can all reduce stigmatization.[178, 179] More recently, there has been a shift in approaches within the substance use movement in Canada. Utilizing a strengths-based and resilience approach instead of a risk-based perspective has led to increased availability and accessibility of harm reduction services and initiatives for reducing substance-related harms, such as supervised consumption sites, naloxone distribution and training, educational initiatives related to lower-risk substance use, and drug contamination testing.[180]

DISCUSSION GROUP QUOTE

"Being Indigenous doesn't make you more prone to HIV. Living without hope does."

DISCUSSION GROUP QUOTE

"Members of communities who are affected by stigma should be involved. [They] should be leading the conversation."

DISCUSSION GROUP QUOTE

"What has happened to us, is not who we are! If you look at who we are, there in lies the solution."

Building an Inclusive Health System

The Stigma Pathways to Health Outcomes Model (Stigma Model) offers a comprehensive approach to understanding stigma and the real and measurable impact it has on physical and mental health outcomes. The Stigma Model also demonstrates that stigma is not simply an interaction between people but a process influenced by larger social, cultural, political, and economic forces.

Responding to stigma in the health system requires an equally comprehensive approach, through system-wide interventions in education, training, practice, and policy. This chapter presents a new **Action Framework for Building an Inclusive Health System** (Action Framework), developed for this report. Whereas the Stigma Model helps to understand the nature and extent of the problem of stigma, the Action Framework explores where and how it can be addressed.

The Experience of Stigma Revisited

Let's revisit Charles and Cynthia, who we met in Chapter Two. Previously, we examined the ways in which Charles and Cynthia experienced stigma in the health system and how this negatively impacted their overall health. Now, let's see how their experiences could have been different if they had been treated in inclusive environments that met their needs.

Charles

Charles, a Black, gay man who is living with HIV, recently moved to a mid-sized town in Ontario and believes he may have signs of heart disease. Charles books an appointment with his new doctor regarding his symptoms. At the appointment, his doctor takes the time to review his social and family history. As a routine part of getting to know each patient, his new doctor always asks patients for their preferred name and pronoun. When Charles sees how much his new doctor prioritizes patient trust, he feels comfortable sharing that he is gay. She knows that Charles is at higher risk of heart troubles because of his age and family history, and also due to social determinants such as his

racialized identity status. Charles' doctor determines that the best course of action is to refer him to a specialist at the hospital for further testing. Charles feels heard and respected by his doctor and appreciates her thoroughness. Charles is nervous about the tests with the specialist but when he arrives, he is treated with respect and dignity by the hospital staff. He also notices that the specialist and some of the other health professionals look like him. The specialist focuses on Charles' presenting symptoms and does not ask questions about his HIV status or sexual orientation when it is inappropriate to do so. Even when doing more diagnostic testing, the specialist and other health professionals do not take unnecessary precautions. The results of the tests show that Charles has early stage heart disease; however, because the disease was detected early, Charles' prognosis is good. Charles will continue to have follow-up appointments periodically with the specialist to monitor his health. Charles feels comfortable attending these appointments due to the excellent care he has received and the trust he has in his doctors.

Cynthia

Cynthia is a Cree woman living in Saskatchewan with her two young children. She is pregnant with her third child and has recently learned of complications with her pregnancy. Cynthia has been receiving care at a First Nations health centre in her community but needs specialist care at a large hospital. A nurse from the health centre refers her to the hospital's new Indigenous Health Program, where an Elder is available to provide guidance and cultural and spiritual support to Cynthia before, during, and after her treatments.

When it is time for her treatment, Cynthia's doctor introduces herself. She asks Cynthia about her experience and her priorities before thoroughly explaining the treatment, timelines, and next steps. Cynthia's doctor talks to Cynthia and encourages Cynthia to ask questions so they can make decisions together. The doctor began the appointment with this approach because the hospital recently implemented an institutional policy requiring and supporting all health professionals to learn and implement a cultural safety model of practice. Cynthia feels respected and the introduction eases her anxiety about the appointment. The Elder collaborates with Cynthia's healthcare team to facilitate communication and cultural understanding to create and maintain a culturally safe care plan. Cynthia continues to meet with the Elder during future treatments who also connects her to an appropriate, funded childcare facility where she can take her two children while she attends her ongoing appointments. Cynthia feels well supported by the Elder and her healthcare team at the hospital who successfully manage her pregnancy complications while providing culturally relevant care. Cynthia carries her baby to term and gives birth to a healthy baby.

An Action Framework for Building an Inclusive Health System

The complex and reinforcing processes that fuel stigma drivers and practices require system-wide responses. Using a public health lens, it is important to prioritize broad interventions that can have the most benefit to the greatest number of people.[181] Population- and institution-level interventions to address stigma drivers and to prevent stigma practices are most aligned with this approach. To mitigate individual-level harms, it is also necessary to implement interventions to better support individuals who have experienced stigma.

While actions have been organized according to various levels, complementary and synergistic interventions will need to be implemented across all levels to achieve the most impact. Though much of the research in this field has explored the impact of one intervention at one level, researchers increasingly emphasize the importance of working at multiple levels to reinforce and sustain change.[91, 100, 106, 113, 182–187] Additionally, attention to using de-stigmatizing language is important at all levels and in all interventions.

Policy leaders, researchers, practitioners, and service providers are encouraged to use the Stigma Model to understand different stigmas. The Action Framework then provides direction on developing multi-level and comprehensive approaches that respect differences across stigma experiences while offering the potential for lasting effects across stigmas (Table 2). The Action Framework can also serve as a starting point for other stigmas not summarized in this report, such as those related to age, class, and other health conditions.

An evidence summary on interventions to address stigma in the health system will be available on the 2019 CPHO annual report web page.

INTERVIEW QUOTE

"One of the things that gives me hope about addressing stigma is that first off, we're starting to realize that it needs to be addressed. That we're starting to recognize that this is one of those fundamental issues that is... that impacts everybody in society. Because if we don't name it, if we don't start to take action, if we don't start to see this as a problem, we can't move forward."

TABLE 2: Action Framework for Building an Inclusive Health System

How stigma operates across levels (examples)	Interventions to address stigma across levels (examples)	Potential outcomes (examples)
Individual		
Level of Stigma: person who experiences stigma		
• Enacted stigma (i.e., unfair treatment) (e.g., psychological stress) • Internalized stigma (e.g., low self-esteem and feelings of shame) • Anticipated stigma (e.g.,does not access support)	• Group-based supports to change stigmatizing beliefs, improve coping skills, support empowerment, and build social support	• Reduction in internalized stigma • Improved psychological well-being and mental health
Interpersonal (person-to-person)		
Level of Stigma: family, friends, social and work networks, healthcare and service providers		
• Language (e.g., using derogatory terms or dehumanizing labels; refusing to use preferred name and/or pronoun) • Intrusive attention and questions • Hate crimes and assault	• Education interventions to target myths and lack of knowledge. Include components that encourage examining personal values, biases, and beliefs • Contact interventions, including sharing personal stories, to target stigmatizing beliefs and attitudes	• Better understanding of the facts about stigmatized health conditions • Increased understanding of diverse perspectives and experiences of stigma • Growing social acceptance • Reduction in stereotyping
Institutional		
Level of Stigma: health system organizations, medical and health training schools, community sector organizations, social service organizations		
• Being made to feel "less than" (e.g., having to wait longer than others to be seen; lack of empathy from staff) • Physical environment is not inclusive (e.g., washrooms are single-sex; undersized chairs in public areas) • Institutional policies that cause harm (e.g., unnecessary drug tests; low investment of services)	• Ongoing and continued training targeting conscious and implicit bias • Implementation of cultural safety and cultural humility models • Safe and inclusive physical environments • Workforce diversity initiatives • Institutional collaboration with community; policies that support and fund meaningful engagement with people with lived experience of stigma • Implement trauma- and violence-informed care models • Accountability and monitoring frameworks that include stigma reduction indicators	• Institutional environment is inclusive, welcoming and diverse • Organizations are able to meet the needs of all populations • Reduction in stigmatizing beliefs and attitudes among staff • Improved patient/client ratings of care, satisfaction and trust • Patient/client outcomes improve
Population		
Level of Stigma: mass media, policies, and law		
• Widely held stereotypes • Negative portrayals in film and television (e.g., people with mental illness portrayed as violent) • Discriminatory policies and laws • Inadequate legal protections, or lack of enforcement of these protections	• Mass media campaigns to challenge stereotypes and prejudice • Guidelines to reduce stigma in media reports • Protective laws and policies • Addressing discrimination within existing laws and policies	• Reduction in stigmatizing beliefs, attitudes, and intended behaviour among the public • Reduction in discrimination practices

Table 2 provides a high-level summary of types of interventions that can be considered when addressing stigma in the health system, using examples rooted in evidence. The following section takes a deeper look into how these interventions have been applied in practice and how they might be expected to address stigma in and across different levels. It is noteworthy that considerable research on stigma comes from the field of mental health. This is in part due to a worldwide focus on mental health as well as leadership in Canada.

Also included in this section are examples of interventions (in text boxes) identified as promising by participants in CPHO discussion groups.

Individual- and Interpersonal-level Interventions

Strengthening Resilience

The Stigma Model emphasizes the importance of addressing stigma drivers and intervening to prevent stigma and discrimination. However, it is also necessary to support those who have experienced stigma. Reducing the impact of stigma on well-being is often the target of individual-level psychoeducation programs.[193–195] These interventions are frequently in a group format with cognitive and behavioural elements, such as cognitive-behavioural therapy or acceptance and commitment therapy, and are intended to change internalized stigmatizing beliefs, improve coping skills, support empowerment, and/or build social supports.[193–197] Promising results have been highlighted in systematic reviews of these approaches as a support for people living with HIV, people who use substances, and people living with mental illness, though the evidence is mixed.[193–198] The potential for coping and community-support interventions to mitigate the impact of stigma have also been identified for LGBT communities.[106, 199]

INTERVIEW QUOTE

"I think that kind of dialogue is starting to occur, I would say and it is largely led by Indigenous communities and who are saying that is not appropriate to just focus on deficiencies. We need to focus on strength-based models, look at groups that are thriving and look at that as models for other groups to follow, and understand self-determination and other factors that remove stigma."

Building Awareness, Changing Attitudes

Most of the stigma intervention research has focused on challenging stereotypes and prejudice held by individuals, with the goal of reducing stigma practices at an interpersonal level. This research base has generally focused on education and contact interventions to reduce stigma associated with stigmatized health conditions, but there is little research on long-term impact. Some systematic reviews suggest contact interventions are particularly effective in reducing stigma, while others suggest that education and contact interventions offer similar impacts.[198, 200, 201]

Education interventions use facts to target stereotypes and challenge prejudice. In contact interventions, people from groups that experience stigma share their personal stories. These connections are intended to challenge negative attitudes and behaviours, break down "us" vs. "them" categories, and highlight all the other aspects of someone's identity (e.g., mom, baseball lover, teacher). Education and contact interventions have both been associated with small-to-medium immediate effects upon self-reported stigma knowledge and/or attitudes in systematic reviews related to mental illness or HIV.[198, 201–204] These interventions have also shown promise in reducing self-reported stigma related to substance use.[190, 197]

DISCUSSION GROUP QUOTE

"We [the broader health system] tend to be more and more involving, the people who are bearing the greatest burden of that form of stigma, of a particular form of stigma, we are tending to involve people in creating the solutions."

Discussion Group Reflections on Addressing Stigma

Participants highlighted the CHAMPS study (Community Champions HIV/AIDS Advocates Mobilization Project) as an example of a stigma reduction intervention that brought together community leaders and people living with HIV. CHAMPS enlisted people living with HIV and HIV-negative community leaders, including those from the faith, social justice, and media sectors to participate in a training workshop. As part of the workshops, participants engaged in reflection and experiential learning activities to become more aware of their own biases and responses to stigma and to develop strategies to address stigma. Results indicated that the training changed attitudes as well as behaviours over the course of several months in both people living with HIV and community leaders.[205]

Institutional-level Interventions

Stigma drivers and practices also exist at institutional and population levels, where stigma is embedded and sustained. The organization as a whole is an important target of change.[108, 206–210] This includes organizational-level interventions, such as creating inclusive physical environments, building workforce diversity, and policy and practice changes. This shifts the focus and responsibility for healthcare inter-actions from individuals to include the broader factors that shape these interactions.[22, 208, 210] Relatedly, multi-level interventions are also included in this section, to highlight important advances in the health field regarding anti-stigma and equity-oriented initiatives.

