PARTICIPANT WORKBOOK

2017

CHALLENGING ORGANIZATIONAL STIGMA

Providing safer and more inclusive sexual health, harm reduction and STBBI-related services

Calgary Sexual Health Centre

CANADIAN PUBLIC HEALTH ASSOCIATION

ASSOCIATION CANADIENNE DE SANTÉ PUBLIQUE

In April 2014, the Canadian Public Health Association (CPHA) launched the project *Impacting attitudes and values: Engaging health professionals to decrease stigma and discrimination and improve sexually transmitted and blood-borne infection (STBBI) prevention*. Funded by the Public Health Agency of Canada, this project aims to enhance the prevention of STBBIs and reduce the associated stigma and discrimination by developing capacity building resources for health and social service providers.

As part of this project and in collaboration with the Calgary Sexual Health Centre (CSHC), CPHA developed a suite of professional development workshops that were pilot tested in several Canadian cities with a diverse group of frontline service providers.

CANADIAN PUBLIC HEALTH ASSOCIATION
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Calgary Sexual Health Centre

CHALLENGING ORGANIZATIONAL STIGMA

PROVIDING SAFER AND MORE INCLUSIVE SEXUAL HEALTH, HARM REDUCTION AND STBBI-RELATED SERVICES

AT THE END OF THIS WORKSHOP, YOU WILL:

- increase your knowledge of the various forms of stigma and the many factors that contribute to STBBI-related stigma, including attitudes, values, and beliefs as well as organizational policies and practices;
- increase your ability to identify organizational strengths and challenges in addressing stigma; and
- enhance your skills in developing strategies to decrease stigma on an organizational level and to create safer and more inclusive environments for clients.

WORKSHOP AGENDA

- **Module 1:** Introduction
- **Module 2:** Exploring stigma and the factors that contribute to stigma
- **Module 3:** Strategies to reduce stigma and create safer and more inclusive services
- **Module 4:** Closing

What would you like to get out of this workshop?

KEY TERMS

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed.
Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.[1]

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.[1]

Sexual health requires a positive and respectful approach to sexuality and sexual relationships.

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services
- seek, receive and impart information related to sexuality
- sexuality education
- respect for bodily integrity
- choose their partner
- decide to be sexually active or not
- consensual sexual relations
- consensual marriage
- decide whether or not, and when, to have children
- pursue a satisfying, safe and pleasurable sexual life[2]

The responsible exercise of human rights requires that all persons respect the rights of others.

1 *Defining sexual health*, World Health Organization, 2006. Accessed on March 18, 2015 from http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/.

2 *Defining sexual health*, World Health Organization, n.d. Accessed on March 18, 2015 from http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/. Note that this definition does not represent an official WHO position.

KEY TERMS

Sex-positivity

Adopting a sex-positive approach means respecting the diversity of human sexuality and talking with your clients openly and without judgement about their sexuality. A sex-positive approach respects the sexual rights of all persons, yet also acknowledges that not all persons have learned about or experienced sexuality in a positive and affirming way.

Harm reduction

Harm reduction encompasses policies, strategies and services which aim to assist people who use substances to live safer and healthier lives. Harm reduction recognizes that people use substances for many reasons; reduction of substance use and/or abstinence is not required in order to receive respect, compassion or services.[3] Adoption of harm reduction strategies, policies and services can have many benefits for people who use substances, including improved prevention of STBBIs, decreased overdoses, increased capacity for self-care and increased stability.[4] Example harm reduction strategies to discuss with clients include: use of barrier methods during sexual activity, use of sterile needles, not using substances when alone, etc.

Trauma- and violence-informed care (TVIC)

Trauma-informed care (TIC) focuses on creating environments where clients do not experience further traumatization or re-traumatization and where they can make decisions about their treatment needs at a pace that feels safe to them.[5] TVIC expands on the concept of TIC to acknowledge the broader social and structural conditions that impact health, including, but not limited to, institutional policies and practices.[6] Talking about sexuality and substance use can be difficult; using a TVIC approach can help to ensure that the broader structural and social conditions are acknowledged and that organizational policies and practices as well as provider practices do not contribute to re-traumatization. Example TVIC strategies include acknowledging the effects of historical and structural conditions, seeking service user input about safe and inclusive strategies, encouraging service user empowerment in relation to treatment options and adoption of harm reduction strategies, and implementing policies and processes that allow for flexibility and encourage shared decision-making. [5, 6]

Social determinants of health approach

Various structural and social conditions, such as income, housing, social inclusion, employment and education, can impact your clients' health and ability to adopt and maintain STBBI prevention strategies.[7] When discussing sexual health and substance use, it is important to ask your clients about the structural and social conditions that may be impacting their health and to be aware of local resources and referrals, as needed.

