CASE 4: Journeying Together—Unlearning is the New Learning

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Journeying Together—Unlearning is the New Learning

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Please be aware that the text below may be triggering to some, and includes various forms of trauma including violence, physical and sexual abuse.

Ellie Domen pulled away from the table, trying to compose herself before speaking. She had been sitting in a stakeholder committee meeting for the past 40 minutes discussing ways to restructure a research project being developed by her organization, Trinity HIV/AIDS Society (THAS). The project has been in the development stage for the past three months and this was her third meeting reviewing Ellie's suggested curriculum.

Ellie has been working for her organization, THAS, for three years and was recently promoted from her previous position as a Women's Health Program Coordinator to working as the Newcomer Program Coordinator. The THAS is an ethnospecific AIDS organization that serves priority populations such as African, Caribbean, Black (ACB), and 2SLGBTQ+ communities, people using substances, and people who have chronic comorbidities including HIV/AIDS. Trinity HIV/AIDS Society is the only ethnospecific AIDS organization serving ACB communities in Trinity's urban centre, providing services to community members who experience increased vulnerability to HIV because of intersecting stigma and discrimination, and because of social and structural barriers such as a lack of access to adequate housing, financial, and social support. The organization serves members of the ACB community who have HIV/AIDS, although services are not limited to HIV status.

Ellie's responsibilities, among others, involve overseeing the development and implementation of the Newcomer Photovoice Project for which THAS recently received funding. Photovoice is a participatory action research method that employs photography and group dialogue as a means to gain a better understanding of a community issue or concern (Neighbourhood Action Strategy and Public Health Services, 2014). The purpose of the Newcomer Photovoice Project is to help communities understand the lived experiences of newcomers that are often placed into positions of marginalization, and to strengthen participants' sense of belonging to the Trinity region. Ellie's education in social work and experience in newcomer resettlement have positioned her well to apply her skills, social work concepts, perspectives, and knowledge about social determinants of health into practice. This new project allows Ellie to draw on her professional experience and apply it to a new context, where she is working with newcomers within her community.

Although the stakeholders agreed that Ellie's curriculum was strong, they felt it lacked in its ability to accurately represent and address the needs of Trinity's newcomer community. The rest of the meeting was filled with conversations on how to best navigate restructuring the project's curriculum to ensure it reflects the literacy skills, education, and cultural needs of newcomers in the region. Most of the stakeholders at the meeting were representatives from

organizations focused on Canadian immigrants and newcomer health, ACB community health, women's health, and intersectoral HIV/AIDS services.

Ellie looked across the table to her manager, whose presence signaled support for her project. Ellie could not help but feel defeated because her efforts designing the curriculum were now being tossed away. Her immediate thoughts shifted as she looked up to see an anti-Islamophobia poster on the boardroom door. She was reminded of the purpose of the project and its capacity to amplify the voices of newcomers and their diverse experiences adjusting to life in Canada. Ellie was confident in the curriculum she developed, however through the many stakeholder consultations in which she has been involved, she also recognized it could be stronger in application. Ellie realized there are many complex elements to consider when putting together the curriculum. In addition to ensuring the curriculum helps build social and community connections, she is now tasked with building a curriculum that promotes equity needs, is culturally responsive, inclusive, antiracist and anti-oppressive, and meets individual language, literacy, and learning abilities.

BACKGROUND

Immigration has strongly influenced Canada's current ethnic and cultural makeup. Canada is known as a multicultural country with a public emphasis on the social importance of immigration (Brosseau & Dewing, 2009). Immigration plays an integral part in the development of multiculturalism within Canada, with the majority of immigrants representing visible minority communities. A visible minority is a person who belongs to a visible minority group; The Employment Equity Act defines visible minorities as "persons, other than Aboriginal peoples, who are non-Caucasian in race or non-white in colour" (Government of Canada, 2015). Visible minorities are commonly also referred to as "racialized communities". It is estimated that one in four Canadians are foreign-born, which represents more than one fifth of Canada's total population (Government of Canada, 2017). The increasing number of immigrants has contributed to the growth of the visible minority population in Canada. In 2016, data revealed that approximately seven million people (22.3%) of Canada's population identified as a visible minority (Government of Canada, 2017).