While institutions are at the core of this section, other interventions are included that target health providers at individual or interpersonal levels. These interventions are designed and delivered in the context of the participants' roles in health systems, and best implemented alongside other efforts across healthcare institutions. A whole-organization approach also emphasizes the bidirectional influence between individuals and institutions.

Addressing Bias in Health Practice

To improve practice and more adequately meet the needs of all patients, it is important to understand and address both implicit and conscious stigma beliefs and practices. There is a growing awareness of the nature and potential impact of implicit bias on health inequal-ities.[211–213] Common approaches targeting implicit bias among health providers include efforts to reduce implicit associations or to control how they influence judgement and behaviour.[213] This kind of self-reflection can include perspective-taking (consciously assessing an interaction from a patient's perspective) and individuation (consciously focusing on specific information about an individual rather than assumptions based on social identity).[211–213] Though the field is still emerging, there are some promising findings.[212, 213] Addressing implicit bias has also been identified as being important to reduce stigma and discrimination for Indigenous peoples in Canada, people experiencing mental illness, LGBTQ2+ populations, and people who use substances.[22, 197, 214, 215]

DISCUSSION GROUP QUOTE

"So many systems think our families are broken and they don't know what we need. People know what they need but we just don't listen to them."

Education, contact and skill-building interventions for healthcare providers are the most common approaches targeting conscious stigma in health facilities related to HIV, mental illness, and/or substance use.[113] Many interventions include multiple approaches; contact and knowledge-building are the most common. In a recent systematic review, several anti-stigma initiatives were identified as having promising results, but methodological variations made it difficult to compare across fields or draw firm conclusions about effectiveness.[113]

Narrative reviews focused on mental health, and extending farther back than five years, suggested more success. Though the research base is small, contact and education interventions showed promise in reducing self-reported stigma among health providers, specifically short-term improvements in knowledge and behaviour.[198, 204]

Mental Health Commission of Canada's Opening Minds Initiative (MHCC)

The "Understanding Stigma" workshop was developed to address mental illness stigma among healthcare professionals using social contact alongside educational and action-oriented components.[216] A meta-analysis of six replications of the program had encouraging results. The workshop was associated with self-reported changes in attitudes and intended behaviour.[216]

MHCC also supported the evaluation of a number of anti-stigma interventions across the country. This research identified a number of key program elements to address mental health stigma for health-care providers (see below), with multiple forms of social contact and an emphasis on recovery identified as most important for effective programs.[217]

Key program elements of "Opening Minds"

1. Social contact in the form of a personal testimony from a trained speaker who has experienced mental illness

2. Multiple forms or points of social contact, where people with lived experience can be seen as educators rather than patients

3. Focus on behaviour change by teaching skills that help healthcare providers know what to say and do

4. Engage in myth-busting

5. Enthusiastic facilitator or instructor who models a person-centred approach

6. Emphasize and demonstrate recovery as a key part of messaging, including the important role of health providers in this process

INTERVIEW QUOTE

"What we have found is that education programs that share stories… We call it contact-based education or social contact. People hearing from individuals with lived experiences of mental health problems and mental illness who talk about their stories share what it was like when they had a mental illness, but talk about the importance of getting treatment and how their lives have changed dramatically once they got that help that was needed."

Educational curricula and training also have potential to build knowledge and change attitudes among health providers related to LGBT populations and their health.[218] While the stigma experienced by patients who are transgender has had limited focus in research, contact interventions have been identified as an approach that may address provider bias.[106]

As previously noted, addressing stigma in health systems requires concurrent efforts across health institutions. Research has identified emerging practices but there are no conclusions about effectiveness. Approaches to changing policy and practice include: targeting all levels of clinical, non-clinical and management staff including trainees; changing physical aspects of the environment; tailoring approach to organizational context and culture; and targeting multiple levels concurrently.[108, 113, 219, 220] For organizations providing services to people who experience stigma related to their health conditions, this can also involve changing what "success" looks like. For example, research in Canada explored varying ideas about success among health and social service providers who work with women who are pregnant and using substances; service providers suggested that success for clients could include having their self-defined needs met, experiencing stability and self-respect, recognizing strength and resilience, and healing in their own time.[221]

Cultural Competence to Cultural Safety

The field of cultural competency offers another approach to address stigma in healthcare institutions. Broadly, cultural competency interventions involve developing awareness, knowledge and attitudes among health providers to help them work more effectively in cross-cultural situations.[222] This has generally been a focus for stigma and discrimination related to social identities, such as racialized and Indigenous populations, but the language and overall lens has broadened to include other groups such as LGBT populations.[106, 210, 218]
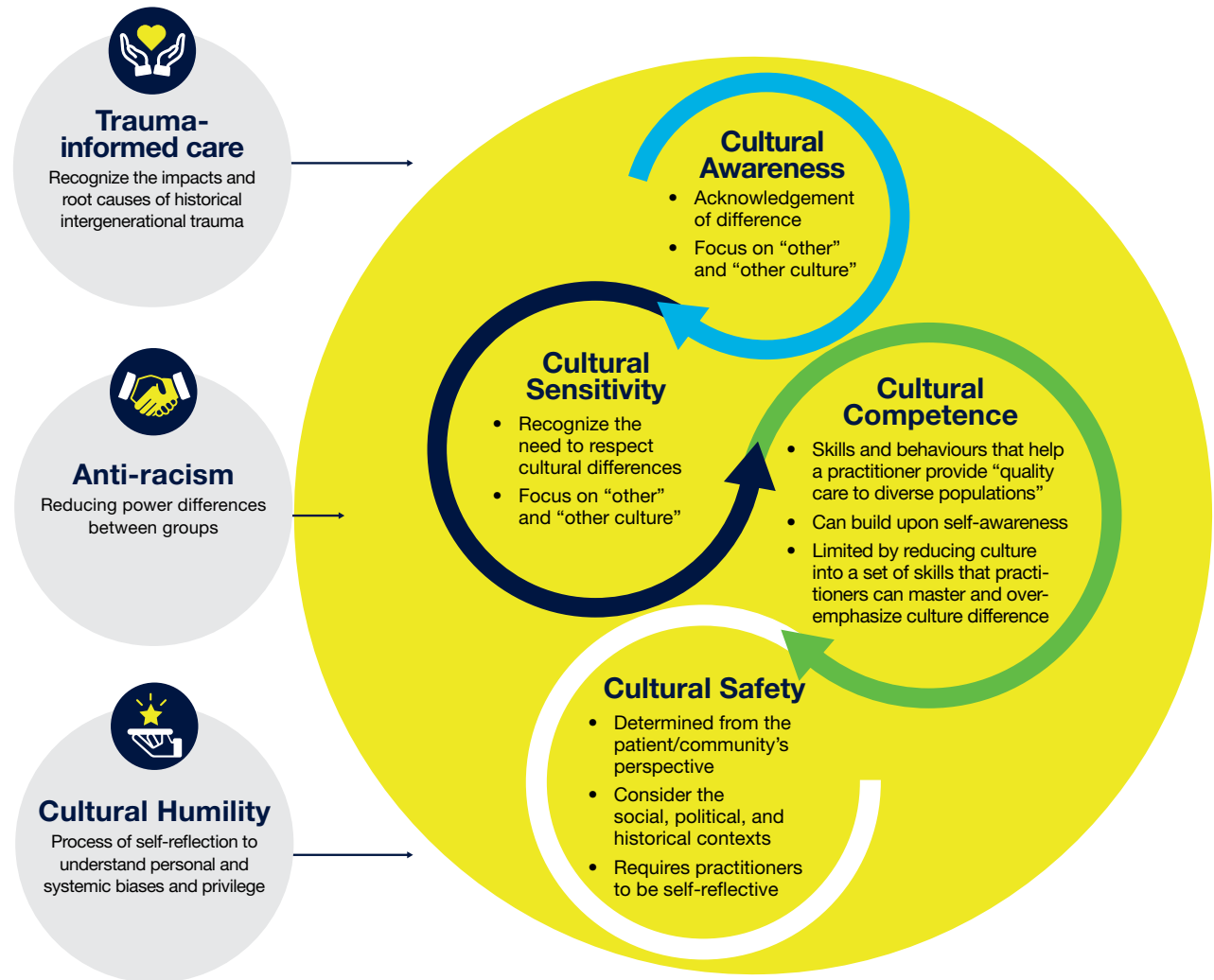
This is an evolving field. Previous approaches focused on teaching healthcare providers about the needs and experiences of particular racial or cultural groups, and these were criticized for oversimplifying and stereotyping "culture" and ignoring diversity within.[222] While training for healthcare providers remains the most common approach to building cultural competence in health systems for Indigenous peoples and racialized populations the scope has expanded to include a focus on institutional change.[206, 207, 210, 222] This includes culturally specific programs for patients, patient navigators, and workforce diversity.[206, 207, 219] In systematic reviews, some initiatives were associated with improvements in self-reported provider knowledge or attitudes as well as patient-reported health care access, and/or patient satisfaction.[206, 207, 222] However, results were mixed and the quality of research was low.[210, 222] There was no or weak evidence for impact on patient outcomes.[210, 222]

DISCUSSION GROUP QUOTE

"Health systems should look like the people who come to visit them."

FIGURE 9: Continuum of Cultural Safety*

Trauma-informed care
Recognize the impacts and root causes of historical intergenerational trauma

Anti-racism
Reducing power differences between groups

Cultural Humility
Process of self-reflection to understand personal and systemic biases and privilege

Cultural Awareness
- Acknowledgement of difference
- Focus on "other" and "other culture"

Cultural Sensitivity
- Recognize the need to respect cultural differences
- Focus on "other" and "other culture"

Cultural Competence
- Skills and behaviours that help a practitioner provide "quality care to diverse populations"
- Can build upon self-awareness
- Limited by reducing culture into a set of skills that practitioners can master and over-emphasize culture difference

Cultural Safety
- Determined from the patient/community's perspective
- Consider the social, political, and historical contexts
- Requires practitioners to be self-reflective

* Adapted from NCCIH and BC First Nations Health Authority by the CPHO Health Professional Forum.

In response to critiques and alongside a growing focus on addressing racial health inequalities, factors such as trust/mistrust, bias, power, privilege, discrimination, and critical reflection have become a focus within "cultural competence". [222] Many different individual-, interpersonal- and institutional-level initiatives are now considered "cultural competence" interventions, though there is considerable variation in approach and level of intervention.

Approaches focused on "cultural safety" have emerged in response to the limitations of previous practices. Cultural safety moves away from a focus on differences in culture to a view of the health system environment as a site for change (Figure 9).[208] As a model of health care created by Indigenous nurse educators in New Zealand, cultural safety was designed in response to the health implications of colonialism, and looks at power dynamics in health systems.[22, 223] It is intended to create spaces where everyone feels respected and physically, emotionally, socially, and spiritually safe.

While evidence is still emerging, research in Canada has identified a number of key components in cultural safety interventions. This includes provider self-reflection, addressing bias and discrimination, building relationships with patients, sharing power, validating a patient's way of knowing, and meaningful training for healthcare providers.[22, 208, 223, 224] Aspects of this are embedded in "cultural humility" which is an important related concept to be used by healthcare providers to enable cultural safety.[225] It is a process of self-reflection, to understand bias and build respectful approaches and relationships rooted in mutual trust.[225] Cultural humility involves an awareness of oneself as a learner in relation to understanding someone else's experiences.[225]

Institutional-level cultural safety interventions include building partnerships with communities, creating safe and welcoming physical spaces reflective of the populations they serve (e.g., signage in Indigenous languages, sacred spaces in hospitals), institutional commitments to cultural safety, and hiring and supporting Indigenous healthcare providers.[22, 208, 223, 224] Healthcare organizations can also change internal policies to support cultural safety, such as creating flexibility in appointment scheduling to increase responsiveness, while building trusting relationships.[208]

In addition to Indigenous peoples, cultural safety has the potential to support other groups facing discrimination. In particular, cultural safety has been identified as relevant for transgender populations and racialized populations.[109, 174, 227]

DISCUSSIONS GROUP QUOTES

"…Holistic care is crucial, it is not a tick box, and you need to understand the whole person and the lived experience."

"What we do at the [interpersonal level] helps alleviate the individual stigma, but only if the structural [systemic] stigma is positively changed."