3 Adapted from Streetworks Edmonton, 2015.

4 *Understanding harm reduction: Substance use*, HealthLinkBC, 2015. Accessed March 15, 2015 from: https://www.healthlinkbc.ca/healthlinkbc-files/substance-use-harm-reduction.

5 *Trauma-informed practice guideline*, BC Provincial Mental Health and Substance Use Planning Council, 2013.

6 *VEGA briefing note on trauma- and violence-informed care*, VEGA Project and PreVAiL Research Network, 2016.

7 *Factors that impact vulnerability to STBBIs*, Canadian Public Health Association, 2014.

DRAWING ACTIVITY: EQUALITY VERSUS EQUITY

Equity means fairness. Equity in health means that peoples' needs guide the distribution of opportunities for well-being. Equity in health is not the same as equality in health status. Inequalities in health status between individuals and populations are inevitable consequences of genetic differences and various social and economic conditions, or a result of personal lifestyle choices. Inequities occur as a consequence of differences in opportunity, which result, for example in unequal access to health services, nutritious food or adequate housing. In such cases, inequalities in health status arise as a consequence of inequities in opportunities in life.[8]

ACTIVITY: HEALTH PROMOTION AND PREVENTION CAMPAIGNS

Think back to the early messages you received about STBBIs, sexual health and substance use through health promotion/ prevention campaigns (e.g., through posters, commercials, social media campaigns or educational presentations). Consider:

- the common themes;
- how you felt in response to these campaigns; and
- how health promotion/prevention approaches have evolved over time.

8 *Public health practice: Glossary of terms*, Public Health Agency of Canada, 2007. Accessed February 1, 2017 from http://www.phac-aspc.gc.ca/php-psp/ccph-cesp/glos-eng.php#e.

STIGMA - BRAINSTORM ACTIVITY

What is stigma?

Where do we see stigma?

What is the impact of stigma on our clients?

STIGMA DEFINED

Perceived stigma: awareness of negative societal attitudes, fear of discrimination and feelings of shame.[9]

Internalized stigma: an individual's acceptance of negative beliefs, views and feelings towards themselves and the stigmatized group they belong to.[9]

Enacted stigma: encompasses acts of discrimination, such as exclusion or acts of physical or emotional abuse (towards an individual's real or perceived identity or membership to a stigmatized group).[9, 10]

Layered or compounded stigma: refers to a person holding more than one stigmatized identity (e.g., HIV positive serostatus, sexual orientation, race, ethnicity).[9]

Institutional or structural stigma: stigmatisation of a group of people through the implementation of policy and procedures.[11]