In North America, the terms newcomer and immigrant are broad terms that include various categories of immigrants from a wide range of ethnicities and cultures. Although ACB, South Asian, Latinx, and other communities are commonly bundled together, they differ in their culture, traditions, and language. As a result, it is necessary to understand and distinguish these terms in order to appropriately engage with stakeholders and mobilize and sustain grassroots activism. Canada defines foreign-born populations or immigrant populations as people who are, or who have been, landed immigrants or permanent residents in Canada (Government of Canada, 2017). The foreign-born population excludes nonpermanent residents (i.e., people in Canada who have a work or study permit, or who are refugee claimants), whereas the terms recent immigrant or newcomer refer to landed immigrants who came to Canada up to five years prior to a given census year (Government of Canada, 2008).

The *Immigration and Refugee Protection Act* (2010) defines three basic classes of permanent residents immigrating to Canada (Citizenship and Immigration Canada, 2010). These classes are:

Economic class immigrants. These immigrants are selected for their skills and ability to contribute to Canada's economy. The majority of immigrants in this category are skilled workers.

Family class immigrants. This class includes immigrants sponsored by a Canadian citizen or permanent resident living in Canada, such as spouses, partners, parents, grandparents, or other qualifying relatives.

Refugees or protected persons. This class includes immigrants who are accepted as permanent residents under Canada's Refugee and Humanitarian Resettlement Program. There are three categories of refugees:

- **Government-assisted refugees.** Immigrants who are selected abroad for resettlement to Canada and receive initial resettlement assistance from the federal government.

- **Privately sponsored refugees.** Immigrants selected abroad for resettlement to Canada and are privately sponsored by organizations, individuals, or groups of individuals.

- **Refugees landed in Canada.** Immigrants who have had their refugee claims accepted and who subsequently applied for, and were granted, permanent resident status in Canada.

Immigrants living without status in Canada, also known as undocumented immigrants, are not captured in immigration statistics. However, anecdotal evidence from service providers and intersectoral organizations working with non-status immigrants suggests that there are between 200,000 and 500,000 people in Canada who are living without status (Toronto Public Health and Access Alliance Multicultural Health and Community Services, 2011).

Many different languages are spoken in Canada. Census data from 2016 showed that 81.2% of recent immigrants who settled in Toronto, Ontario reported a language other than English or French as their mother tongue, up from 2011 (Statistics Canada, 2019). During this same period, 74.2% of established immigrants reported a language other than English as their mother tongue. It was also found that an increasing proportion of recent immigrants could not conduct a conversation in either English or French (Statistics Canada, 2019). The top mother tongue languages for recent immigrants arriving in the City of Toronto were Mandarin, Urdu, Russian, Arabic, Tagalog, Spanish, Farsi, Gujarati, Punjabi, Bengali, Korean, Chinese, Tamil, and Hindi (Statistics Canada, 2019).

RACISM AND HEALTH OF NEWCOMERS

There is a growing awareness of the role discrimination and racism play in the provision of health care and services to newcomers. Racism can take many forms at a variety of levels, from conscious and unconscious interactions between people to deeply engrained practices occurring at the systemic level (Pollock et al., 2011). Discrimination and racism can be conceived of as any practice, judgement, or action that creates and reinforces oppressive relations or conditions that marginalize, exclude, and/or restrain the lives of those encountering discrimination (Pollock et al., 2011). The concept of racialization refers to the social processes through which categorization takes place (Hyman, 2009). This concept is particularly useful when highlighting the ways in which certain groups face discrimination and are continuously subjected to differential treatment and access to resources that contribute to their individual social determinants of health.

