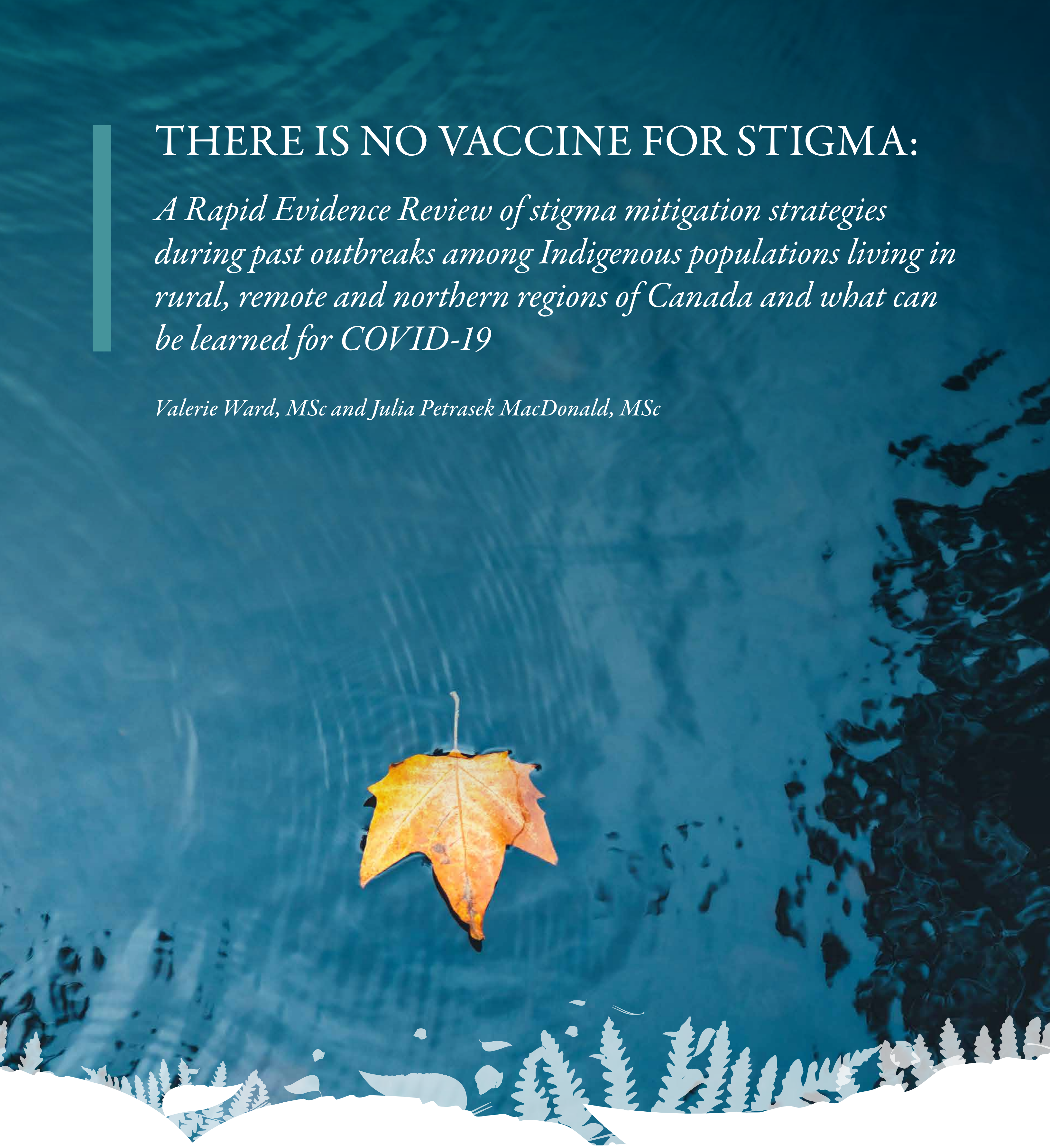


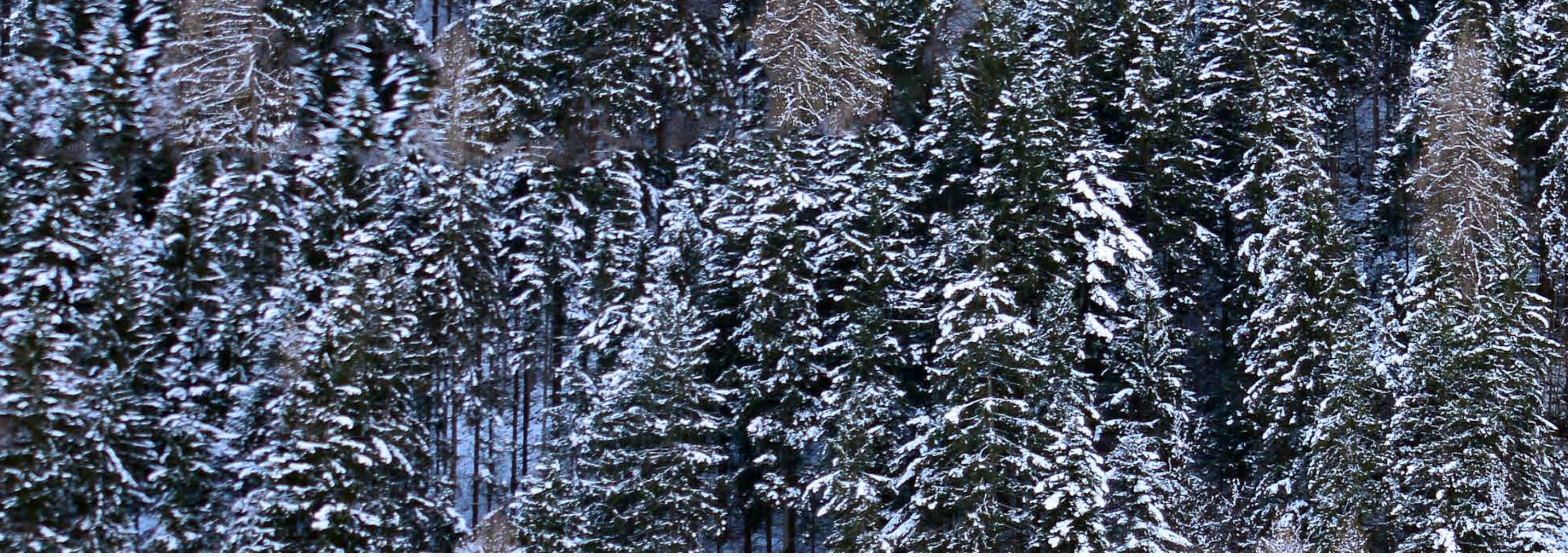
THERE IS NO VACCINE FOR STIGMA:

A Rapid Evidence Review of stigma mitigation strategies during past outbreaks among Indigenous populations living in rural, remote and northern regions of Canada and what can be learned for COVID-19

Valerie Ward, MSc and Julia Petrasek MacDonald, MSc

National Collaborating Centre for Indigenous Health
Centre de collaboration nationale de la santé autochtone

CHRONIC AND INFECTIOUS DISEASES



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Guided by the National Collaborating Centre of Methods and Tools Rapid Review Guide (Dobbins, 2017), this rapid review seeks to answer the question, "What are the best practices for preventing and mitigating COVID-19 related stigma in Indigenous rural, remote and northern communities within Canada?" The paper synthesizes information from 25 papers that explored stigma mitigation strategies used by Indigenous communities during past infection disease outbreaks and factors that need to be considered when undertaking such strategies within rural, remote, northern and Indigenous contexts.

Une version française est également publiée sur le site ccnsa.ca, sous le titre : *Il n'y a pas de vaccin contre la stigmatisation : un examen rapide des données probantes sur les stratégies d'atténuation de la stigmatisation pendant les éclosions dans les populations autochtones vivant dans des régions rurales, éloignées et du Nord du Canada et les leçons à en tirer pour la COVID-19*

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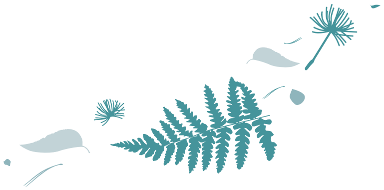

National Collaborating Centre for Indigenous Health
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northern health
the northern way of caring

The mandate of the Task Group on COVID-19 and Stigma was to serve as a platform to develop evidence-based recommendations and material on how to best counteract COVID-19 related stigma

PREFACE

The mandate of the Task Group on COVID-19 and Stigma was to serve as a platform to develop evidence-based recommendations and material on how to best counteract COVID-19 related stigma for the Public Health Working Group on Remote and Isolated Communities. This document, developed in collaboration and with expert advice from members of the COVID-19 Public Health Working Group on Remote and Isolated Communities, was created in partial fulfillment of the Working Group's mandate. Member organizations include:

- Assembly of First Nations
- Inuit Tapiriit Kanatami[1]
- Métis National Council
- Northwest Territory Métis Nation
- Nunavik Regional Board of Health and Social Services
- Council of Yukon First Nations
- Dene Nation
- Department of National Defence
- First Nations Health Authority
- Government of Newfoundland and Labrador
- Government of Northwest Territories
- Government of Nunavut
- Government of Yukon
- Saskatchewan Health Authority
- Indigenous Services Canada
- Public Health Agency of Canada
- BC First Nations Health Authority
- National Collaborating Centre for Indigenous Health

Co-Chairs of the COVID-19 Public Health Working Group on Remote and Isolated Communities

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[1] While Inuit Tapiriit Kanatami are part of the COVID-19 Public Health Working Group on Remote and Isolated Communities, they do not endorse this document.

KEY MESSAGES

Considerations in developing stigma mitigation strategies include:

1. Context specific strategies:

There is no one-size-fits all stigma mitigation strategy. Stigma mitigation strategies should be context and community specific. Stigma mitigation strategies should be allowed to evolve in response to community needs and changing circumstances. They should be based on the wishes and needs of the community and reflect the culture and values of a community. What works in one community should not be assumed to work in all communities.

2. Strengths-based and resilience focused:

Mitigation strategies directed at stigma and COVID-19 among Indigenous populations should acknowledge the resilience and strengths that exist within Indigenous communities and have existed for centuries. We recommend working with community to draw on local knowledge and stories, and move away from a disease-centered and deficit-based lens.

3. Recognize the sovereign rights of First Nations, Inuit, and Métis Peoples:

Decision makers must be familiar with, and acknowledge, the harmful experiences of colonial policies, as well as the ongoing impacts of these colonial practices toward First Nations, Inuit and Métis. In addition, decision makers should honour these communities as sovereign nations that need to be consulted and empower them to be decision makers for their own communities.

4. Multi-faceted:

Like layers of an onion, we need multiple strategies which address multiple systems concurrently. Stigma is a complex, multi-faceted, construct that is enforced at individual, community, and organizational/systemic levels. Stigma mitigation strategies should reflect this reality and in turn be multi-layered and focused on multiple systems (more than just educating the individual). Strategies may include education, sharing stories, group discussions, decriminalization of COVID-19, organizational commitment to tackling stigma, and more.

5. Dynamic strategies:

COVID-19 is a rapidly unfolding situation and strategies must incorporate and respond to new issues as they arise. Stigma mitigation strategies must be permitted to change/evolve depending on new information and progression of the pandemic.

6. Humility:

Decision makers should be humble while working with stakeholders and other decision makers. They should entertain a willingness to work together and listen to each other, regardless of culture, ethnicity, gender, and race, and to honor each other's stories. They should be willing to be empathetic to themselves and each other and reflect on their biases and assumptions. They should be inclusive and encourage and embrace diversity in order to celebrate our shared humanity and what unites us.

7. Partnered approach:

   In order to prioritize and create culturally specific strategies for stigma mitigation, decision makers should partner with community champions and leaders. It may be beneficial to draw on community knowledge when developing these strategies.

8. Methodical, rigorous and aware of gaps in the literature:

   We recommend that when doing a Rapid Evidence review on Indigenous topics, which are under-researched/under-represented in academic literature, it is of value to include grey literature sources, such as news articles, oral accounts, and stories to better represent a more wholesome account. This can be done in a methodical and rigorous way, as demonstrated in this paper.

There also remains a dearth of literature related to best practices around stigma mitigation strategies, and specifically Indigenous-led strategies. Gaps are outlined below and offer important opportunities for future research.

1. Misinformation and lack of knowledge as drivers of stigma: to date, there is minimal information discussing the role of misinformation and lack of knowledge as drivers for COVID-19 related stigma, especially as it relates to and manifests in northern, rural, remote, and Indigenous communities in Canada. More research is needed to better understand the roles of misinformation regarding COVID-19 and how this drives fears and anxiety. An important area for research related to fear may include the experiences of being quarantined or entering self-quarantine.

2. Impacts of public health measures related to COVID-19 on Indigenous communities and Peoples: currently, there is no literature on the impacts of COVID-19 public health measures as they relate to potential stigma within Indigenous communities. Research is needed to explore how public health measures during pandemics might impact and/or perpetuate stigma within communities and should be prioritized as an important area for further study. In addition, at this time we do not have enough information to comment on specific public health measures and how these might drive stigma. It would be worthwhile to explore how various public health measures might impact and perpetuate stigma in various contexts (e.g. in rural, northern, remote communities).