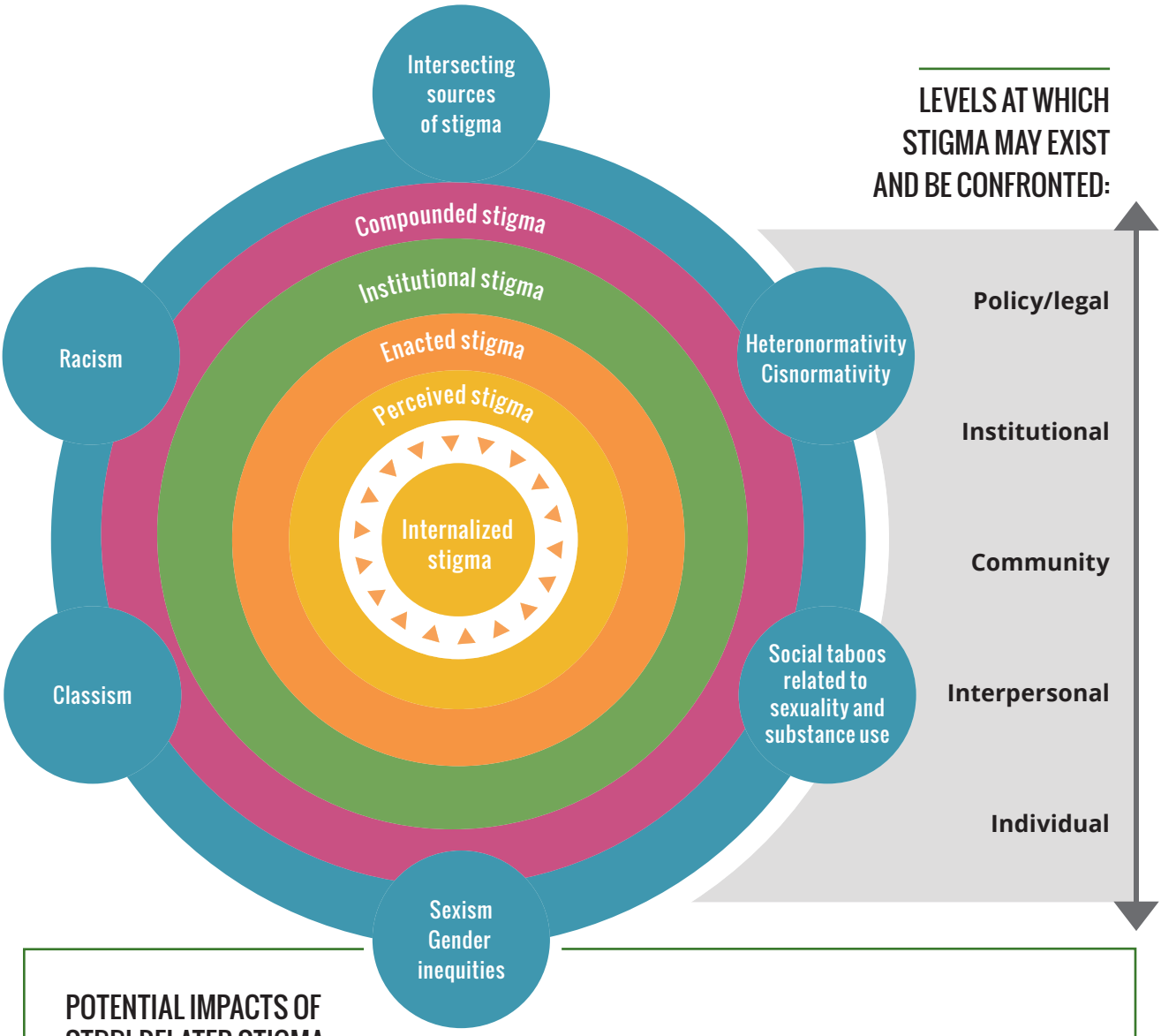
Notes:

9 Loutfy MR, Logie CH, Zhang Y, et al. Gender and ethnicity differences in HIV-related stigma experienced by people living with HIV in Ontario, Canada. *PLoS ONE* 2012; 7(12):e48168.

10 Stangl A, Brady L, Fritz K. *Measuring HIV stigma and discrimination*. Strive, 2012. Available at: http://strive.lshtm.ac.uk/sites/strive.lshtm.ac.uk/files/STRIVE_stigma%20brief-A3.pdf (Accessed January 7, 2015).

11 Corrigan PW, Markowitz FE, Watson AC. Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin* 2004; 30(3): 481-491.

STIGMA DEFINED



POTENTIAL IMPACTS OF STBBI-RELATED STIGMA:

- adoption of unhealthy behaviours
- fear of disclosure
- limited uptake of available STBBI-related services
- inappropriate planning and implementation of STBBI prevention and support programs

Adapted from:
Churcher S. Stigma related to HIV and AIDS as a barrier to accessing health care in Thailand: A review of recent literature. *WHO South-East Asia J Public Health* 2013;2:12-22.

Loutfy MR, Logie CH, Zhang Y et al. Gender and ethnicity differences in HIV-related stigma experienced by people living with HIV in Ontario, Canada. *PLoS ONE* 2012;7(12):e48168.

Stangl A, Brady L, Fritz K. *Measuring HIV stigma and discrimination*. Strive, 2012. Available at: http://strive.lshtm.ac.uk/sites/strive.lshtm.ac.uk/files/STRIVE_stigma%20brief-A3.pdf.