Discussion Group Reflections on Addressing Stigma

In response to British Columbia's Transformative Change Accord First Nations Health Plan, devolving First Nations health services in the province of British Columbia back to First Nations, the San'yas Indigenous Cultural Safety Training Program was created and delivered across all British Columbia Health Authorities.[226]

Cultural Safety Declarations

On April 23, 2019, the Public Health Agency of Canada, along with Health Canada and Indigenous Services Canada, signed the *Declaration of Commitment to Advance Cultural Safety and Humility in Health and Wellness Services and Organizations* with the British Columbia First Nations Health Authority. The declaration reflects a shared commitment to creating an environment where Indigenous peoples feel safe in accessing the Canadian health system. The overarching goal is to identify opportunities to reduce the systemic barriers and harms that Indigenous peoples experience, raise awareness about existing systemic discrimination, and address inequities in outcomes for Indigenous peoples. Cultural humility requires self-reflection to understand biases, address power imbalances and develop respectful processes where people feel safe to access health systems. The Declaration addresses the Calls to Action numbers 23 and 57 put forth by the Truth and Reconciliation Commission of Canada that calls upon all levels of government to ensure that healthcare professionals and public servants are educated on the history of Indigenous peoples.

DISCUSSION GROUP QUOTE

"We need to bring humanness into this. More faces to narratives. There needs to be champions at the moment and leaders, but we do not want to tokenize either. We need to all want it."

Trauma- and Violence-informed Care

Stigma practices can include and are exacerbated by interpersonal and structural violence. Trauma- and violence-informed care has emerged in recognition of the many forms of trauma and the potential for sustained impacts of trauma.[230] This approach shifts thinking from "What is wrong with you?" to considering "What happened to you?". This supports an exploration of how trauma influences well-being and its potential impact on behaviour.[231] This approach is not intended to provide specialized therapeutic support to address trauma but rather to reduce the potential for harm and retraumatization. This includes attention to a variety of potentially traumatizing experiences in health care, including being in a physically vulnerable position during an exam, or loud waiting rooms. It also includes a recognition of the emotional intensity of disclosing trauma and the importance of asking about trauma in a sensitive, respectful, and appropriate manner.[231]

The four principles of trauma- and violence-informed care are:[232]

1. building awareness among health providers about trauma, violence and its impacts on people's lives and behaviour,

2. creating emotionally and physically safe and welcoming environments for everyone, including using non-stigmatizing language,

3. fostering opportunities for choice, collaboration and connection, and

4. using a strengths-based and capacity-building approach to support people.

Institutional Accountability

The broader policy environment can influence the success of institutional initiatives. For example, there is little focus within current accountability frameworks related to stigma reduction, which makes it hard to track existing activity or impacts, and means there is little structure or incentive to support new or ongoing efforts.[235] The potential of this approach has been identified in systematic reviews of organizational cultural competency initiatives.[219] While research is too limited and varied to support firm conclusions, audit and quality improvement activities have been found to provide a structure to identify and drive action on aspects of culturally competent healthcare for Indigenous peoples.[219]

Accountability frameworks that focus on stigma reduction could be supported by monitoring the accessibility, quality and/or relevance of health services. This could include breaking down quality improvement data to explore the different experiences of groups most likely to experience stigma, which would require meaningful and respectful collection of patient demographic data.[236–238]

Discussion Group Reflections on Addressing Stigma

The Truth and Reconciliation Commission's (TRC) Calls to Action offer a path forward, to address racism experienced by Indigenous peoples in the health system and beyond. Discussion Group participants shared examples of a local and provincial initiative aiming to respond to the 94 Calls to Action:

Following the release of the TRC's Calls to Action, Saskatoon Health Region (now part of the Saskatchewan Health Authority) developed a framework for action and accountability across the health system. This framework refers to the Calls to Action numbers 18–24 surrounding health. For instance, Call to Action number 23 asks all levels of government to increase the number of First Nations, Inuit, and Métis professionals working in the healthcare field, ensure the retention of First Nations, Inuit, and Métis healthcare providers in Indigenous communities, and provide cultural competency training for all healthcare professionals. The TRC Engagement Framework outlines action at multiple levels where staff can respond to the Calls to Action in ways that "draw connections between everyday work as practitioners and systemic change in our community and beyond."[228] This framework offers opportunities and examples on actions that empower staff to respond to the Calls to Action within the health system at the partnership, organizational, departmental and practitioner levels.

To respond to Call to Action number 22, regarding inclusion of Elders as a strategy to improve care of Indigenous patients, a primary care clinic in Vancouver's downtown east side engaged Indigenous Elders to provide cultural mentorship to patients through one-on-one sessions, group cultural teaching circles, and land-based ceremony. Of the 37 patients who participated in a follow-up interview, all but one participant described a benefit from their work with Elders.[229]

DISCUSSION GROUP QUOTE

"People just love the Elders being involved in health care with them. Then we also involved the Elders in the community, in advisory committees, in all our meetings. We would bring together quarterly meetings and have everybody's input, about the direction we're going in, so people really felt welcomed, wanted, felt heard, had their voices heard."

EQUIP: A Canadian Health Equity Intervention

One promising Canadian example of a theoretically-informed and empirically-tested health equity intervention that addresses stigma drivers and practices is <ins>EQUIP Health Care</ins>. EQUIP is a multi-level intervention that combines a focus on cultural safety, trauma- and violence-informed care, and harm reduction as key dimensions of Equity-Oriented Health Care (EOHC) that must be contextually tailored to the setting, community and diverse populations served. EQUIP involves staff education and focuses on changing practice, as well as the development and implementation of an organization-wide action plan for change.

In four Canadian primary health clinics, the EQUIP model was associated with an increase in self-reported awareness and confidence related to equity-oriented health care among staff.[209] It was also associated with organizational strategies to address racism at multiple levels, improving the physical space of waiting rooms, and organizational policy and practice changes to support harm reduction.[209] Longitudinal research completed with EQUIP clinic patients suggests that when patients received EOHC, they felt greater comfort and confidence in the care they received and, subsequently, greater confidence in their ability to manage and prevent health problems.[234] This increase in confidence predicted patient-reported improvements in depressive symptoms, PTSD symptoms, chronic pain, and quality of life.[234]

EQUIP is now being tested in three diverse emergency departments and is integrating the concept of Front-line Ownership, in which direct service providers identify priorities and lead changes towards destigmatizing practices and EOHC.

Population-level Interventions

At the population level, interventions address stigma drivers and practices by targeting social norms as well as public policy. Interventions at this level cut across multiple systems, and can powerfully influence stigma within and beyond the health system.

Changing Social Norms

Population-level campaigns challenge stereotypes and prejudice using education and contact models similar to individual- and interpersonal-level interventions. Evaluation activities have generally focused on mass media campaigns targeting mental health stigma, including *Time to Change* (England) and *Beyond Blue* (Australia). There is evidence for small to moderate short-term positive impacts of population-level mass media campaigns to influence stigma, with all research from narrative reviews in the field of mental health.[189, 198] Alongside local initiatives, *Time to Change* targeted the general population through national mass media and social marketing activity, with a focus on education, reducing prejudice and changing behaviour.[189]

There was an improvement in self-reported knowledge, attitudes, and intended behaviour at the population-level, as well as a reduction in discrimination reported by mental health service users.[189, 198, 239] Australia's *Beyond Blue* used population-level mass media activities, among others, to target public knowledge, beliefs, and skills related to mental health.[198] The campaign was associated with positive changes in self-reported public attitudes.[198]

Stigma is also impacted by media representations, which can influence stigma drivers like fear and prejudicial attitudes.[240] In mental health, media-based anti-stigma interventions include media coverage monitoring after national or local anti-stigma initiatives or the release of mental health reporting guidelines, as well as education for journalists or journalism students. There is little research on the effectiveness of these interventions, and findings are mixed, but the most promising approaches include contact-based educational interventions and guidelines developed and shared by authoritative institutions.[240]

Discussion Group Reflections on Addressing Stigma

Participants discussed interventions that promoted empowerment through the arts. For example, documentaries such as "Take Me to the Prom" detail experiences of LGBTQ2+ people going to their high school proms decades after leaving high school.[241] Arts-based interventions can improve representation in the media and have the potential to change social norms.

Rights and Protections for All Canadians

Laws and policies can prevent and provide protections against discriminatory behaviour, while also signalling that stigma and prejudice are unacceptable.[183, 242] In Canada, this includes the *Canada Human Rights Act* and the *Canadian Charter of Rights and Freedoms*. Population-level policy interventions targeting stigma drivers and practices have the greatest potential for widespread impact.[106, 191, 242] This is evident in research exploring the relationship between policies and health inequalities.

An important example in Canada is the extensive research identifying associations between residential school attendance among Indigenous peoples and a wide variety of mental and physical health inequalities for former residential school attendees as well as subsequent generations.[243] Residential schools attempted to erase the language, cultural practices and beliefs of Indigenous children, and many children also experienced physical, sexual, and/or emotional abuse.[243] Residential schooling has been linked to poorer physical health, including increased rates of chronic and infectious diseases, as well as mental distress, depression, substance use, stress, and suicidal behaviour.[243]

Much of the other population-level research on the link between stigmatizing policies and population health outcomes comes from the United States. Jim Crow laws—state and local laws that, until 1964, had legalized racial segregation—have been associated with health inequalities in breast cancer, infant death and premature mortality among Black Americans.[244–246] In another example, passing state-level laws permitting denial of services to same-sex couples was associated with an increase in the proportion of sexual minority adults reporting mental distress.[247] Conversely, laws that extend equal rights are linked to increased well-being. In a longitudinal study of bisexual and lesbian women in Chicago, civil union legislation was associated with lower levels of stigma consciousness, perceived discrimination, and depressive symptoms.[248]

DISCUSSION GROUP QUOTE

« Il faut aller au-delà des systèmes existants. [On a] besoin d'une sensibilisation et … [un] message fort de société...Les autres personnes non-minorité doivent être influencé par la réalité – le prochain combat, c'est celui-là qui faut absolument traiter. »

"It is necessary to go beyond existing systems. [We] need awareness and... [a] strong social message... Other non-minority people must be influenced by reality—the next battle is the one that must be dealt with."

There is limited research evaluating the impact of population-level policy initiatives related to stigma on health inequalities in the Canadian context. However, existing laws, such as the criminalization of HIV non-disclosure and personal drug use, have been identified for their role in furthering stigma.[249–253] Discrimination has also been codified into legislation such as the *Indian Act*. Passed nearly 150 years ago, this law continues to govern and restrict key spheres of life, such as land, identity, self-governance, and economic activity for First Nations.[22, 254–256] This occurs alongside inadequate resources for Indigenous education, housing and health and social services.[22, 116]

There is a recent example of how evidence has informed new policies to reduce stigma. In December 2018, Canada was the first country to sign on to the global U=U (Undectable is Untransmittable) Campaign. This campaign is based on evidence demonstrating that, when an individual is being effectively treated for HIV and maintains a suppressed viral load, there is effectively no risk of sexual transmission. Stigma remains one of the greatest barriers for Canadians in accessing HIV prevention, testing, treatment and support, and this shift has important implications for reducing HIV stigma. In response, Justice Canada announced it would issue a new directive related to the prosecution of HIV non-disclosure, based on the scientific evidence reviewed by the Public Health Agency of Canada.[257]

Principles to Guide Anti-stigma Interventions

Despite an increase in anti-stigma intervention research, it is still difficult to know "what works", in what context, to address stigma and discrimination. This is a common challenge in intervention research. Time and/or resources are often inadequate to rigorously design, implement, and evaluate interventions (see text box). This process is even more complicated for population-level interventions. This has led to an uneven distribution of research across levels and a mismatch between the focus of most

intervention research (individual or interpersonal levels) and the levels where the greatest impact is possible (institutional or population levels).

A better understanding of what works also requires the greater inclusion of diverse voices and ways of knowing. While the responsibility for change rests in the hands of decision-makers and system leaders, it is communities themselves who have a long history of strength and leadership in the face of stigma and discrimination. The foundation of our efforts to address stigma and discrimination comes from the community, including people with lived experience and community-based organizations. Communities experiencing stigma have supported each other to build solidarity and challenge stigma drivers and practices, in order to mitigate the impacts of stigma experiences among individuals, families and communities.[22, 258, 259]

Expanding Our View of Evidence

Colonialism and racism have influenced which knowledge systems are valued and which are not. This has resulted in the dominance of western biomedical knowledge, and devaluation of Indigenous knowledge systems or "ways of knowing".[22] It is important that our collective efforts are informed by Indigenous ways of knowing, as well as the experiential knowledge of people with lived experience of stigma. For this report, this knowledge comes from Indigenous and racialized scholars, as well as our discussion groups.