3. Impacts of stigma on already stigmatized populations: research has shown that stigma is intersectional and can impact people in different ways, depending on their identities, cultures, etc. However, more research is needed to explore how stigma related to COVID-19 impacts individuals and communities who might already be negatively stigmatized due to culture, gender, religion etc., including how Indigenous Peoples in Canada might be impacted further by stigma related to COVID-19.

4. Impacts of stigma on community relationships: a further gap in the literature is research on experiences of stigma within smaller communities, such as rural, remote, and Indigenous communities, as it relates to COVID-19. Some First Nations communities in northern British Columbia have reported positive COVID-19 cases and this information has been published in local newspapers and on social media. Understanding the implications of this public reporting of private health information and how this might perpetuate stigma within communities and for individuals is unclear at this time, thus more research is required.

5. Education as a stigma mitigation strategy: while research has demonstrated that education has promise in stigma mitigation, there lacks sufficient research to understand what this education might look like in the context of COVID-19, and with regards to Indigenous Peoples. It is also recommended that a definition of 'education' be established to include not only passive forms of education (i.e. receiving information through pamphlets, presentations etc.), but to be inclusive of critical self-reflection and principles of humility.

6. Sharing personal stories as a stigma mitigation strategy: none of the papers identified in this review explored the role of personal story as a stigma mitigation tool for COVID-19. As such, the impact of sharing stories and personal experiences of COVID-19 on reducing stigma remains unknown and should be further researched, especially among those living in rural, remote and Indigenous communities.

7. Although cultural safety is not directly suggested in the literature as a way to mitigate stigma, we suggest the same principles of cultural safety (i.e. self-reflection and learning, humility, respect and dignity in relationships) can be used as part of a strategy to tackle stigma related to COVID-19 within healthcare systems and facilities, especially related to Indigenous Peoples. As such, further research should be done to explore how principles of cultural safety, humility, and competency relate to stigma mitigation, and potential strategies.

What are the best practices for preventing and mitigating COVID-19 related stigma in Indigenous, rural, remote and northern communities within Canada?

EXECUTIVE SUMMARY

The novel Coronavirus 2019 (COVID-19) has become an important public health topic. Public health measures, including physical distancing and travel restrictions, have the potential to prevent or exacerbate stigma. Stigma around COVID-19 has the potential to negatively affect health outcomes for Indigenous Peoples living in rural, remote and northern regions of Canada. The potential for COVID-19 to generate stigma resulted in the formation of a Task Group on Stigma and COVID-19 to provide evidence-based recommendations and material for the Public Health Working Group on Remote and Isolated Communities.

We undertook a Rapid Evidence Review, guided by the National Collaborating Centre of Methods and Tools Rapid Review Guide (Dobbins, 2017), to gather existing evidence to answer the following research question: **What are the best practices for preventing and mitigating COVID-19 related stigma in Indigenous, rural, remote and northern communities within Canada?** In order to answer this question, we asked:

1. What stigma mitigation strategies have been used by Indigenous communities in Canada during previous epidemics, pandemics, or infectious disease outbreaks (i.e. COVID-19, HIV/AIDS, Tuberculosis, H1N1 influenza)?

2. What factors need to be considered when undertaking stigma mitigation related to infectious diseases within rural, remote, northern, and Indigenous communities within Canada?

The literature search was conducted in May 2020 and repeated in October 2020. Six databases were systematically searched, including: Pubmed, CINAHL, PsychInfo, OVID Medline, Web of Science, and Native Health Database. Seven additional papers were included based on a review of reference lists or recommendations by the Working Group as being relevant to the topic, for a total of 25 papers. The 25 retrieved papers were reviewed and critically appraised by two independent assessors and the evidence was synthesized below.

This rapid review identified six broad themes which explore the topic of best practices for stigma mitigation among Indigenous, rural, remote and northern communities in the face of an infectious disease outbreak such as COVID-19. The themes include: 1) pathogen factors; 2) fear, anxiety and misinformation; 3) stigmatised identities; 4) structural and systemic drivers; 5) culture and community; and 6) public health and media. Some of the stigma mitigation strategies discussed in the literature include: providing education and information to address fear and anxiety; sharing personal stories, especially from those who belong to stigmatised groups, to tackle stigma; and implementing systemic and structural plans to mitigate and combat racism and stigma within workplaces. Other strategies include developing culturally informed and relevant health services and considering the possible impacts of public health measures. Knowing that stigma may disproportionately impact Indigenous Peoples, it is our recommendation that any future strategies centre Indigenous ways of knowing and experiences of stigma.