ACTIVITY: STIGMA CASE SCENARIO

Read the case scenario that has been provided to you. Take some time to identify the different types of stigma and to brainstorm some potential solutions to address the stigma found in this scenario.

Notes:

- Service providers working in sexual health, harm reduction and STBBI prevention, testing and treatment need to understand the far-reaching impacts of stigma.
- Stigma can lead to harmful outcomes for individuals living with or affected by STBBIs such as psychological stress, fear of disclosure and avoidance of prevention, testing and treatment services.[12,13,14,15,16]
- Stigma within health service settings can impact the quality of care as well as a client's well-being and confidence in the health care process.[17]

12 Balfe M, Brugha R, O'Donovan D, O'Connell E, Vaughn D. Young women's decisions to accept chlamydia screening: influences of stigma and doctor-patient interactions. *BMC Public Health* 2010;10(425).

13 Fortenberry DJ, McFarlane M, Bleakley A, Bull S, Fishbein M, Grimley DM, Malotte KC, Stoner, BP. Relationships of stigma and shame to gonorrhea and HIV screening. *Am J Public Health* 2002;92(3): 378-81.

14 Mahajan AP, Sayles JN, Patel VA, Remien RH, Ortiz D, Szekeres G, et al. Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward. *AIDS* 2008;22(Suppl 2): S67-S79.

15 Mill J, Edwards N, Jackson R, Austin W, MacLean L, Reintjes F. Accessing health services while living with HIV: Intersections of stigma. *Can J of Nurs Res* 2009;41(3): 168-85.

16 Rusch ML, Shoveller JA, Burgess S, Stancer K, Patrick DM, Tyndall MW. Preliminary development of a scale to measure stigma relating to sexually transmitted infections among women in a high risk neighbourhood. *BMC Womens Health* 2008;8(21).

17 Kinsler JJ, Wong MD, Sayles JN, Davis C, Cunningham WE. The effect of perceived stigma from a health care provider on access to care among a low-income HIV-positive population. *AIDS Patient Care STDs* 2007;21(8):584-92.

WHAT FACTORS CONTRIBUTE TO STIGMA?

- lack of knowledge of different STBBIs, including transmission modes and treatment options, resulting in an inappropriate fear of contagion;
- lack of comfort in discussing sexuality and/or substance use;
- negative attitudes and values, often unconscious or implicit, towards sexuality and substance use;
- the language used during client-provider interactions and on communications materials (e.g., posters, pamphlets, signage) is not inclusive or safe for all clients;
- interaction with other forms of social inequities (e.g. racism, classism, ableism, heteronormativity);
- lack of culturally safe care for different population groups, often due to lack of training/ exposure to different population groups;
- restrictive or discriminatory (often unintentionally) policies and procedures within organizations (e.g. fees for missed appointments); and
- structural drivers of stigma (e.g. criminalization of HIV non-disclosure, inappropriate focus on 'at-risk' populations).

Based on key informant interviews and focus groups with service providers and clients from across Canada (Canadian Public Health Association, 2017).

Notes:

SEE

What are some indicators within your workplace that would signify that it is an inclusive space for all people?

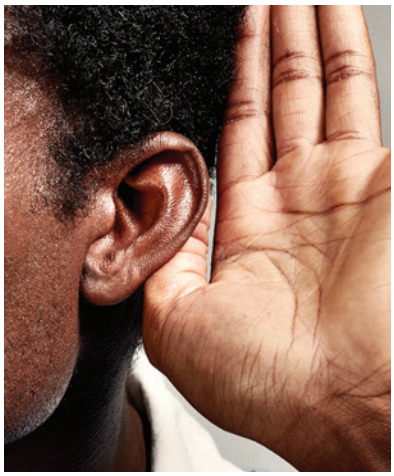
What are some indicators that would signify barriers for service, or that might make people feel unsafe?

What changes could be made?

The physical space of an organization is often the first indication of whether services are truly safe and inclusive spaces. There are many small changes that can be made by way of posters, signage, pamphlets, artwork and magazines to indicate that services are accepting of all persons.

HEAR

What do people hear within a safe space?



Is the language used within your workplace inclusive and respectful?

Is there space for private conversations?