The Action Framework is a starting point that identifies promising interventions based on our knowledge to date. Our efforts to develop, adapt, implement, and evaluate anti-stigma interventions can create meaningful change now while also advancing this field into the future. Several principles were identified through the evidence review that, alongside key tenets in public health, can provide useful guidance for our next steps.

Core Principles for Developing Anti-stigma Interventions

1. Driven by collaboration between health system leaders and people with lived experience of stigma

2. Designed based on research evidence, diverse ways of knowing, and experiential knowledge

3. Multi-level, with particular attention to multi-level initiatives that prioritize institutional- and/or population-level interventions to address systemic stigma and discrimination in health systems

4. Guided by approaches such as cultural safety and trauma- and violence-informed practice

5. Attends to intersectionality, including the strengths, resources, and solidarity within communities who experience stigma

6. Grounded in principles of intervention research and implementation science, to advance knowledge in the field

FIGURE 10: **What Does a Stigma-free Health System Look Like?[xv]**

xv   These ideas came from two discussion groups. Participants were asked what a stigma-free health system would look like to them.

Way Forward

While stigma is shaped and kept in place by larger social and economic forces, including historical policies and practices, the health system can be a powerful leading sector to support change in Canada. If we use our full capacity at all levels across the health sector, we can influence change on a broader scale.

Those who work in health set out to help others live a healthy life and get quality care if they are sick, so critiquing our health system and examining our personal biases is difficult at both emotional and cognitive levels. However, for us to move forward, we have to acknowledge unacceptable policies and practices that perpetuate power dynamics and withhold resources from those who may need them the most.

To create a more inclusive health system, it takes brave leadership and sustained commitment to change the status quo through multiple actions, at multiple levels. It requires a more proactive approach to address common and distinctive barriers experienced by stigmatized individuals as they try to access health resources.

We each have a role in this.

Health System Leaders

Researchers

Individuals

As **HEALTH SYSTEM LEADERS**, we need to ensure that health policies protect and support people who face stigma, and dismantle policies that discriminate and exclude them from receiving health services.

We can deliver high-quality services to all of our patients and clients in safe, respectful, and welcoming environments. This requires implementation of a range of complimentary actions including:

- cultural safety policies and practices that equip staff to provide sensitive and appropriate programs and services;

- trauma- and violence-informed approaches that ensure health professionals use non-stigmatizing language and understand trauma as a risk to achieving optimal health; and

- support and fund the collaboration and meaningful engagement with people who have living experience of stigma in developing health policies and programs.

Health education institutions and professional associations must work with partners, including stigmatized persons, to guide the transformation of practices, curricula, and professional competencies of health providers to ensure that stigma in our health system is no longer perpetuated.

It is crucial that we **measure and monitor the progress of our actions**. This is a key component of institutional change and necessary if we are going to make a difference. We can systematically stratify our data by groups that are most likely to be stigmatized and critically reflect on the results. Regular monitoring and setting goals and targets for the institution, staff, and patient improvement can lead to lasting, improved health outcomes and quality of care.

As **RESEARCHERS**, understanding health inequities is an important goal of our work. To do this, we must address the fundamental and unacceptable gaps in our national data—we do not have good disaggregated data on the health status of diverse populations or their experiences of stigma. For example, we are not able to consistently report on life expectancy for people who identify as LGBTQ2+, those who are marginally housed, people who use substances, and other diverse populations. We must also facilitate collaborative research across health, social, and behavioural sciences that helps us look at the impact of multiple stigmas. Priority must be placed on strengthening intervention and implementation research so that we can determine what works for those experiencing stigma related to health conditions and social identities.

As **INDIVIDUALS**, we bring our worldviews and personal histories to our work. We have biases and we are vulnerable to the use of stigmatizing language.

What can you do about yours?

1. **Work on your thought processes and challenge your filters.** Stop using dehumanizing language. Biases can be unlearned. Identify and challenge negative stereotypes or myths in the media, and self-monitor your own thoughts.

2. **Bring this awareness to your organization.** Critically examine your organizational culture and make changes to any discriminatory policies or exclusionary practices. Implement the Action Framework described in this report within your organization.

3. **Commit to ongoing learning.** Acknowledging, understanding, and challenging your own biases and systemic stigma is a life-long commitment. Continue to challenge yourself and your organization, and look for ways to improve.

In Canada, we have deep and well-rooted values of respect, diversity, and inclusivity. This positions us to continue strengthening these foundations and promote optimal health for all.

Ending stigma and building an inclusive health system is an important legacy we can leave our future generations.

Chief Public Health Officer's Health Status Dashboard

Dashboard Overview

The dashboard uses a diverse set of health indicators to provide a snapshot of the overall health of Canadians. Indicators are grouped in three broad categories: general health status (Table A), factors influencing health (Table B) and health outcomes (Table C). The dashboard is reviewed annually to ensure that most recent indicator results are included. Previous dashboard version results are used in cases where no updates are available.[260] Indicator results per sex are provided, as available. High-level trend analysis results report positive ("better"), negative ("worse") or neutral ("similar") data trends over time. In a few cases, a trend conclusion may not be available ("N/A") due to data or methodological limitations. International benchmarking results compare Canada relative to similar high-income countries, such as the Organisation for Economic Cooperation and Development (OECD) member average. Possible results are "better" or "worse" than benchmark and "N/A" in the event that no comparable international indicator was identified.

TABLE A: General Health Status

Topic	Indicator	Result	Result by sex		Most current year	Data source	Trend over time (up to 15 years)	International benchmark
Life expectancy at birth	Overall life expectancy in years	82	F 84	M 80	2015–2017	Vital Statistics	Better	Similar[i]
Health adjusted life expectancy (HALE) at birth	Overall HALE in years	70	F 71	M 69	2010–2012	Multiple sources[ii]	Better	Better[iii]
Perceived health	% of population aged 12 years and older reporting "very good" or "excellent" health	61	F 60	M 61	2018	Canadian Community Health Survey	Similar	Better[iv,v]
Perceived mental health	% of population aged 12 years and older reporting "very good" or "excellent" mental health	69	F 66	M 71	2018	Canadian Community Health Survey	Worse	N/A

i   Organization for Economic Cooperation and Development, Health at a Glance 2017.

ii   Statistics Canada, Canadian Vital Statistics, Birth and death databases and population estimates; Canadian Community Health Survey; National Population Health Survey, Health institutions component; Residential Care Facilities Survey; Canadian Health Measures Survey; Census of population.

iii   World Health Organization, World Health Statistics 2018.

iv   Organization for Economic Cooperation and Development, Society at a Glance 2016.

v   Compared to most other countries, Canada had a different set of survey question response categories, creating a positive bias for this estimate.

TABLE B: Factors Influencing Health

Topic	Indicator	Result	Result by sex		Most current year	Data source	Trend over time (up to 15 years)	International benchmark
Social factors								
Community belonging	% of population aged 12 years and older reporting a "somewhat strong" or "very strong" sense of belonging to local community	68	F 70	M 67	2018	Canadian Community Health Survey	Similar	N/A
Poverty (Canada's Official Poverty Line)	% of population living below Canada's official poverty line, based on the Market Basket Measure	10	F 10	M 9	2017	Canadian Income Survey	Better	N/A
Childhood poverty (Canada's Official Poverty Line)	% of children living below Canada's official poverty line, based on the Market Basket Measure	9	F 9	M 9	2017	Canadian Income Survey	Better	N/A
Education	% of population aged 25 years and older without a certificate, diploma or degree	13	F 13	M 14	2018	Labour Force Survey	Better	Better[vi]
Core housing need	% of households in core housing need[vii]	13	N/A		2016	Census	Similar	N/A
Food insecurity	% of households that are food insecure (moderate or severe)[viii]	8	F 10	M 7	2018	Canadian Community Health Survey	Similar	N/A

Continued on next page

---

vi   Organization for Economic Cooperation and Development, Education at a Glance 2018.

vii A household in core housing need is one whose dwelling is considered unsuitable, inadequate or unaffordable and whose income levels are such that they could not afford alternative suitable and adequate housing in their community.

viii Moderately food insecure: indication of compromise in quality and/or quantity of food consumed; severely food insecure: indication of reduced food intake and disrupted eating patterns.

Topic	Indicator	Result	Result by sex		Most current year	Data source	Trend over time (up to 15 years)	International benchmark
Substance Use								
Smoking	% of population aged 15 years and older who report being a current daily or occasional smoker (cigarettes only)	15	F 13	M 17	2017	Canadian Tobacco, Alcohol and Drugs Survey	Similar	Better[i]
Cannabis	% of population aged 15 years and older who report daily or almost daily cannabis use in past 3 months	3	F 3	M 4	2017	Canadian Tobacco, Alcohol and Drugs Survey	Similar[ix]	Worse[x]
Alcohol	% of population aged 12 years and older who report heavy drinking[xi]	19	F 15	M 24	2018	Canadian Community Health Survey	Similar	Similar[i]
Opioids	Rate of apparent opioid-related deaths per 100,000	12	N/A		2018	Opioid surveillance	Worse	N/A
	Rate of hospitalizations due to opioid poisonings per 100,000	17	F 15	M 18	2017	Hospital Morbidity Database	Worse	N/A

Continued on next page

---

ix   Limited number of available data points—interpret with caution.

x   World Health Organization, Cannabis use lifetime.

xi   Heavy drinking: males having five or more drinks, or women having four or more drinks, on one occasion, at least once a month in the past year.

Topic	Indicator	Result	Result by sex		Most current year	Data source	Trend over time (up to 15 years)	International benchmark
Childhood risk and behavioural factors								
Bullying	% of grade 6–10 students who were victims of bully-ing more than once or twice in the past two months	28	F 29	M 27	2018	Health Behaviour in School-aged Children	Similar	Similar[xii]
Physical activity	% of children and youth (aged 5 to 17 years) that accumulate an average of at least 60 min-utes of moderate-to-vigorous physical activity per day	39	F 26	M 52	2016–2017	Canadian Health Measures Survey	Similar	N/A
Sedentary behaviour	% of children and youth (aged 5 to 17 years) who report meeting seden-tary behaviour recommenda-tions[xiii]	54	N/A		2016–2017	Canadian Health Measures Survey	N/A	N/A
Overweight and obesity	% of population aged 5 to 17 years classified as overweight by WHO definition	18	F 21	M 16	2016–2017	Canadian Health Measures Survey	Similar	Similar[i,xiv]
	% of population aged 5 to 17 years classified as obese by WHO definition	11	F 9	M 12	2016–2017	Canadian Health Measures Survey	Similar	Similar[i, xiv]
Child abuse	% of population aged 15 years and over who experienced any of three types of child abuse[xv] before age 15	34	F 32	M 37	2014	General Social Survey	N/A	N/A

Continued on next page

xii   Organization for Economic Cooperation and Development, PISA 2015 Results (Volume III).

xiii   Sedentary behaviour recommendations: spending two hours or less per day watching television or using a computer during leisure time.

xiv   The indicator used combined children who are overweight and obese.

xv   Types of child abuse considered are physical abuse, sexual abuse and/or witnessing violence by a parent or guardian against another adult.

Topic	Indicator	Result	Result by sex		Most current year	Data source	Trend over time (up to 15 years)	International benchmark
Early childhood protective factors								
Early development index	% of children vulnerable in one of five areas of development[xvi] prior to entering grade 1	26	F 20	M 34	Pool of various years	Offord Centre for Child Studies, McMaster University	N/A	N/A
Immunization	% of 2-year-old population that has received one dose of measles vaccine	90	F 92	M 89	2017	Childhood National Immunization Coverage Survey	Similar	Worse[xvii]
	% of 2-year-old population that has received the recommended 4 doses for diptheria, pertussis and tetanus	76	F 78	M 74	2017	Childhood National Immunization Coverage Survey	Similar	Worse[xvii]
	% of 2-year-old population that has received three doses of polio vaccine	91	F 91	M 90	2017	Childhood National Immunization Coverage Survey	Similar	N/A
	% of 2-year-old population that has received one dose of varicella (chickenpox) vaccine	83	F 84	M 82	2017	Childhood National Immunization Coverage Survey	Similar[xviii]	N/A

Continued on next page

---

xvi   The five areas of development are Physical Health and Well-Being; Social Competence; Emotional Maturity; Language and Cognitive Development; and, Communication Skills and General Knowledge.

xvii Organization for Economic Cooperation and Development, OECD Family Database.

xviii Interpret with caution due to data quality concern.