INTRODUCTION

The first recognized and reported case of the novel coronavirus 2019 (COVID-19) was identified on December 31, 2019 (World Health Organization [WHO], 2020). Almost one month later, on January 30, 2020, the WHO deemed COVID-19 a public health emergency requiring worldwide attention (WHO, 2020). On March 11, 2020, the WHO designated the outbreak a pandemic (WHO, 2020). Public health measures, such as recommendations for physical distancing, closing of borders, travel restrictions, contact tracing, and mandatory self-quarantine after travel abroad or known exposure were among some of the measures put in place to control the spread of COVID-19. Public health responses have varied widely nationally, provincially and even regionally as the situation has evolved.

While important for containment and prevention (Lewnard & Lo, 2020; The Lancet, 2020), the public health responses to COVID-19 have the potential to prevent or exacerbate stigma (UNAIDS, 2020). For example, naming a virus can result in unintentional economic and social impacts, by stigmatizing certain communities or industries, as was the case with swine flu and Middle Eastern Respiratory Syndrome (MERS) (WHO, 2020). Fear of becoming infected can lead to stigmatisation of those who test positive (UNAIDS, 2020), which may prevent individuals from being tested or seeking out care. Furthermore, many Indigenous communities responded with their own public health measures to protect their communities, Elders and vulnerable people. Recognizing the potential for stigma stemming from COVID-19, a Task Group on Stigma and COVID-19 was developed to provide evidence-based recommendations and material for the Public Health Working Group on Remote and Isolated Communities (Task Group on Stigma and COVID-19, 2020). A rapid evidence review was undertaken to guide the development of stigma mitigation strategies for COVID-19 related stigma within and towards Indigenous, rural, remote and northern communities within Canada. This evidence review asked: **What are the best practices for preventing and mitigating COVID-19 related stigma in Indigenous, rural, remote and northern communities within Canada?** In order to answer this question, we asked:

1. What stigma mitigation strategies have been used by Indigenous communities in Canada during previous epidemics, pandemics or infectious disease outbreaks (i.e. COVID-19, HIV/AIDS, Tuberculosis [TB], H1N1 influenza)?

2. What factors need to be considered when undertaking stigma mitigation related to infectious diseases within rural, remote, northern and Indigenous communities within Canada?

CURRENT KNOWLEDGE

What is stigma?

Stigma manifests when labels are used to separate persons described as 'normal' from the 'abnormal' other (Cain et al., 2013a; Logie, 2020a; Public Health Agency of Canada [PHAC], 2019a). Stigma serves to position those who have a condition that is deemed undesirable as lower than those who do not have the condition, and it results in a loss of power and status (Cain et al., 2013; Logie, 2020). Stigma is grounded in larger, complex societal issues related to racism, gender, and sexism, and when acted upon, it can result in discrimination or unfair treatment (Eaton & Kalichman, 2020). From a social-ecological approach, stigma can also be internalized when the person comes to believe these stigmatized perspectives about themselves (Logie, 2020), beliefs that can further impact their relationships with other people (Budhwani et al., 2018; Budhwani & De, 2019; B. Turan et al., 2017).

For the purposes of this paper, stigma is considered a complex, socially constructed, and intersectional concept. This socially constructed stigma is further reinforced by health, legal, employment and other institutions, as well as by systemic policies and influences. (Logie et al., 2011; Stangl et al., 2019; J.M. Turan et al., 2019). Rather than existing in siloes, stigma interfaces with many different aspects of identity: health, gender, race, income, and sexuality (to name a few), potentially producing a 'layering' effect (Mill et al., 2010). For example, intersecting stigma – such as racism and poverty – interact with HIV-related stigma to harm health engagement and outcomes (Cain et al., 2013), potentially presenting analogous barriers to COVID-19 testing and treatment (Page et al., 2020). For example, in a study by Cain et al. (2013), 72 Indigenous people living with HIV/AIDs and depression were asked about their experience receiving their diagnosis of HIV. Disclosing a diagnosis of HIV led several participants to feel rejected by those around them, be cut off from their loved ones, and in some cases being told to leave their community. Furthermore, a sense of isolation from others was self-imposed due to feelings of anticipated rejection (Cain et al., 2013). At the time of this research, stigma around COVID-19 is currently unfolding, thus little is known about how, and the extent to which, COVID-19 is contributing to social stigma, power hierarchies, and a sense of 'othering,' particularly within rural, northern, remote and Indigenous Peoples in Canada.