The language of service providers, administrators, forms and policies is instrumental in the construction of a safe space. Language sends a strong message to existing and prospective clients about your organization's attitudes and beliefs related to sexual and gender diversity, sexuality, culture, substance use, harm reduction, etc.

FEEL

Are services provided in a way that is considerate of the impacts of stigma?

Are the unique experiences of individuals honoured and recognized?

How do people feel within these spaces?

How do we know how clients are feeling?

It is imperative that organizations create a feeling amongst clients that their diverse experiences, beliefs, and identities are heard, acknowledged, and respected. Central to this is the implementation of mechanisms for clients to voice their concerns and share their thoughts on service delivery and improvement.

REFLECTION ACTIVITY

It is helpful to reflect on the needs of your current clients and of the community at large, and to start thinking about issues of stigma and discrimination.

- What is the role of your organization in the community?
- What is the profile of your existing clients? Why do you think these individuals come to you for services?
- What members of the community, if any, are not coming to your organization? In your view, why are they not accessing your services?

If some people in your community are not seeking services from your organization, they may be experiencing or perceiving some form of stigma, they may be choosing to access services elsewhere, or they may not be accessing services at all. The best way to determine whether there is an unmet need in your community is to reach out to these people, either by talking with them individually, or in a small group. If your organization does not have a relationship with a particular group, consider partnering with another organization or volunteer group that does.

Once you have determined whether people are able to access the services they need, you can plan accordingly. If they are accessing services elsewhere, then providing them with information and referrals may be sufficient. If, however, a group of people are not able to access the services they need, then you must determine what your organization can do for them given available resources.

ORGANIZATIONAL ASSESSMENT TOOL FOR SEXUALLY TRANSMITTED AND BLOOD-BORNE INFECTIONS AND STIGMA

THE TOOL WILL HELP ORGANIZATIONS TO:

- Identify their strengths and challenges related to stigma and discrimination.
- Increase awareness of organizational issues (e.g., policies, procedures, culture and environment) that create stigmatizing and/or discriminatory experiences for clients.
- Develop strategies to decrease stigma and discrimination and create safer and more supportive environments.

GETTING STARTED

1. Identify who should participate in the organizational assessment process. In some cases, only one part of the organization (e.g. sexual health clinic) will do the assessment, and in others the whole organization will be involved.
2. Engage the entire "chain" of staff and volunteers with whom clients come in contact .
3. Identify where/how this assessment process fits with your organizational policies and processes. Ideally, the tool can be incorporated into regular quality improvement practices as a way of reinforcing a welcoming and supportive culture throughout the organization, rather than being seen as an "extra" process.
4. Encourage all staff and volunteers involved in the assessment process to complete the *Self-assessment tool for STBBIs and stigma* and reflect on their own attitudes, values and beliefs related to STBBIs.

COMPLETING THE ASSESSMENT PROCESS

To complete the assessment process, staff and volunteers should:

1. Complete the assessment individually and note their responses to each question. Managers should ensure a supportive, constructive environment, so that staff and volunteers feel they can respond openly to the questions.
2. Meet to discuss their responses to the questions as well as their reflections on the process. This is an important learning opportunity and should foster frank and constructive discussion of organizational challenges and strengths.
3. As a group, choose a rating for the organization on each of the criteria.
4. As a group, identify priority areas for action.

Notes:

DEVELOPING AN IMPROVEMENT PLAN

Next, your organization should develop an improvement plan to address the priority issues identified in the assessment process. This plan should reflect the time and resources available to ensure that the plan's deliverables are reasonable and achievable.

1. Bring together a working group to develop the plan, consisting of staff and volunteers who have an understanding of the primary organizational challenges, strengths and decision-making power.
2. Obtain senior management approval of the plan.
3. Circulate the plan to relevant staff and volunteers so they know what actions are required on their part.
4. Keep the working group regularly informed of the plan's progress.
5. Revisit your organizational assessment at regular intervals (at least yearly) to assess progress and enhance awareness of stigma and discrimination.

Notes:

ACTIVITY: DEVELOPING A POLICY STATEMENT

Notes:

SAMPLE POLICY STATEMENT FOR A COMMUNITY HEALTH CENTRE:

The Centre believes in the uniqueness and potential of every individual, and values diversity as an asset to the organization, to our society and to community life. We strive to ensure that every staff person, student, client, board member, community member and volunteer feels welcome and respected at our Centre.