Topic	Indicator	Result	Result by sex	Most current year	Data source	Trend over time (up to 15 years)	International benchmark
Maternal and infant health factors							
Low birthweight	Birth-weight less than 2,500 grams (% of live births)	7	F 7 M 6	2017	Vital Statistics	Similar	Similar[i]
Breastfeeding	% of female population aged 15 to 55 years who had a baby in last 5 years that report exclusively breastfeeding for at least 6 months, without additional liquid/water or solid food	37	N/A	2018	Canadian Community Health Survey	Similar	Similar[i]

TABLE C: Health Outcomes

Topic	Indicator	Result	Result by sex		Most current year	Data source	Trend over time (up to 15 years)	International benchmark
Chronic diseases and injuries								
Cancer	Incidence rate of all newly diagnosed cancers, per 100,000 (all ages)	516	F 496	M 548	2017	Canadian Cancer Registry	N/A	Similar[i]
	Incidence rate of all newly diagnosed colo-rectal cancers, per 100,000 (all ages)	66	F 55	M 80	2017	Canadian Cancer Registry	Similar	N/A
Cardiovascular disease	Incidence rate of all newly diagnosed cases of ischemic heart disease, per 100,000 (age 20 years and older)	599	F 489	M 716	2016	Canadian Chronic Disease Indicators	Better	Better[i]
Diabetes	Incidence rate of all newly diagnosed cases of diabetes, per 100,000 (age 1 year and older)	604	F 541	M 668	2016	Canadian Chronic Disease Indicators	Better	Similar[i]
Mood disorders	% of population aged 12 and over who reported that they have been diagnosed by a health professional as having a mood disorder[xix]	9	F 11	M 7	2018	Canadian Community Health Survey	Worse	N/A

Continued on next page

xix   Mood disorder includes depression, bipolar disorder, mania or dysthymia.

Topic	Indicator	Result	Result by sex		Most current year	Data source	Trend over time (up to 15 years)	International benchmark
Chronic diseases and injuries								
Dementia (including Alzheimer's disease)	Rate of newly diagnosed dementia cases, including Alzheimer's disease, per 100,000 (age 65 years and older)	1351	F 1489	M 1193	2016	Canadian Chronic Disease Indicators	Better	Similar[i]
Suicide	Suicide mortality rate per 100,000	11	F 6	M 17	2017	Mortality Database	Similar	Similar[i]
Unintentional injuries	Rate of hos-pitalizations due to unintentional injuries per 100,000 (age-standardized)	599	F 550	M 636	2017–2018	Canadian Institute for Health Information Health Indicators	Better	N/A
Communicable diseases								
Tuberculosis	Incidence rate of active tuberculosis disease cases per 100,000	5	F 4	M 6	2017	Canadian Tuberculosis Reporting System	Similar	Better[xx]
Hepatitis C	Rate of reported Hepatitis C disease cases per 100,000	32	F 24	M 39	2017	Notifiable Diseases Surveillance	Similar	Better[xxi]
HIV	Incidence rate of HIV diagnosis per 100,000	7	F 3	M 10	2017	Notifiable Diseases Surveillance	Similar	N/A

xx   World Health Organization. (2018). Global Tuberculosis Report.
xxi   World Health Organization. (2017). Global Hepatitis Report.

Acknowledgements

References

1. Hatzenbuehler, M. L., Phelan, J. C. & Link, B. G. Stigma as a fundamental cause of population health inequalities. *Am. J. Public Health* 103, 813-821 (2013).

2. Statistics Canada. Changes in life expectancy by selected causes of death, 2017. (2019).

3. Public Health Agency of Canada. Key Health Inequalities in Canada: A National Portrait. (2018).

4. Public Health Agency of Canada. Pan-Canadian Health Inequalities Data Tool, 2017 Edition.

5. Kirmayer, L. J. & Valaskakis, G. G. Healing traditions: The mental health of Aboriginal peoples in Canada. (2009).

6. Hamm, N. C. *et al.* Trends in chronic disease incidence rates from the Canadian Chronic Disease Surveillance System. *Health promotion and chronic disease prevention in Canada: research, policy and practice* 39, 216-224 (2019).

7. Centre for Surveillance and Applied Research, Public Health Agency of Canada. Canadian Chronic Disease Indicators, 2018 Edition. (2018).

8. Public Health Agency of Canada. Unpublished data.

9. Public Health Agency of Canada. Dementia in Canada, including Alzheimer's disease: Highlights from the Canadian Chronic Disease Surveillance System. (2017).

10. Public Health Agency of Canada. Canadian Chronic Disease Indicators, Quick Stats, 2018 Edition. (2018).

11. Livingston, G. *et al*. Dementia prevention, intervention, and care. *The Lancet* 390, 2673-2734 (2017).

12. Petrasek MacDonald, J., Ward, V. & Halseth, R. Alzheimer's disease and related dementias in Indigenous populations in Canada: Prevalence and risk factors. (2018).

13. Statistics Canada. Table 13-10-0096-01 Health characteristics, annual estimates.

14. Statistics Canada. Table 13-10-0392-01 Deaths and age-specific mortality rates, by selected grouped causes.

15. Statistics Canada. Suicide among First Nations people, Métis and Inuit (2011–2016): Findings from the 2011 Canadian Census Health and Environment Cohort (CanCHEC). (2019).

16. Health Canada. First Nations Mental Wellness Continuum Framework: Summary Report. (2015).

17. Greenwood, M., de Leeuw, S., Lindsay, N. M. & Reading, C. Determinants of Indigenous Peoples' Health in Canada: Beyond the Social. *Canadian Scholars' Press Inc.* (2015).

18. Special Advisory Committee on the Epidemic of Opioid Overdoses. National Report: Apparent opioid-related deaths in Canada (January 2016 to December 2018). Public Health Agency of Canada. (2019).

19. Special Advisory Committee on the Epidemic of Opioid Overdoses. National Report: Apparent opioid-related deaths in Canada (January 2016 to March 2019). Public Health Agency of Canada. (2019).

20. Russell, C., Firestone, M., Kelly, L., Mushquash, C. & Fischer, B. Prescription opioid prescribing, use/misuse, harms and treatment among Aboriginal people in Canada: a narrative review of available data and indicators. *Rural and Remote Health* 16, 3974 (2016).

21. First Nations Health Authority. First Nations Opioid Overdose Deaths Rise in 2018. (2019).

22. Allan, B. & Smylie, J. First Peoples, Second Class Treatment: The role of racism in the health and well-being of Indigenous peoples in Canada. *The Wellesley Institute* (2015).

23. Health Canada. Canadian Tobacco, Alcohol and Drugs Survey (CTADS): summary of results for 2017. (2019).

24. Health Canada. Consider the Consequences of Vaping. (2019).

25. McConnell, R. *et al.* Electronic Cigarette Use and Respiratory Symptoms in Adolescents. *Am J Respir Crit Care Med* 195, 1043-1049 (2017).

26. Chun, L. F., Moazed, F., Calfee, C. S., Matthay, M. A. & Gotts, J. E. Pulmonary toxicity of e-cigarettes. *Am J Physiol Lung Cell Mol Physiol* 313, L193–L206 (2017).

27. Soneji, S. *et al*. Association Between Initial Use of e-Cigarettes and Subsequent Cigarette Smoking Among Adolescents and Young Adults: A Systematic Review and Meta-analysis. *JAMA pediatrics* 171, 788-797 (2017).

28. Hammond, D. *et al*. Prevalence of vaping and smoking among adolescents in Canada, England, and the United States: repeat national cross sectional surveys. *BMJ* 365, l2219 (2019).

29. *Cannabis Act.* S.C. 2018, c. 16, (2018).

30. Statistics Canada. Cannabis Stats Hub. (2018).

31. Leos-Toro, C., Rynard, V., Murnaghan, D., MacDonald, J. & Hammond, D. Trends in cannabis use over time among Canadian youth: 2004–2014. *Preventative Medicine* 118, 30-37 (2019).

32. Zuckermann, A., Battista, K., de Groh, M., Jiang, Y. & Leatherdale, S. T. Prelegalisation patterns and trends of cannabis use among Canadian youth: results from the COMPASS prospective cohort study. *BMJ Open* 9, e026515 (2019).

33. Statistics Canada. National Cannabis Survey, fourth quarter 2018. (2019).

34. Asbridge, M., Hayden, J. A. & Cartwright, J. L. Acute cannabis consumption and motor vehicle collision risk: systematic review of observational studies and meta-analysis. *BMJ* 344, e536 (2012).

35. Statistics Canada. National Cannabis Survey, second quarter 2018. (2018).

36. Statistics Canada. Heavy drinking, 2018. (2019).

37. The Canadian Institute for Health Information. Alcohol harm on the rise for Canadian women. (2018).

38. Public Health Agency of Canada. Accelerating our response: Government of Canada five-year action plan on sexually transmitted and blood-borne infections. (2019).

39. Choudhri, Y., Miller, J., Sandhu, J., Leon, A. & Aho, J. Infectious and congenital syphilis in Canada, 2010–2015. *Canada Communicable Disease Report* 44, 43-47 (2018).

40. Public Health Agency of Canada. Report on sexually transmitted infections in Canada: 2013–2014. (2017).

41. Public Health Agency of Canada. Summary: Estimates of HIV Incidence, Prevalence, and Canada's Progress on Meeting the 90-90-90 HIV Targets, 2016. (2018).

42. Public Health Agency of Canada. Report on Hepatitis B and C in Canada: 2016. (2019).

43. Trubnikov, M., Yan, P. & Archibald, C. Estimated prevalence of Hepatitis C Virus infection in Canada, 2011. *CCDR* 40, 429-436 (2014).

44. Health Canada. Vaccination Coverage Goals and Vaccine Preventable Disease Reduction Targets by 2025. (2019).

45. Health Canada. Measles: For Health Professionals. (2019).

46. Public Health Agency of Canada. Preliminary results from the 2017 childhood National Immunization Coverage Survey (cNICS). (2019).

47. Public Health Agency of Canada. Measles and Rubella Weekly Monitoring Reports. (2013–2019).

48. Public Health Agency of Canada. Measles & Rubella Weekly Monitoring Report – Week 52: December 23 to December 29, 2018. (2019).

49. Public Health Agency of Canada. Measles surveillance in Canada: 2017. (2019).

50. Public Health Agency of Canada. Measles surveillance in Canada: 2016. (2017).

51. Public Health Agency of Canada. Vaccine Preventable Disease: Surveillance Report to December 31, 2015. (2017).

52. World Health Organization. Ten threats to global health in 2019. (2019).

53. Tam, T. Handle with Care: Preserving Antibiotics Now and Into the Future – Chief Public Health Officer of Canada's 2019 Spotlight Report. (2019).

54. O'Neill, J. Antimicrobial Resistance: Tackling a crisis for the health and wealth of nations – The Review on Antimicrobial Resistance. (2014).

55. Public Health Agency of Canada. Canadian Antimicrobial Resistance Surveillance System. (2018).

56. Public Health Agency of Canada. Healthcare-Associated Infections and Antimicrobial Resistance. *CCDR* 44, 271-308 (2018).

57. Public Health Agency of Canada. Pan-Canadian framework for action on antimicrobial resistance. *Can Commun Dis Rep* 43, 217-9 (2017).

58. Public Health Agency of Canada. Canadian Antimicrobial Resistance Surveillance System 2017 Report. (2017).

59. Public Health Agency of Canada. Tackling Antimicrobial Resistance and Antimicrobial Use: A Pan-Canadian Framework for Action. (2017).

60. Lowe, C. F. *et al*. Antimicrobial stewardship for hospitalized patients with viral respiratory tract infections. *Am J Infect Control* 45, 872-875 (2017).

61. Silverman, M. *et al.* Antibiotic Prescribing for Nonbacterial Acute Upper Respiratory Infections in Elderly Persons Antibiotic Prescribing for Nonbacterial AURIs in Elderly Persons. *AIM* 166, 765-774 (2017).