Discrimination and racism experienced by newcomer communities inhibit their educational and occupational achievements while compromising living conditions, reducing health status, and impeding access to various health care services (Pollock et al., 2011). This inequality creates a form of systemic subordination and oppression for newcomer communities. Discrimination and

racism are considered to be key determinants of health (Pollock et al., 2011). In Canada, newcomer, immigrant, and refugee populations encounter multiple and intersecting forms of discrimination. Discriminating practices impact the quality of different types of care received across various settings, notably within hospital and health care service settings. Evidence suggests that discriminatory practices and encounters in Canada are likely subtle, elusive, or systemic relative to traditionally overt forms (e.g., verbal and physical abuse) (Pollock et al., 2011).

It is likely that Westernized cultural theories of health, and Westernized beliefs and values surrounding health and how health and illness are perceived, experienced, and communicated, may be driving unconscious discrimination. Health care systems within Canada are generally homogenous, reflecting Westernized perceptions, values, and priorities, despite the diversity in populations (Pollock et al., 2011). Common barriers to accessing health services among racialized groups in Canada are the lack of culturally competent care among service providers and the lack of respect for alternative health values and practices (Pollock et al., 2011).

LAYERS OF STIGMA

The Joint United Nations Programme on HIV/AIDS (2011) defines stigma as:

> A dynamic process of devaluation that significantly discredits an individual in the eyes of others, such as when certain attributes are seized upon within particular cultures or settings and defined as discreditable or unworthy. When stigma is acted upon, the result is discrimination. Discrimination refers to any form of arbitrary distinction, exclusion, or restriction affecting a person, usually (but not only) because of an inherent personal characteristic of perceived membership of a particular group.

Stigma can lead to harmful outcomes for people, particularly for vulnerable populations such as newcomers to Canada, 2SLGBTQ+ people, and people using substances. By identifying the different layers of stigma, and the many levels of stigma that people experience, work can be undertaken to address stigma better. It is important to consider the different layers of stigma because stigma is often worsened by health promotion or public health interventions that emphasize “at-risk” populations (Canadian Public Health Association, 2017). This can perpetuate negative attitudes that are based on sexual orientation, gender identity, race, and class, etc.

Different Types of Stigma

According to the Canadian Public Health Association (2017), there are five different types of stigma, shown as overlapping circles (see Exhibit 1). The overlapping circles highlight their interconnectedness. These are encircled by intersecting sources of stigma, including racism, gender inequality, heteronormativity, cisnormativity, classism, colonization, ableism, etc. The diagram further highlights the socioecological levels at which individuals experience stigma and at which organizations can introduce stigma-reducing actions and interventions.

1. **Perceived stigma**. This refers to awareness of negative societal attitudes, fear of discrimination, and feelings of shame. For example, when clients visit THAS, they often worry about other people in the waiting room overhearing their reason for their visit and perhaps judging them. When clients enter the clinic, they may notice posters targeted at groups of people who look like them, which may make them feel singled out and more anxious.

2. **Internalized stigma**. This refers to an individual's acceptance of negative beliefs, views, and feelings toward themselves and the stigmatized group to which they belong. For example, when newcomers enter THAS they are asked to complete medical and confidentiality forms. They may feel nervous about filling out these forms because of their precarious immigration status and/or health coverage. They are nervous and ashamed about asking for financial aid or services that support uninsured immigrants.

3. **Enacted stigma**. This encompasses acts of discrimination such as exclusion or acts of physical or emotional abuse, perhaps toward an individual's real or perceived identity or membership in a stigmatized group. For example, after a conversation with their service provider, someone may feel they acquired a sexually transmitted blood-borne infection because of their "risky" behaviour, or that they deserve the infection because of their personal choices and identity.

4. **Layered or compounded stigma**. This type of stigma refers to a person having more than one stigmatized identity (e.g., HIV positive serostatus, sexual orientation, race, or ethnicity). For example, a newcomer to Canada may feel unwelcome visiting THAS because of their ethnicity, and they may also feel unwelcome at their local immigration service organization because of their HIV status.

5. **Institutional or structural stigma.** This refers to stigmatization of a group of people through the implementation of policies and procedures. For example, because THAS is located at the west end of town, clients often find it difficult to reach the site by bus or by other modes of public transportation. The clinic is open every day from 9 a.m. to 5 p.m., but clients are often unable to visit during the day because the clinic hours conflict with their work or life schedules.