The Centre is non-discriminatory in its practices and policies, and takes an active role to eliminate discrimination on the basis of race, ancestry, place of origin, skin colour, ethnic origin, citizenship, creed, religion, age, gender, sexual orientation, marital status, family status, health status, job position, economic status, disability, or physical attributes and appearance.

The Centre will not tolerate discrimination of any kind, whether engaged in by employees, directors, students or volunteers. Centre programs and activities are conducted in a manner that is sensitive to diversity and an individual's right to appropriate services.

Issues of discrimination that are not resolved will be addressed through the Centre's conflict resolution policy.

NEXT STEPS

As part of the assessment process, priority issues need to be identified and action taken in a timely manner. Organizations have multiple issues and demands to address at any one time, so planning is paramount. Identify clear priorities for action and what resources are available so a reasonable improvement plan can be developed.

1. Pick your priorities for action.
2. Bring together a working group.
3. Clarify the problem(s)/issue(s) you are trying to address.
4. Identify the potential solutions to address the issue(s).
5. Develop the improvement plan.
6. Get approval from management.
7. Circulate the improvement plan.
8. Check-in and evaluate progress on the plan.
9. Celebrate your achievements!

ACTION PLAN

Brainstorm one or several things that you can do differently to improve service delivery and reduce stigma within your organization. You may choose to focus on small changes within your own practice or to advocate for larger changes to organizational policies or procedures.

A NOTE ABOUT ACTIVELY ENGAGING CLIENTS AND COMMUNITY GROUPS

By "tailoring" rather than "targeting" programs to particular client groups, there is a better chance of avoiding stigma and the more subtle ways that programs can isolate, rather than integrate, different population groups. To be effective, community/client engagement needs to be respectful and authentic.

Involving prospective clients – especially those from marginalized groups – in the tailoring process offers your organization three valuable resources:

1. Insight into how clients perceive your organization, which is a good way to address potential "blind spots" related to stigma within your organization.
2. The experience and expertise of clients, as well as their energy to help your organization develop or review initiatives.
3. Commitment because when clients believe in what your organization is doing, they can act as "ambassadors" for you within the community.

If your organization does not have a relationship with marginalized groups in your community, develop a partnership with a group or organization that does (e.g., groups working with the LGBTQ community, people living with HIV, or newcomers to Canada).

GLOSSARY

ALLY: A person who is actively supportive of LGBTQ+ people and their rights. Allies may be gay, straight, transgender, queer, two-spirit, etc.

ASEXUAL: A person whose attraction to others does not include sexuality.

BISEXUAL: A person who is physically and emotionally attracted to their own gender and other genders.

BLOOD-BORNE INFECTION: An infection transmitted by direct blood contact from one individual to another through injured skin or a mucous membrane, or transmitted through substance use and sexual contact (e.g., hepatitis B and C, HIV).

CISGENDER: A person whose gender identity is the same as the sex they were assigned at birth.

CISNORMATIVITY: The assumption that all people are cisgender or that those assigned male at birth grow up to be men and those assigned female at birth grow up to be women. It may also refer to the oppression experienced by transgender people in a society that represents cisgender people as dominant, normal and superior.

DISCRIMINATION: Unjust treatment based on an individual belonging or perceived to be belonging to a traditionally marginalized social group (e.g., by race, gender, orientation, etc.).

EQUITY/EQUITABLE: Equity means fairness. Equity in health means that peoples' needs guide the distribution of opportunities for well-being. Equity in health is not the same as equality in health status. Inequalities in health status between individuals and populations are inevitable consequences of genetic differences and various social and economic conditions, or a result of personal lifestyle choices. Inequities occur as a consequence of differences in opportunity, which result, for example in unequal access to health services, nutritious food or adequate housing. In such cases, inequalities in health status arise as a consequence of inequities in opportunities in life (Public Health Agency of Canada, 2007).

GAY: A man who is physically and emotionally attracted to other men. Some women attracted to women may also identify as gay.