62. Centers for Disease Control and Prevention. CDC: 1 in 3 antibiotic prescriptions unnecessary. (2016).

63. Bush, E. and Lemmen, D.S., (eds). Canada's Changing Climate Report. (Government of Canada, Ottawa, ON) (2019).

64. Berry, P., Clarke, K., Fleury, M. D. & Parker, S. *Human Health in Canada in a Changing Climate: Sector Perspectives on Impacts and Adaptations* (eds Warren, F. J. & Lemmen, D. S.) 191-232 (Government of Canada, Ottawa, ON, 2014).

65. Environment and Climate Change Canada. Working Group on Adaptation and Climate Resilience: Final Report.

66. Council of Canadian Academies. Canada's Top Climate Change Risks. (2019).

67. Howard, C. *et al.* Lancet Countdown 2018 Report: Briefing for Canadian Policymakers. (2018).

68. Cunsolo Willox, A. *et al*. "From this place and of this place:" Climate change, sense of place, and health in Nunatsiavut, Canada. *Soc. Sci. Med.* 75, 538-547 (2012).

69. Bouchard, C. *et al*. Increased risk of tick-borne diseases with climate and environmental changes. *Can Commun Dis Rep* 45, 83-89 (2019).

70. Public Health Agency of Canada. Surveillance of Lyme disease. (2018).

71. Smith, B. A. & Fazil, A. How will climate change impact microbial foodborne disease in Canada? *Can Commun Dis Rep* 45, 108-113 (2019).

72. Ludwig, A. *et al*. Increased risk of endemic mosquito-borne diseases in Canada due to climate change. *Can Commun Dis Rep* 45, 91-97 (2019).

73. Orpana, H., Vachon, J., Dykxhoorn, J., McRae, L. & Jayaraman, G. Monitoring positive mental health and its determinants in Canada: the development of the Positive Mental Health Surveillance Indicator Framework. *HPCDP* 36 (2016).

74. First Nations Information Governance Centre. National Report of the First Nations Regional Health Survey Phase 3: Volume Two. (2018).

75. Statistics Canada. Table 14-10-0118-01 Labour force characteristics by educational degree, annual. (2019).

76. Statistics Canada. Table 11-10-0135-01 Low income statistics by age, sex and economic family type.

77. Beedie, N., Macdonald, D. & Wilson, D. Towards Justice: Tackling Indigenous Child Poverty in Canada. (2019).

78. Clair, M. in *Core Concepts Stigma in Sociology* (ed Ryan, J. M.) 318-322 (John Wiley & Sons Ltd., 2019).

79. Pachankis, J. E. *et al*. The Burden of Stigma on Health and Well-Being: A Taxonomy of Concealment, Course, Disruptiveness, Aesthetics, Origin, and Peril Across 93 Stigmas. *Pers. Soc. Psychol. Bull.* 44, 451-474 (2018).

80. Phelan, J. C., Link, B. G. & Dovidio, J. F. Stigma and prejudice: one animal or two? *Soc. Sci. Med.* 67, 358-367 (2008).

81. Link, B. G. & Phelan, J. C. Conceptualizing Stigma. *Annu. Rev. Sociol.* 27, 363-385 (2001).

82. Hatzenbuehler, M. L., Phelan, J. C. & Link, B. G. Stigma as a fundamental cause of population health inequalities. *Am. J. Public Health* 103, 813-821 (2013).

83. Godley, J. Everyday Discrimination in Canada: Prevalence and Patterns. *Canadian Journal of Sociology* 43, 111-142 (2018).

84. Siddiqi, A., Shahidi, F. V., Ramraj, C. & Williams, D. R. Associations between race, discrimination and risk for chronic disease in a population-based sample from Canada. *Soc. Sci. Med.* 194, 135-141 (2017).

85. Statistics Canada. Infographic: Police-reported hate crime in Canada, 2017. (2018).

86. Veale J. *et al*. Being Safe, Being Me: Results of the Canadian Trans Youth Health Survey. (2015).

87. Centre for Chronic Disease Prevention, Public Health Agency of Canada. Positive Mental Health Surveillance Indicator Framework: Quick Statistics, adults (18 years of age and older), Canada, 2016 Edition. (2016).

88. Burczycka, M. Violent victimization of Canadians with mental health-related disabilities, 2014. (2018).

89. McQuaid, R. J. *et al*. Life in Recovery from Addiction in Canada. (2017).

90. Elias, A. & Paradies, Y. Estimating the mental health costs of racial discrimination. *BMC Public Health* 16, 1205 (2016).

91. van Brakel, W. H. *et al*. Out of the silos: identifying cross-cutting features of health-related stigma to advance measurement and intervention. *BMC Medicine* 17, 13 (2019).

92. Brent, R. J. The value of reducing HIV stigma. *Soc. Sci. Med.* 151, 233-240 (2016).

93. Monette, L. E. *et al*. Inequalities in determinants of health among Aboriginal and Caucasian persons living with HIV/AIDS in Ontario: results from the Positive Spaces, Healthy Places Study. *Can. J. Public Health* 102, 215-219 (2011).

94. Mallory, C., Sears, B., Wright, E. & Conron, K. The Economic Impact of Stigma and Discrimination against LGBT People in Georgia. *The Williams Institute*, 1-69 (2017).

95. Evans-Lacko, S. *et al*. How much does mental health discrimination cost: Valuing experienced discrimination in relation to healthcare care costs and community participation. *Epidemiology and Psychiatric Sciences* 24, 423-434 (2014).

96. Kulesza, M., Larimer, M. E. & Rao, D. Substance Use Related Stigma: What we Know and the Way Forward. *Journal of addictive behaviours, therapy & rehabilitation* 2, 782 (2013).

97. Stepanikova, I. & Oates, G. R. Perceived Discrimination and Privilege in Health Care: The Role of Socioeconomic Status and Race. *Am. J. Prev. Med.* 52, S86-S94 (2017).

98. Romeo, R., McCrone, P. & Thornicroft, G. The Economic Impact of Mental Health Stigma. *Mental Health Economics*, 401-414 (2017).

99. Dewa, C. & Hoch, J. When Could a Stigma Program to Address Mental Illness in the Workplace Break Even? *Canadian Journal of Psychiatry* 59, 34-39 (2014).

100. Stangl, A. L. *et al*. The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. *BMC Medicine* 17, 31 (2019).

101. Turan, J. M. *et al*. Challenges and opportunities in examining and addressing intersectional stigma and health. *BMC Med.* 17, 7-018-1246-9 (2019).

102. Major, B., Dovidio, J. F., Link, B. G. & Calabrese, S. K. Stigma and Its Implications for Health: Introduction and Overview in *The Oxford Handbook of Stigma, Discrimination and Health* (eds Major, B., Dovidio, J. F. & Link, B. G.) (Oxford University Press, 2018).

103. Grollman, E. A. Multiple disadvantaged statuses and health: the role of multiple forms of discrimination. *Journal of Health & Social Behavior* 55, 3-19 (2014).

104. Bauer, G. R. Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity. *Soc. Sci. Med.* 110, 10-17 (2014).

105. Kelly, J. & Westerhoff, C. Does it matter how we refer to individuals with sub-stance-related conditions? A randomized study of two com-monly used terms. *Int. J. Drug Policy* 21, 202-207 (2010).

106. White Hughto, J. M., Reisner, S. L. & Pachankis, J. E. Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. *Soc. Sci. Med.* 147, 222-231 (2015).

107. Yang, L. H., Wong, L. Y., Grivel, M. M. & Hasin, D. S. Stigma and substance use disorders: an international phenomenon. *Current Opinion in Psychiatry* 30, 378-388 (2017).

108. Knaak, S., Mantler, E. & Szeto, A. Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthcare management forum* 30, 111-116 (2017).

109. Bailey, Z. D. *et al*. Structural racism and health inequities in the USA: evidence and interventions. *Lancet* 389, 1453-1463 (2017).

110. Nelson, S. E. & Wilson, K. Understanding barriers to health care access through cultural safety and ethical space: Indigenous people's experiences in Prince George, Canada. *Soc. Sci. Med.* 218, 21-27 (2018).

111. Wylie, L. & McConkey, S. Insiders' Insight: Discrimination against Indigenous Peoples through the Eyes of Health Care Professionals. *J. Racial Ethn. Health. Disparities* 6, 37-45 (2019).

112. Alencar Albuquerque, G. *et al*. Access to health services by lesbian, gay, bisex-ual, and transgender persons: systematic literature review. *BMC International Health & Human Rights* 16, 2 (2016).

113. Nyblade, L. *et al*. Stigma in health facilities: why it matters and how we can change it. *BMC Medicine* 17, 25 (2019).

114. James, C. *et al*. *Race & Well-being: The Lives, Hopes, and Activism of African Canadians* (Brunswick Books, 2010).

115. Staats, C. Understanding Implicit Bias: What Educators Should Know. *American Educator* 39, 29-33 (2016).

116. Loppie, S., Reading, C. & de Leeuw, S. Aboriginal Experiences with Racism and its Impacts. *National Collaborating Centre for Aboriginal Health* (2014).

117. Palad, C. J., Yarlagadda, S. & Stanford, F. C. Weight stigma and its impact on paedi-atric care. *Current Opinion in Endocrinology, Diabetes & Obesity* 26, 19-24 (2019).

118. Inuit Tapiriit Kanatami. Social Determinants of Inuit Health in Canada. *Inuit Tapiriit Kanatami* (2014).

119. Reading, C. L. & Wien, F. Health Inequalities and Social Determinants of Aboriginal Peoples' Health. *National Collaborating Centre for Aboriginal Health* (2009).

120. Paradies, Y., Bastos, J. L. & Priest, N. *Prejudice, Stigma, Bias, Discrimination, and Health in The Cambridge Handbook of the Psychology of Prejudice* 559-581 (Cambridge University Press, 2016).

121. Alberga, A. S., McLaren, L., Russell-Mayhew, S. & Von Ranson, K. M. Canadian Senate Report on Obesity: Focusing on Individual Behaviours versus Social Determinants of Health May Promote Weight Stigma. *Journal of Obesity 2018* (2018).

122. Bombay, A., Matheson, K. A. & Anisman, H. Intergenerational Trauma: Convergence of Multiple Processes among First Nations peoples in Canada. *Journal of Aboriginal Health* 5, 6-47 (2009).

123. Feagin, J. & Bennefield, Z. Systemic racism and U.S. health care. *Soc. Sci. Med.* 103, 7-14 (2014).

124. National Inquiry into Missing and Murdered Indigenous Women and Girls. Reclaiming Power and Place: The Final Report of the National Inquiry Into Missing and Murdered Indigenous Women and Girls. (2019).

125. Courtwright, A. & Turner, A. N. Tuberculosis and stigmatization: pathways and interventions. *Public Health Rep. 125 Suppl* 4, 34-42 (2010).

126. Mahajan, A. P. *et al*. Stigma in the HIV/AIDS epidemic: a review of the literature and recommendations for the way forward. *AIDS* 22, S67-S79 (2008).

127. Macpherson, D. W., Gushulak, B. D. & Macdonald, L. Health and foreign policy: influences of migration and population mobility. *Bull. World Health Organ.* 85, 200-206 (2007).

128. Schabas, R. Is the Quarantine Act relevant? *CMAJ : Canadian Medical Association journal = journal de l'Association medicale canadienne* 176, 1840-1842 (2007).

129. Craig, G. M., Daftary, A., Engel, N., O'Driscoll, S. & Ioannaki, A. Tuberculosis stigma as a social determinant of health: a systematic mapping review of research in low incidence countries. *Int. J. Infect. Dis.* 56, 90-100 (2017).

130. Daftary, A., Frick, M., Venkatesan, N. & Pai, M. Fighting TB stigma: we need to apply lessons learnt from HIV activism. *BMJ Glob. Health.* 2, e000515-2017-000515. (2017).

131. Donnelly, L. R. *et al*. Stigma Experiences in Marginalized People Living With HIV Seeking Health Services and Resources in Canada. *Journal of the Association of Nurses in AIDS Care* 27, 768-783 (2016).

132. Jackson-Best, F. & Edwards, N. Stigma and intersectionality: a systematic review of systematic reviews across HIV/AIDS, mental illness, and physical disability. *BMC Public Health* 18, 919 (2018).

133. Boksa, P., Joober, R. & Kirmayer, L. J. Mental wellness in Canada's Aboriginal communities: striving toward reconciliation. *Journal of psychiatry & neuroscience: JPN* 40, 363-365 (2015).

134. Lyons, T. *et al*. A qualitative study of transgender individuals' experiences in residential addiction treatment settings: stigma and inclusivity. *Substance Abuse Treatment, Prevention, & Policy* 10, 17 (2015).