TRAUMA-INFORMED CARE

Trauma is recognized as an experience or experiences that overwhelm a person's capacity to cope (BC Provincial Mental Health and Substance Use Planning Council, 2013). Trauma that occurs early in life, including child abuse, neglect, witnessing violence, and disrupted attachment, as well as other traumatic experiences such as enduring violence, accidents, or war, can be outside one's control and can be devastating. Trauma is a continuum and differs in magnitude, complexity, frequency, and duration, and whether it results from an interpersonal or external source (BC Provincial Mental Health and Substance Use Planning Council, 2013).

Different Types of Trauma

To respond appropriately, it is important for people who work in health care settings, emergency departments, or social services to recognize the different types of trauma. The British Columbia Provincial Mental Health and Substance Use Planning Council (2013) lists five different types of trauma:

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1. **Single-incident trauma.** This type of trauma is related to an unexpected and overwhelming event such as an accident, natural disaster, a single episode of abuse or assault, sudden loss, or witnessing violence.

   Photovoice Participant Story, Lidia. Lidia experienced a severe Traumatic Brain Injury (TBI) following a collision between a car and her bicycle while on a leisure ride in Norval, Ontario.

In a comatose state, Lidia was airlifted to the nearest major trauma centre whereupon a neurosurgeon operated to relieve the pressure building up from a blood clot on her brain. Lidia spent eight weeks in a specialist rehabilitation centre, before being discharged to home. Lidia was incapable of doing anything other than get through each day during the first nine months. Lidia is still working toward being completely healthy so she can begin to live her life fully, be independent, and work at full capacity. She still faces numerous limitations as a consequence of the TBI, but chooses to focus on the positives.

2. **Complex or repetitive trauma.** This trauma relates to the ongoing abuse, domestic violence, war, or ongoing betrayal that often involves being trapped emotionally and/or physically.

   Photovoice Participant Story, Fiona. Having been diagnosed with post-traumatic stress disorder (PTSD) at age 35, Fiona knows there is not one aspect of her life that has gone untouched by this mental illness. Fiona's PTSD was triggered by several traumas, including a childhood full of physical, mental, and sexual abuse, and a knifepoint attack that left her thinking she would die. Fiona knew she would never be the same after that attack. For her, there was no safe place in the world, not even her home. Fiona endures ongoing challenges because of PTSD; however, she is taking medication and undergoing behavioural therapy to help her regain control of her life.

3. **Developmental trauma.** This form of trauma results from exposure to early, ongoing, or repetitive trauma received as an adolescent, during infancy, or childhood. It involves neglect, abandonment, physical abuse or assault, sexual abuse or assault, emotional abuse, witnessing violence or death, and/or coercion or betrayal. This often occurs within the child's caregiving system and interferes with healthy attachment and development.

   Photovoice Participant Story, Julian. Julian was separated from his mother, Leah, at the United States border after an arduous two-week journey from Central America that included a boat ride, extensive walking, and bus travel. Julian was three years old when he arrived in May 2018 at the Rio Grande City, Texas port of entry. Leah and Julian were seeking asylum because they feared the wrath of the MS-13 crime gang. Four days after their arrival, immigration officials made Leah place Julian in a truck. Leah could only watch as he cried and scrambled to get back to them as the vehicle drove away. After spending about six weeks in a detention facility in Texas, 2,500 kilometres away from Julian, Leah was able to reclaim her son from an immigrant children's shelter in New York. They later resettled in Canada. Julian was afraid to be away from Leah for more than a few minutes, and it took almost a year for him to fully trust her again.

4. **Intergenerational trauma.** This refers to the psychological or emotional effects that can be experienced by people who live with trauma survivors. Coping and adaptation patterns developed in response to trauma can be passed from one generation to the next.