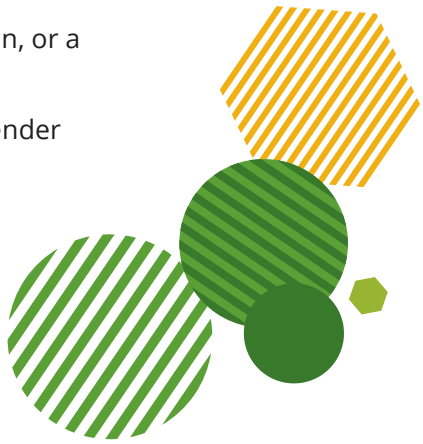
GAY-STRAIGHT ALLIANCE (GSA): Student-run organizations found in some K-12 schools and universities that create safe and supportive spaces for LGBTQ+ individuals and allies.

GENDER EXPRESSION: The way people communicate their gender identity to others by how they dress, act and/or refer to themselves.

GENDER IDENTITY: A person's internal sense of being a woman or man, or a combination of both, or neither.

GENDER NON-BINARY/GENDERQUEER: Terms for a person whose gender identity is neither woman nor man.

GENDER ROLES: Socially constructed and culturally behavioural norms, such as communication styles, careers and family roles, that are often expected of people based on their assigned sex (Canadian AIDS Society, 2015).



HETERONORMATIVITY: The assumption or belief that every person is heterosexual until proven otherwise, and by default treating individuals as if they would be in a relationship with somebody of the opposite gender.

HOMOPHOBIA/TRANSPHOBIA: An irrational hatred of people who are, or are perceived to be LGBTQ. Often exhibited by prejudice, discrimination, intimidation or acts of violence.

INTERSEX: A general term used to describe people who are born with reproductive or sexual anatomy that does not fit the typical definitions of female or male.

LESBIAN: A woman who is physically and emotionally attracted to women.

LGBTQ: An acronym to describe the following identities: Lesbian, Gay, Bisexual, Transgender and Queer.

NALOXONE: A medication that reverses the effect of overdose from opioids. Peer administered naloxone programs train people in the community to administer naloxone if they witness an overdose.

NEEDLE EXCHANGE PROGRAMS: This is an evidence-based program to prevent the transmission of STBBIs. People can bring in needles and other paraphernalia that they have used for injecting substances and receive sterile injecting equipment. This is typically offered in a setting where various other psychosocial supports or referrals are available.

ORIENTATION: A person's identity in relation to the gender they are attracted to.

OPIOID DEPENDENCY PROGRAM: This is a program for individuals that would like to stop using opiate-based substances. People receive a prescription of methadone or Suboxone® maintenance treatment in an outpatient setting. As part of these programs, people may engage in a wide variety of psychosocial supports to address substance use.

PANSEXUAL: A person who is physically and emotionally attracted to people of any gender.

QUEER: Historically used as a negative term for homosexuality and is still often used as a derogatory term against LGBTQ people. Many LGBTQ people and communities have reclaimed the word and use it in a positive way to refer to themselves and aspects of their identity.

QUESTIONING: A person who is unsure of their sexual orientation or gender identity and experiencing a process of self-discovery.

SAFER INHALATION EQUIPMENT (ALSO KNOWN AS SAFER CRACK PIPE PROGRAMS): Programs where people who inhale substances are provided with new inhalation equipment such as pipes to reduce and prevent the transmission of hepatitis C.

SEX: The category someone is assigned at birth based on their physical body parts and biology.

SEXUALLY TRANSMITTED INFECTION (STI): An infection passed from one person to another through sexual activity, including vaginal, oral or anal sex as well as genital skin-to-skin contact. STIs are grouped into three categories: viral infections (e.g., genital herpes, human immunodeficiency virus (HIV), hepatitis B), bacterial infections (e.g., chlamydia, gonorrhea and syphilis) and parasitic/fungal infections (e.g., trichomoniasis, pubic lice, yeast infection).
NOTE: The term sexually transmitted disease is no longer used.

SOCIAL DETERMINANTS OF HEALTH (SDH): The social and economic factors that influence people's health. These are apparent in the living and working conditions that people experience every day. The SDH influence health in many positive and negative ways. Extreme differences in income and wealth, for example, have negative health consequences for those who are living in poverty and these effects are magnified when these people are congregated in poor regions. In contrast, those who are well-off and living in well-off regions have better overall health.

STRAIGHT: A person who is attracted to people of the opposite sex or gender to their own.