135. Henderson, C. *et al*. Mental health-related stigma in health care and mental health-care settings. *The Lancet Psychiatry* 1, 467-482 (2014).

136. Stockton, M. A., Giger, K. & Nyblade, L. A scoping review of the role of HIV-related stigma and discrimination in noncommunicable disease care. *PloS one* 13, e0199602 (2018).

137. Reisner, S. L. *et al*. Substance Use to Cope with Stigma in Healthcare Among U.S. Female-to-Male Trans Masculine Adults. *Lgbt Health* 2, 324-332 (2015).

138. Lyons, T. *et al*. Experiences of Trans Women and Two-Spirit Persons Accessing Women-Specific Health and Housing Services in a Downtown Neighborhood of Vancouver, Canada. *Lgbt Health* 3, 373-378 (2016).

139. Geter, A., Herron, A. R. & Sutton, M. Y. HIV-Related Stigma by Healthcare Providers in the United States: A Systematic Review. *AIDS Patient Care & Stds* 32, 418-424 (2018).

140. Kennedy-Hendricks, A. *et al*. Social Stigma Toward Persons With Prescription Opioid Use Disorder: Associations With Public Support for Punitive and Public Health-Oriented Policies. *Psychiatric Services* 68, 462-469 (2017).

141. Argento, E., Goldenberg, S. & Shannon, K. Preventing sexually transmitted and blood borne infections (STBBIs) among sex workers: a critical review of the evidence on determinants and interventions in high-income countries. *BMC infectious diseases* 19, 212 (2019).

142. Monteiro, S. S., Villela, W. V. & Soares, P. S. The interaction between axes of inequality in studies on discrimination, stigma and HIV/AIDS: contributions to the recent international literature. *Global public health* 8, 519-33 (2013).

143. Goldman, M., W-Y Shih, A., O'Brien, S. F. & Devine, D. Donor deferral policies for men who have sex with men: past, present and future. *Vox Sang.* 113, 95-103 (2018).

144. Paradies, Y., Bastos, J. L. & Priest, N. Prejudice, Stigma, Bias, Discrimination, and Health in *The Cambridge Handbook of the Psychology of Prejudice* (eds Sibley, C. G. & Barlow, F. K.) 559-581 (Cambridge University Press, Cambridge, 2016).

145. Ylioja, T. & Craig, S. L. Exclusionary health policy: responding to the risk of poor health among sexual minority youth in Canada. *Social Work in Public Health* 29, 81-86 (2014).

146. Williams, D. R., Lawrence, J. A. & Davis, B. A. Racism and Health: Evidence and Needed Research. *Annu. Rev. Public Health* 40, 105-125 (2019).

147. Storla, D. G., Yimer, S. & Bjune, G. A. A systematic review of delay in the diagnosis and treatment of tuberculosis. *BMC Public Health* 8, 15 (2008).

148. Katz, I. T. *et al*. Impact of HIV-related stigma on treatment adherence: systematic review and meta-synthesis. *Journal of the International AIDS Society* 16, 18640-18640 (2013).

149. Gee, G. C. & Ford, C. L. Strcutural Racism and Health Inequities. *Du Bois Rev.* 8, 115-132 (2011).

150. Saewyc, E. *et al*. Hazards of stigma: the sexual and physical abuse of gay, lesbian, and bisexual adolescents in the U.S. and Canada. *Child Welfare* 85, 195-213 (2006).

151. Shannon, C.,A., Rospenda, K.,M., Richman, J.,A. & Minich, L.,M. Race, Racial Discrimination, and the Risk of Work-Related Illness, Injury or Assault: Findings from a National Study. *J Occup Environ Med* 51, 441-448 (2009).

152. Meyer, I. H. Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychol. Bull. 12*9, 674-697 (2003).

153. Shepherd, C. C. J., Li, J., Cooper, M. N., Hopkins, K. D. & Farrant, B. M. The impact of racial discrimination on the health of Australian Indigenous children aged 5–10 years: analysis of national longitudinal data. *International Journal for Equity in Health* 16, 116 (2017).

154. McEwen, B. S. Stress, Adaptation, and Disease: Allostasis and Allostatic Load. *Ann. N. Y. Acad. Sci.* 840, 33-44 (1998).

155. Paradies, Y. *et al.* Racism as a determinant of health: a protocol for conducting a systematic review and meta-analysis. *Systematic Reviews* 2, 85 (2013).

156. Berger, M. & Sarnyai, Z. "More than skin deep": stress neurobiology and mental health consequences of racial discrimination. *Stress* 18, 1–10 (2015).

157. Pascoe, E. A. & Smart Richman, L. Perceived discrimination and health: a meta-analytic review. *Psychol. Bull.* 135, 531-554 (2009).

158. Paine, S., Harris, R., Cormack, D. & Stanley, J. Racial Discrimination and Ethnic Disparities in Sleep Disturbance: the 2002/03 New Zealand Health Survey. *Sleep* 39, 477-485 (2016).

159. Krieger, N. Discrimination and health inequities. *Int. J. Health Serv.* 44, 643-710 (2014).

160. Rueda, S. *et al*. Examining the associations between HIV-related stigma and health outcomes in people living with HIV/AIDS: a series of meta-analyses. *BMJ Open* 6, e011453 (2016).

161. McCann, E. & Brown, M. Homelessness among youth who identify as LGBTQ+: A systematic review. *J Clin Nurs* 28, 2061-2072 (2019).

162. Lukachko, A., Hatzenbuehler, M. L. & Keyes, K. M. Structural racism and myocardial infarction in the United States. *Soc. Sci. Med.* 103, 42-50 (2014).

163. Brondolo, E., Love, E. E., Pencille, M., Schoenthaler, A. & Ogedegbe, G. Racism and Hypertension: A Review of the Empirical Evidence and Implications for Clinical Practice. *Am J Hypertens* 24, 518-529 (2011).

164. Prather, C. *et al.* Racism, African American Women, and Their Sexual and Reproductive Health: A Review of Historical and Contemporary Evidence and Implications for Health Equity. *Health Equity* 2, 249-259 (2018).

165. Thoits, P. Resisting the Stigma of Mental illness. *Social psychology quarterly* 74, 6-28 (2011).

166. Shih, M. Positive Stigma: Examining Resilience and Empowerment in Overcoming Stigma. *Annals of the American Academy* 591, 175-185 (2004).

167. Poindexter, C. C. & Shippy, R. A. HIV diagnosis disclosure: stigma management and stigma resistance. *J. Gerontol. Soc. Work.* 53*,* 366-381 (2010).

168. Veenstra, G. & Patterson, A. C. Black-White Health Inequalities in Canada. *J. Immigr Minor. Health.* 18, 51-57 (2016).

169. Veenstra, G. Black, White, Black and White: mixed race and health in Canada. *Ethn. Health* 24, 113-124 (2019).

170. Keyes, C. L. M. The Black-White Paradox in Health: Flourishing in the Face of Social Inequality and Discrimination. *Journal of Personality* 77, 1677-1705 (2009).

171. Chandler, M. J. & Lalonde, C. E. in *Healing traditions: The mental health of Aboriginal peoples in Canada* (eds Kirmayer, L. & Valaskakis, G.) 221-248 (University of British Columbia Press, 2008).

172. Rennick-Egglestone, S. & *et al*. Mental Health Recovery Narratives and Their Impact on Recipients: Systematic Review and Narrative Synthesis. *The Canadian Journal of Psychiatry* (2019).

173. Auger, M., Howell, T. & Gomes, T. Moving toward holistic wellness, empowerment and self-determination for Indigenous peoples in Canada: Can traditional Indigenous health care practices increase ownership over health and health care decisions? *Can. J. Public Health* 107, e393-e398 (2016).

174. Tu, D. *et al*. Partnering with Indigenous elders in primary care improves mental health outcomes of inner-city. *Canadian Family Physician/Le Médecin de Famille Canadien* 65, 274-281 (2019).

175. Chambers, L. A. *et al*. Stigma, HIV and health: a qualitative synthesis. *BMC Public Health* 15, 848-848 (2015).

176. Epstein, S. *Impure Science: AIDS, Activism, and the Politics of Knowledge* 480 (University of California Press, Berkeley, 1998).

177. Parsons, A., Reichl, A. & Pedersen, C. Gendered Ableism: Media Representations and Gender Role Beliefs' Effect on Perceptions of Disability and Sexuality. *Sexuality and Disability* 35, 207-225 (2017).

178. Dyck, E. Dismantling the asylum and charting new pathways into the community: mental health care in twentieth century Canada. *Histoire Soc.* 44, 181-196 (2011).

179. Sealy, P. A. The impact of the process of deinstitutionalization of mental health services in Canada: an increase in accessing of health professionals for mental health concerns. *Soc. Work. Public. Health.* 27, 229-237 (2012).

180. Rudzinski, K., McDonough, P., Gartner, R. & Strike, C. Is there room for resilience? A scoping review and critique of substance use literature and its utilization of the concept of resilience. *Subst. Abuse Treat. Prev. Policy.* 12, 41 (2017).

181. Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. (2008).

182. Cook, J. E., Purdie-Vaughns, V., Meyer, I. H. & Busch, J. T. A. Intervening within and across levels: A multilevel approach to stigma and public health. *Soc. Sci. Med.* 103, 101-109 (2014).

183. Cummings, J. R., Lucas, S. M. & Druss, B. G. Addressing public stigma and disparities among persons with mental illness: the role of federal policy. *Am. J. Public Health* 103, 781-785 (2013).

184. Earnshaw, V. A. *et al.* Stigma-Based Bullying Interventions: A Systematic Review. *Developmental review: DR* 48, 178-200 (2018).

185. Hatzenbuehler, M. L. Structural stigma: Research evidence and implications for psychological science. *Am. Psychol.* 71, 742-751 (2016).

186. Parker, C. M., Hirsch, J. S., Philbin, M. M. & Parker, R. G. The Urgent Need for Research and Interventions to Address Family-Based Stigma and Discrimination Against Lesbian, Gay, Bisexual, Transgender, and Queer Youth. *Journal of Adolescent Health* 63, 383-393 (2018).

187. Rao, D. *et al*. A systematic review of multi-level stigma interventions: state of the science and future directions. *BMC medicine* 17, 41 (2019).

188. Paradies, Y. *et al.* Racism as a Determinant of Health: A Systematic Review and Meta-Analysis. *PLoS ONE* 10, e0138511 (2015).

189. Gronholm, P. C., Henderson, C., Deb, T. & Thornicroft, G. Interventions to reduce discrimination and stigma: the state of the art. *Soc. Psychiatry Psychiatr. Epidemiol.* 52, 249-258 (2017).

190. National Academies of Sciences. *Ending Discrimination Against People with Mental and Substance Use Disorders: The Evidence for Stigma Change* (The National Academies Press, Washington, DC, 2016).

191. Wight, D., Wimbush, E., Jepson, R. & Doi, L. Six steps in quality intervention development. *J. Epidemiol. Community Health* 70, 520 (2016).

192. Wallace, M., Crear-Perry, J., Richardson, L., Tarver, M. & Theall, K. Separate and unequal: Structural racism and infant mortality in the US. *Health Place* 45, 140–144 (2017).

193. Mittal, D., Sullivan, G., Chekuri, L., Allee, E. & Corrigan, P. W. Empirical Studies of Self-Stigma Reduction Strategies: A Critical Review of the Literature. *PS* 63, 974-981 (2012).

194. Büchter, R. & Messer, M. Interventions for reducing self-stigma in people with mental illnesses: A systematic review of randomized controlled trials. *Ger Med Sci* 15 (2017).

195. Ma, P. H. X., Chan, Z. C. Y. & Loke, A. Y. Self-Stigma Reduction Interventions for People Living with HIV/AIDS and Their Families: A Systematic Review. *AIDS and Behavior* 23, 707-741 (2019).

196. Tsang, H. W. *et al*. Therapeutic intervention for internalized stigma of severe mental illness: A systematic review and meta-analysis. *Schizophr. Res.* 173, 45-53 (2016).

197. Livingston, J. D., Milne, T., Fang, M. L. & Amari, E. The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. *Addiction* 107, 39-50 (2012).

198. Thornicroft, G. *et al.* Evidence for effective interventions to reduce mental-health-related stigma and discrimination. *The Lancet* 387, 1123-1132 (2016).