   Photovoice Participant Story, Lindsey. Lindsey's mother, Jacky, had escaped the Rwandan genocide in 1994, fleeing soldiers with only the clothes on her back and her eight young children. Four of Jacky's brothers and sisters didn't make it to safety. After many years, Jacky was able to immigrate to the United States as a refugee, resettling in Nampa, Idaho, where Lindsey was born. Lindsey experiences feelings of unsafety, and struggles with her own mental health, depression, anxiety, and hypervigilance. Although Lindsey had not experienced her mother's trauma firsthand, and she describes her mother as kind and

caring, Lindsey still exhibits the effects of PTSD from transgenerational transmission of trauma.

5. **Historical trauma.** Historical trauma is a cumulative emotional and psychological wounding over the lifespan and across generations stemming from massive group trauma. These collective traumas are inflicted by a subjugating, dominant population.

   Photovoice Participant Story, Claudine. Claudine and her parents arrived in Ottawa in 2001 after surviving the Rwandan genocide, enduring countless acts of violence, and losing several family members. They had fled to the Democratic Republic of the Congo, then to Kenya, and then to Cameroon before being resettled in Ottawa by Catholic charities. Claudine's parents did not have family in Ottawa, but they quickly became close to people within the community who also shared Congolese roots and had had many of the same experiences before arriving in Canada. Her parents came to Canada without any English language skills and suffering from trauma and other scars of war. During Claudine's time in Canada, she was diagnosed and treated for numerous mental illnesses, including PTSD.

Trauma-informed services are built to consider an understanding of trauma in all aspects of service delivery and to place priority on the individual's safety, choices, and control. An important feature of trauma-informed services is to develop an environment that feels safe, where service users can make decisions about their treatment needs and not experience further traumatization or retraumatization.

INTERSECTIONS BETWEEN TRAUMA AND STIGMA

Some populations are subjected to disproportionate burdens of trauma and stigma as a result of deeply entrenched structural violence. Experiences of stigma within health and/or social service settings can be retraumatizing, whereas ongoing experiences of structural stigma (racism, cisnormativity, heteronormativity) can be traumatic (BC Provincial Mental Health and Substance Use Planning Council, 2013). Integrating trauma- and violence-informed care into practice requires understanding the role of stigma in trauma, and multilayered intersection between different types of trauma and the various layers of stigma.

INTEGRATING TRAUMA- AND VIOLENCE-INFORMED CARE

Trauma- and violence-informed care approaches recognize the connection between violence and trauma, and negative health outcomes and behaviours (Public Health Agency of Canada, 2018). The combined approach expands on the concept of trauma-informed care approaches to consider the broader systemic inequities that influence and contribute to interpersonal experiences of trauma and violence. Trauma- and violence-informed care acknowledges the intersection between trauma and many social and health issues. Therefore, it works toward removing some of the stigma attached to HIV/AIDS status, sexuality, and substance use (Public Health Ontario, 2019). This approach encourages the disruption of power imbalances within health and social settings. This is particularly important in the context of newcomers because, historically, these communities are disempowered and marginalized due to real and/or perceived membership within a stigmatized group.

PHOTOVOICE

Photovoice is a participatory action research method developed by Caroline C. Wang and Mary Ann Burris in the early 1990s (Wang & Burris, 1997). Participants of a photovoice project are often provided with a camera and encouraged to consider various photography techniques such as photo composition, lighting and contrast to best capture their perspectives and lived experiences. Upon photo completion, participants are asked to create a short caption for each

photo to reflect the moment. The purpose of photovoice is to provide an opportunity for communities to express their experiences and stories through photography, to connect with others in the community, and to advocate for change (Neighbourhood Action Strategy and Public Health Services, 2014). Photovoice allows communities and individuals to express their issues or concerns about topics that are most important and relevant to them. It is a powerful tool to help others understand and connect with issues because "a picture is worth a thousand words."

SPECIFIC AREA OF INTEREST

Building a Project Curriculum

Ellie had just finished presenting the findings from a literature review and community consultation she had been working on over the past few weeks. Ellie's manager summarized the project and said, "Now, we just need to find some way to fit this all into a 10-week curriculum."

The findings provided a foundation of evidence and research to support the curriculum for the Newcomer Photovoice project. With a focus on building social relationships and community connections, the curriculum included different strategies of engagement, while also addressing the different social and cultural determinants of health.