SUPERVISED INJECTION SITE: Evidence-based health care settings where people who inject substances can use their own personally acquired illicit substances under the supervision of nurses, social workers and other medical staff and where people can access clean syringes, needles and swabs, and safely dispose used needles. People can also receive health care, counseling and referral to social, health and substance use treatment services (adapted from Health Canada, 2008).

TRANS/TRANSGENDER: People whose gender identity, gender expression or behavior does not conform to that typically associated with the sex to which they were assigned at birth.

TWO-SPIRIT: A spiritual identity for some FNMI (First Nations, Metis, Inuit) people. Implies the embodiment of both masculine and feminine spiritual qualities within the same body. Note that this term is not used in all FNMI communities.

UNIVERSAL PRECAUTIONS: The practice of avoiding contact with all bodily fluids through gloves, face masks and a variety of other barriers, whether the health status of said bodily fluid is known or not.

RESOURCES

STBBIS AND STIGMA

Discussing sexual health, substance use and STBBIs: A guide for service providers, Canadian Public Health Association, 2017

Self assessment tool for STBBIs and stigma, Wagner A and Canadian Public Health Association, 2017

Organizational assessment tool for STBBIs and stigma, Canadian Public Health Association, 2017

Reducing stigma and discrimination through the protection of privacy and confidentiality, Canadian Public Health Association and the Canadian HIV/AIDS Legal Network, 2017

SEXUALITY AND STBBIS

Canadian guidelines on sexually transmitted infections, Public Health Agency of Canada, 2006

CATIE, http://www.catie.ca/
Information about HIV/AIDS and Hepatitis C in Canada

Native Youth Sexual Health Network, http://www.nativeyouthsexualhealth.com/
Organization by and for Indigenous youth that works across issues of sexual and reproductive health, rights and justice

Sex & U, http://www.sexandu.ca/
Information and education on topics related to sexual and reproductive health

LGBTQ

Egale, http://egale.ca/
National charity promoting lesbian, gay, bisexual, and trans (LGBT) human rights through research, education and community engagement

Gender Creative Kids, http://www.gendercreativekids.ca
Canadian resource for supporting and affirming gender creative kids within their families, schools and communities

Rainbow Health Ontario, http://www.rainbowhealthontario.ca/
Information and support related to the health and well being of LGBTQ people in Ontario

TRAUMA- AND VIOLENCE-INFORMED CARE

Trauma informed practice guide, BC Provincial Mental Health and Substance Use Planning Council, 2013

Violence, Evidence, Guidance and Action (VEGA) Project, https://projectvega.ca/
A national project developing pan-Canadian public health guidance, protocols, curricula and tools for health and social service providers related to family violence

HARM REDUCTION

Harm reduction training manual: A manual for frontline staff involved with harm reduction strategies and services, BC Harm Reduction Strategies and Services, 2011

The best practice recommendations for Canadian harm reduction programs that provide service to people who use drugs and are at risk for HIV, HCV, and other harms: Part 1, Working Group on Best Practice for Harm Reduction Programs in Canada, 2013

The best practice recommendations for Canadian harm reduction programs that provide service to people who use drugs and are at risk for HIV, HCV, and other harms: Part 2, Working Group on Best Practice for Harm Reduction Programs in Canada, 2015

HIV DISCLOSURE AND THE LAW

Canadian HIV/AIDS Legal Network, http://www.aidslaw.ca
Organization promoting the human rights of people living with and vulnerable to HIV and AIDS, in Canada and internationally

HIV disclosure and the law: A Resource kit for service providers, Canadian HIV/AIDS Legal Network et al., 2012

CANADIAN PUBLIC HEALTH ASSOCIATION

The Canadian Public Health Association (CPHA) is the national, independent, not-for-profit, voluntary association representing public health in Canada. CPHA's members believe in universal and equitable access to the basic conditions which are necessary to achieve health for all Canadians.

CALGARY SEXUAL HEALTH CENTRE

The mission of the Calgary Sexual Health Centre (CSHC) is to normalize sexual health in Alberta by providing evidence-informed, non-judgmental sexual and reproductive health programs and services. The CSHC vision is for all Albertans to experience healthy sexuality across the lifespan.

CANADIAN PUBLIC HEALTH ASSOCIATION
ASSOCIATION CANADIENNE DE SANTÉ PUBLIQUE

Calgary Sexual Health Centre