199. Chaudoir, S. R., Wang, K. & Pachankis, J. E. What Reduces Sexual Minority Stress? A Review of the Intervention "Toolkit". *Journal of Social Issues 73*, 586-617 (2017).

200. Mehta, N. *et al*. Evidence for effective interventions to reduce mental health-related stigma and discrimination in the medium and long term: systematic review. *The British journal of psychiatry: the journal of mental science* 207, 377-384 (2015).

201. Morgan, A. J., Reavley, N. J., Ross, A., Too, L. S. & Jorm, A. F. Interventions to reduce stigma towards people with severe mental illness: Systematic review and meta-analysis. *J. Psychiatr. Res.* 103*,* 120-133 (2018).

202. Mak, W. W. S., Mo, P. K. H., Ma, G. Y. K. & Lam, M. Y. Y. Meta-analysis and systematic review of studies on the effectiveness of HIV stigma reduction programs. *Soc. Sci. Med.* 188, 30-40 (2017).

203. Stangl, A. L., Lloyd, J. K., Brady, L. M., Holland, C. E. & Baral, S. A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come? *Journal of the International AIDS Society* 16, 18734 (2013).

204. Gronholm, P. C., Thornicroft, G., Laurens, K. R. & Evans-Lacko, S. Mental health-related stigma and pathways to care for people at risk of psychotic disorders or experiencing first-episode psychosis: a systematic review. *Psychol. Med.* 47, 1-13 (2017).

205. Wong, J.P., Fung, K. P., & Li, A. T. Integrative strategies to address complex HIV and mental health syndemic challenges in racialized communities: Insights from the CHAMP project. *Canadian Journal of Community Mental Health* 36, 65-70 (2017).

206. Clifford, A., McCalman, J., Bainbridge, R. & Tsey, K. Interventions to improve cultural competency in health care for Indigenous peoples of Australia, New Zealand, Canada and the USA: a systematic review. *Int J Qual Health Care* 27, 89-98 (2015).

207. Truong, M., Paradies, Y. & Priest, N. Interventions to improve cultural competency in healthcare: a systematic review of reviews. *BMC Health Services Research* 14, 99 (2014).

208. Browne, A. J. *et al*. Enhancing health care equity with Indigenous populations: evidence-based strategies from an ethnographic study. *BMC Health Services Research* 16, 544 (2016).

209. Browne, A. J. *et al*. Disruption as opportunity: Impacts of an organizational health equity intervention in primary care clinics. *International journal for equity in health* 17, 154-154 (2018).

210. Butler, M. *et al.* Improving Cultural Competence To Reduce Health Disparities. Comparative Effectiveness Review No. 170. *Agency for Healthcare Research and Quality* (2016).

211. Chapman, E. N., Kaatz, A. & Carnes, M. Physicians and implicit bias: how doctors may unwittingly perpetuate health care disparities. *Journal of general internal medicine* 28, 1504-1510 (2013).

212. Maina I.W., Belton T.D., Ginzberg S., Singh A. & Johnson T.J. A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test. *Social Science and Medicine* 199, 219-229 (2018).

213. Zestcott, C. A., Blair, I. V. & Stone, J. Examining the Presence, Consequences, and Reduction of Implicit Bias in Health Care: A Narrative Review. *Group processes & intergroup relations : GPIR* 19, 528-542 (2016).

214. Merino, Y., Adams, L. & Hall, W. J. Implicit Bias and Mental Health Professionals: Priorities and Directions for Research. *PS* 69, 723-725 (2018).

215. Sabin, J. A., Riskind, R. G. & Nosek, B. A. Health Care Providers' Implicit and Explicit Attitudes Toward Lesbian Women and Gay Men. *Am. J. Public Health* 105, 1831-1841 (2015).

216. Knaak, S. *et al*. Understanding Stigma: A Pooled Analysis of a National Program Aimed at Health Care Providers to Reduce Stigma towards Patients with a Mental Illness. *Journal of Mental Health and Addiction Nursing* 1, 19-29 (2017).

217. Knaak, S., Modgill, G. & Patten, S. Key Ingredients of Anti-Stigma Programs for Health Care Providers: A Data Synthesis of Evaluative Studies. *Can J Psychiatry* 59, S19-26 (2014).

218. Sekoni, A. O., Gale, N. K., Manga-Atangana, B., Bhadhuri, A. & Jolly, K. The effects of educational curricula and training on LGBT-specific health issues for healthcare students and professionals: a mixed-method systematic review. *Journal of the International AIDS Society* 20, 21624-21624 (2017).

219. McCalman, J., Jongen, C. & Bainbridge, R. Organisational systems' approaches to improving cultural competence in healthcare: a systematic scoping review of the literature. *International Journal for Equity in Health* 16, 78 (2017).

220. Ungar, T., Knaak, S. & Szeto, A. C. H. Theoretical and Practical Considerations for Combating Mental Illness Stigma in Health Care. *Community Ment. Health J.* 52, 262-271 (2016).

221. Marcellus, L., MacKinnon, K., Benoit, C., Phillips, R. & Stengel, C. Reenvisioning Success for Programs Supporting Pregnant Women With Problematic Substance Use. *Qual. Health Res.* 25, 500-512 (2015).

222. Jongen, C., McCalman, J. & Bainbridge, R. Health workforce cultural competency interventions: a systematic scoping review. *BMC Health Services Research* 18, 232 (2018).

223. Berg, K. *et al*. Perspectives on Indigenous cultural competency and safety in Canadian hospital emergency departments: A scoping review. *International Emergency Nursing* 43, 133-140 (2019).

224. Brooks-Cleator, L., Phillipps, B. & Giles, A. Culturally Safe Health Initiatives for Indigenous Peoples in Canada: A Scoping Review. *Can. J. Nurs. Res.* 50, 202-213 (2018).

225. First Nations Health Authority. Cultural Humility. First Nations Health Authority (2019).

226. Masinde, W. M. A report on the impact of an integrated cultural safety and antidiscrimination training process on staff working in two primary Health Care Centres. [Graduating Project]. (2017).

227. Kellett, P. & Fitton, C. Supporting transvisibility and gender diversity in nursing practice and education: embracing cultural safety. *Nurs. Inq.* 24, e12146 (2017).

228. Malena-Chan, R., Kewistep, N. & Neudorf, C. Reconciliation: A Population Public Health Responsibility. (2017).

229. Hadjipavlou, G. *et al*. "All my relations": experiences and perceptions of Indigenous patients connecting with Indigenous Elders in an inner city primary care partnership for mental health and well-being. *CMAJ* 190, E608-E615 (2018).

230. Browne, A. J., Varcoe, C., Ford-Gilboe, M., Wathen, C. N. & EQUIP, R. T. EQUIP Healthcare: An overview of a multi-component intervention to enhance equity-oriented care in primary health care settings. *International journal for equity in health* 14, 152-152 (2015).

231. Sweeney, A., Filson, B., Kennedy, A., Collinson, L. & Gillard, S. A paradigm shift: relationships in trauma-informed mental health services. *BJPsych Adv.* 24, 319-333 (2018).

232. EQUIP. Trauma-and-Violence-Informed Care (TVIC): A Tool for Health & Social Service Organizations and Providers. (2017).

233. Obermeyer, C. M., Baijal, P. & Pegurri, E. Facilitating HIV disclosure across diverse settings: A Review. *Am J Public Health* 101, 1011-1023 (2011).

234. Ford-Gilboe, M. *et al.* How Equity-Oriented Health Care Affects Health: Key Mechanisms and Implications for Primary Health Care Practice and Policy. *The Milbank Quarterly* 96, 635-671 (2018).

235. Lavoie, J. G., Varcoe, C., Wathen, C. N., Ford-Gilboe, M. & Browne, A. J. Sentinels of inequity: examining policy requirements for equity-oriented primary healthcare. *BMC Health Services Research* 18, 705 (2018).

236. Hasnain-Wynia, R. & Baker, D. W. Obtaining Data on Patient Race, Ethnicity, and Primary Language in Health Care Organizations: Current Challenges and Proposed Solutions. *Health Serv Res* 41, 1501-1518 (2006).

237. Chin, M. H. Using Patient Race, Ethnicity, and Language Data to Achieve Health Equity. *J Gen Intern Med* 30, 703-705 (2015).

238. Wray, R. *et al.* We ask because we care: The Tri-Hospital + TPH health equity data collection research project: Summary Report. (2013).

239. Henderson, C. *et al.* Public knowledge, attitudes, social distance and reported contact regarding people with mental illness 2009-2015. *Acta Psychiatr. Scand.* 134, 23-33 (2016).

240. Maiorano, A. *et al.* Reducing Stigma in Media Professionals: Is there Room for Improvement? Results from a Systematic Review. *Canadian journal of psychiatry. Revue canadienne de psychiatrie* 62, 702-715 (2017).

241. Moir, A. Take me to the prom. *Hands Up Films* (2019).

242. Blake, V. K. & Hatzenbuehler, M. L. Legal Remedies to Address Stigma-Based Health Inequalities in the United States: Challenges and Opportunities. *The Milbank Quarterly* 97, 480-504 (2019).

243. Wilk, P., Maltby, A. & Cooke, M. Residential schools and the effects on Indigenous health and well-being in Canada a scoping review. *Public Health Rev.* 38, 8 (2017).

244. Krieger, N., Chen, J. T., Coull, B., Waterman, P. D. & Beckfield, J. The unique impact of abolition of Jim Crow laws on reducing inequities in infant death rates and implications for choice of comparison groups in analyzing societal determinants of health. *Am. J. Public Health* 103, 2234-2244 (2013).

245. Krieger, N. *et al.* Jim Crow and premature mortality among the US Black and White population, 1960–2009: an age-period-cohort analysis. *Epidemiology* 25, 494-504 (2014).

246. Krieger, N., Jahn, J. L. & Waterman, P. D. Jim Crow and estrogen-receptor-negative breast cancer: US-born black and white non-Hispanic women, 1992–2012. *Cancer Causes & Control* 28, 49-59 (2017).

247. Raifman, J., Moscoe, E., Austin, S. B., Hatzenbuehler, M. L. & Galea, S. Association of State Laws Permitting Denial of Services to Same-Sex Couples With Mental Distress in Sexual Minority Adults: A Difference-in-Difference-in-Differences Analysis. *JAMA psychiatry* 75, 671-677 (2018).

248. Everett, B. G., Hatzenbuehler, M. L. & Hughes, T. L. The impact of civil union legislation on minority stress, depression, and hazardous drinking in a diverse sample of sexual-minority women: A quasi-natural experiment. *Soc. Sci. Med.* 169, 180-190 (2016).

249. Kesler, M. A. *et al.* Prosecution of non-disclosure of HIV status: Potential impact on HIV testing and transmission among HIV-negative men who have sex with men. *PloS one* 13, e0193269-e0193269 (2018).

250. Patterson, S. E. *et al.* The impact of criminalization of HIV non-disclosure on the healthcare engagement of women living with HIV in Canada: a comprehensive review of the evidence. *Journal of the International AIDS Society* 18, 20572-20572 (2015).

251. Corrigan, P. W. & Nieweglowski, K. Stigma and the public health agenda for the opioid crisis in America. International *Journal of Drug Policy* 59, 44-49 (2018).

252. Henry, B. Stopping the Harm: Decriminalization of People who Use Drugs in BC. *Office of the Provincial Health Officer* (2019).

253. de Villa, E. A Public Health Approach to Drug Policy. (2018).

254. Royal Commission on Aboriginal Peoples. People to people, nation to nation: Highlights from the report of the Royal Commission on Aboriginal Peoples. (1996).

255. Aboriginal Affairs and Northern Development Canada. Creating the conditions for economic success on reserve lands: A report on the experiences of 25 First Nation communities. (2013).

256. Truth and Reconciliation Commission of Canada. Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada. (2015).

257. Department of Justice Canada. Attorney General of Canada to issue Directive Regarding Prosecutions of HIV Non-Disclosure Cases. (2018).

258. Trapence, G. *et al*. From personal survival to public health: community leadership by men who have sex with men in the response to HIV. *The Lancet* 380, 400-410 (2012).

259. Jozaghi, E., Greer, A. M., Lampkin, H. & Buxton, J. A. Activism and scientific research: 20 years of community action by the Vancouver area network of drug users. *Substance Abuse: Treatment, Prevention, and Policy* 13 (2018).

260. Tam, T. Preventing Problematic Substance Use in Youth—Chief Public Health Officer of Canada's 2018 Annual Report. (2018).