Ellie brainstormed ways to promote inclusion within the curriculum. She thought of various activities and icebreakers the participants could engage in to help build social connections. This included photography activities, a food-sharing session where participants were invited to share and cook their favourite food, an employment networking session, and a field trip to learn and understand how to navigate and access different services within the community.

Ellie also listened to newcomer community members to better understand what they wished the project included and what activities would be helpful to build social connections. Some participants mentioned it would be nice if they were able to graduate together at the end of the project, whereas others mentioned that an outing to a social space such as a beach or park would be fun.

By using a model known as DACUM, or Developing a Curriculum (Canadian Vocational Association, 2013) Ellie was able to arrange the curriculum sessions and corresponding activities. Ellie also developed a logic model with her colleagues to organize the different inputs, outputs, and anticipated outcomes of the project.

STAKEHOLDER ENGAGEMENT

Several stakeholders, including Patrolinx and Trinity Council Serving Immigrants (TCSI), were involved in providing input, advice, and support for the Newcomer Photovoice Project.

Patrolinx

Patrolinx, a local community newcomer service provider, agreed to support Ellie with the employment section of the curriculum. Patrolinx is a not-for-profit organization focused on providing newcomer services such as job search workshops, employment and legal assistance, and English language training. During Ellie's conversation with Steve Potrovski, the Manager of Family Services at Patrolinx, several important issues were identified. Steve mentioned that newcomers often struggle identifying with Western social norms more so than having the proper attire or well-structured resume. These norms included verbal and nonverbal communication

such as making eye contact and shaking hands. He further mentioned the importance for newcomers to understand their rights pertaining to employment.

“It’s also crucial that you use a newcomer lens in a way that fosters an inclusive environment and meets newcomers’ individual learning needs when delivering project material.” Steve went on to mention that newcomers who have been established within Canada for one year, compared with those who have been established in Canada for three years, have varying degrees of language literacy.

Newcomers can access language classes through Language Instruction for Newcomers to Canada (LINC), an English proficiency program offered nationally and funded by Immigration, Refugees, and Citizenship Canada.

“There are a set of levels that correspond to each LINC class offered. LINC level one refers to ‘low beginner’, whereas LINC level eight is ‘high intermediate’. Users need to be mindful of the newcomers they are engaging with and their individual abilities.”

TCSI (Trinity Council Serving Immigrants)
TCSI, a provincial council serving immigrants, supports Ellie’s organization, particularly in terms of providing knowledge mobilization and expert opinions on the curriculum topics. Ravnit Patel, a program coordinator at TCSI, suggested using a “storytelling” method to help facilitate conversations during the curriculum.

“Navigating differences in literacy skills and abilities is still something we are trying to figure out. But what I’ve noticed from my own practice is that storytelling can really help to facilitate conversations and break the ice. It also allows participants to tell a story in their own way, whether that be through song, art, or writing—you know what I mean?”

SPECIFIC PROBLEM OF DECISION

Ellie must now build a new curriculum that better reflects and meets the needs of newcomers within her community. She must consider the different types of stigma, trauma, and systemic racism these communities face and incorporate anti-oppressive and anti-racial practices within her new curriculum. Ellie must also work towards ensuring the new curriculum strengthens participants’ sense of belonging to the community through exploring the various social and cultural determinants of health.

CONCLUSION

Through consistent engagement with newcomer communities, and in using an antiracism and anti-oppression framework, a trauma- and violence-informed care approach, and an intersectional and newcomer lens, Ellie is able to develop a living process through which the curriculum can contribute to a culture of learning and community well-being. Ellie reflects on the potential drivers of stigma within her project, and highlights factors that could contribute to stigma, including individual, interpersonal, community, institutional, and policy factors. She works to ensure that her curriculum is delivered in a respectful way by reflecting on her own attitudes, values, and beliefs to increase awareness about the impact her personal biases and/or assumptions may have.

Ellie ensures the curriculum facilitates conversations that are inclusive and consider individual, community, and systemic factors such as oppression, literacy levels, language barriers, transience due to economic migration, sexual health messaging, geographic location of curriculum sessions, etc. Furthermore, she identifies barriers that may prevent newcomers from accessing the photovoice project. These barriers include confidentiality and privacy issues, lack

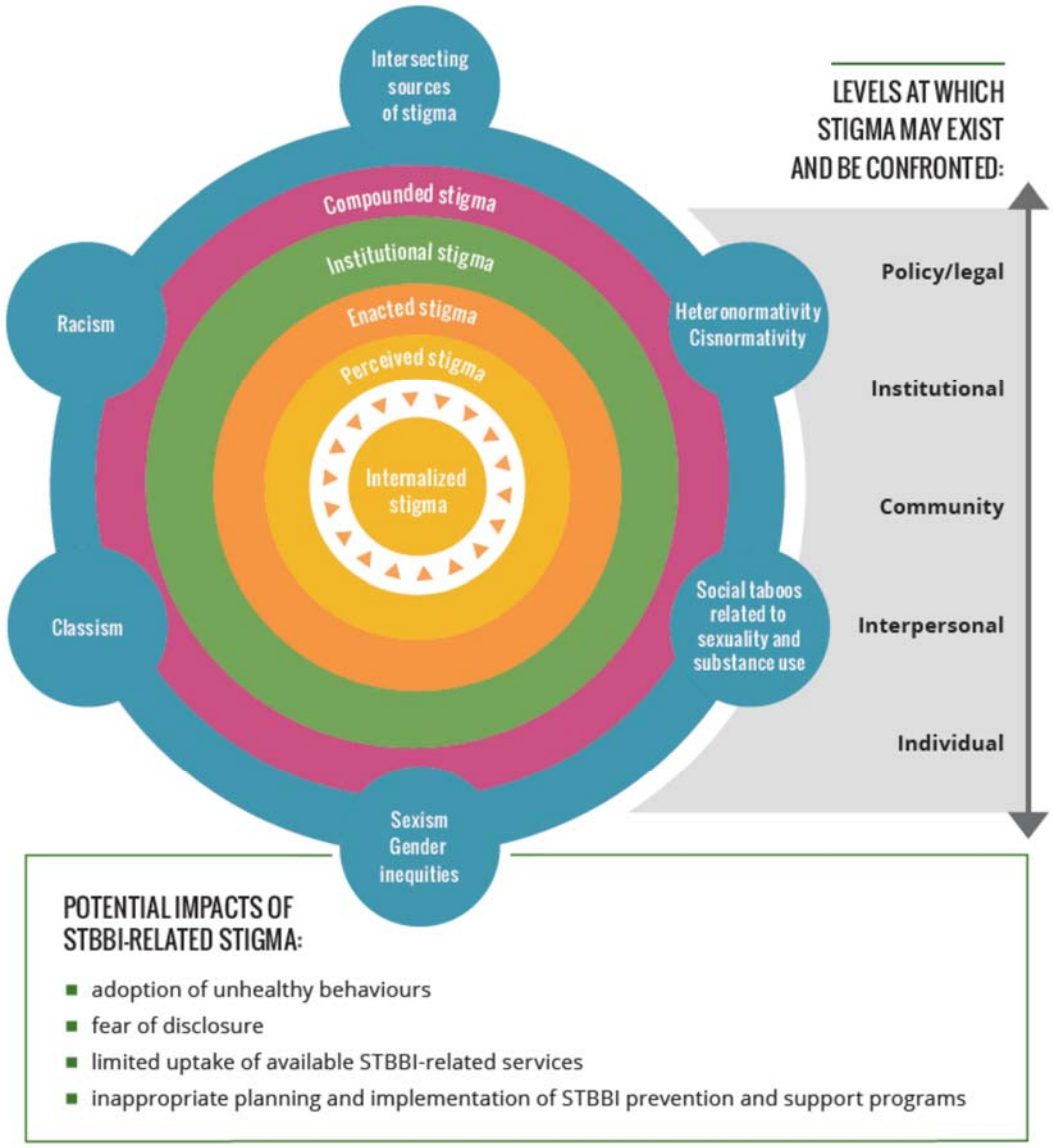
of physical space or visual cues to indicate safety and inclusion, lack of project facilitators who have diverse lived experiences, or the presence of project facilitators who have dismissive attitudes or use body-language that portrays judgement.

Ellie uses three principles—see, hear, and feel—to ensure her curriculum is inclusive and safe, and reduces organizational stigma (CPHA, 2017).
See. Ellie imagines what project attendees first see when they walk into THAS, what their first impressions are, and whether the promotional campaigns on the walls focus on specific populations who are seen as most at risk of contracting sexually transmitted and blood-borne infections (STBBIs). After reflecting, Ellie decides to mount several posters that promote diversity, and she ensures that the facilitators have diverse backgrounds and reflect newcomer communities. She adds a confidentiality component at the beginning of the curriculum to reaffirm to clients that their information will be protected. Ellie also works to ensure that the session rooms are accessible to people who have disabilities and other accessibility needs.

Hear. Ellie considers the type of language spoken by project facilitators and used on the curriculum materials and forms that need to be signed. She looks specifically at pronoun usage and whether there are questions about gender identity. She ensures the language used throughout the project is gender neutral and inclusive, and will promote and normalize conversations about sexuality, HIV/AIDS, immigration status, etc.

Feel. Ellie brainstorms ideas to ensure her curriculum creates a space that fosters a safe feeling among project attendees so they feel comfortable sharing personal experiences, beliefs, and identities. She decides to have a feedback opportunity toward the end of each session to ensure the curriculum reflects the abilities and learning styles of project attendees. She also ensures that all facilitators are culturally competent and trained to deliver material in a culturally responsive manner.

EXHIBIT 1
Stigma Defined



Source: Canadian Public Health Association, 2017.

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INSTRUCTOR GUIDANCE

Journeying Together—Unlearning is the New Learning

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BACKGROUND

Immigration plays an integral part in the development of multiculturalism within Canada, with the majority of immigrants representing visible minority communities. Research shows Canada's newest settlers are more likely to experience health disparities and inequalities compared to non-indigenous and Canadian-born residents. Research further indicates that the access and quality of health services is commonly compromised when health care and/or service providers do not respond appropriately to language and cultural factors impacting newcomer health. Communities vary in culture, traditions, and language, however, are often grouped together. One approach will not fit all with the cultural and ethnic differences within these communities. Ellie is faced with the challenging task to develop a project curriculum that promotes newcomers' sense of belonging to the community. This teaching case highlights the importance of intersectionality, addresses stigma, and discusses the need for providers to apply anti-oppressive and antiracist practices when working with diverse communities. The case introduces strategies that can be employed as living processes by which newcomers may contribute as active stakeholders to the overall culture of learning and community well-being.

OBJECTIVES

1. Explore and reflect how personal biases, assumptions, prejudices, and privileges can lead to conscious or unconscious forms of discrimination and oppression.
2. Identify different approaches to designing a public health program that is culturally responsive, anti-oppressive, antiracist, and acknowledges stigma and trauma.
3. Apply different lenses (transferable knowledge) when working with diverse populations, including intersectional, newcomer, and social determinants of health lenses.
4. Explore how to use trauma- and violence-informed care when working with vulnerable populations, and how to address the different types of stigma.

DISCUSSION QUESTIONS

1. Everyone has, at some point, contributed to stigma without knowing it or meaning to. Can you share or think of a time where you spoke or acted in a way that could have caused stigma or discrimination? If so, what can you learn from this experience?
2. Unlearning our own attitudes, values and beliefs is a key theme throughout this case. What are some negative attitudes, values, and beliefs that are prevalent in society?
3. How do you think service providers can be more sensitive to the challenge's newcomers face, and how can they better support newcomers to navigating health services?

KEYWORDS

Cultural competent care; transferable knowledge; un-learning; intersectionality; stigma; oppression; racism; social and cultural determinants of health; trauma; trauma- and violence-informed care.