Stigma and health outcomes

Being stigmatized within healthcare settings has consistently been associated with negative health outcomes (Benoit et al., 2018; Bruns et al., 2020a; Budhwani & De, 2019; Link & Hatzenbuehler, 2016; PHAC, 2019b). For example, people may not access care until symptoms are unmanageable or not at all due to fear of being stigmatized or labeled as someone who carries the infectious disease (Baral, Karki, & Newell, 2007; Bruns et al., 2020; Cain et al., 2013; Woodgate et al., 2017). Patients who believe or perceive they are being stigmatized may delay seeking care, others may become afraid of those believed to be sick, entire populations may be prejudiced against, and in some cases, stigmatization has led to violence against individuals and groups (Bruns et al., 2020). Stigma around COVID-19 has the potential to negatively affect health outcomes for Indigenous Peoples living in rural, remote and northern regions of Canada.

Drawing from this research and evidence, Indigenous Peoples in Canada are most likely to be disproportionately affected by COVID-19. This is directly related to historic and ongoing processes of colonization. In highlighting the historical context of Indigenous relations with the Canadian state below, we point to racist policies that have shaped and continue to shape Indigenous People's health across Canada. However, it is not our intention to 'reinforce' a disparities discourse that exists very prominently within academia and research related to Indigenous health. Rather, this section is meant to set a context for historical processes and policies that have impacted, and continue to impact, Indigenous communities and peoples, and therefore might disproportionately impact their experiences of stigma with regards to COVID-19. We acknowledge the great need for strength-based approaches in research and Indigenous research methodologies, knowledge and ways of being to address and explore further stigma associated with COVID-19 and other infectious diseases.

Setting the context: a history of colonization

This rapid evidence review is meant to focus specifically on Indigenous Peoples[2] in Canada, and the increase in stigma that Indigenous communities are experiencing due to COVID-19, including in northern, rural and remote communities. As such, it is important that historical and ongoing impacts of colonialism are considered when discussing stigma experienced by Indigenous Peoples, especially in the context of COVID-19 or other infectious diseases (Adelson, 2005; Browne et al., 2009; Greenwood, de Leew, Lindsay, & Reading, 2015). The history of colonization in Canada includes displacement of Indigenous Peoples from their territories and relocation to reserve lands, children forcibly placed in residential schools, and cultural practices banned and outlawed, leading to disruption of Indigenous Peoples and communities. The Indian Act (1876) is one such example that has and continues to negatively affect the health and well-being of First Nations Peoples specifically, across Canada. This has directly contributed to poorer health outcomes and reduced health and well-being across the country, especially when compared to non-Indigenous people in the country. Much of this is well documented (Adelson, 2005; Gracey & King, 2009). Although an in-depth discussion of the impacts of colonial policies, such as the Indian Act, is beyond the scope of this Rapid Evidence Review, we include a discussion in brief to set some context.

Today, Indigenous Peoples across Canada continue to be affected by colonial structures and policies put in place with the intention of assimilating them into mainstream Euro-settler society, or simply eradicating Indigenous communities and cultures. Policies such as the Indian Act continue to impact Indigenous communities and culture through loss of self-determination and self-government (Adelson, 2005). Indigenous voices continue to be marginalized in natural resource decision-making occurring on traditional lands. Ongoing harms to the natural environment impact cultural and traditional practices, disrupts intergenerational relationships and sharing of culture between generations and can negatively influence the health of Indigenous people and communities (Allan & Smylie, 2015). These are racist policies and they continue to shape the health, well-being and lived realities of Indigenous Peoples in Canada. Identifying these systemic and structural policies assists to understand why Indigenous communities are at greater risk of infection, stigmatization, and negative experiences due to COVID-19. Furthermore, these policies have contributed to, and continue to drive, racist and stigmatizing attitudes pointed at Indigenous Peoples by non-Indigenous Canadians, especially within the healthcare system (Allan & Smylie, 2015).

Historical trauma, pandemics, and COVID-19

The impacts of colonization have manifested in historical and inter-generational trauma which has led to mistrust in Western systems, including health care and education (Aguiar & Halseth, 2015; Wesley-Esquimaux et al., 2004). Additionally, infectious diseases have led to devastating impacts on Indigenous communities. When Europeans first arrived in what is now known as Canada, these early settlers brought various infectious diseases such as tuberculosis (TB), smallpox, influenza, measles and whooping cough. Although Europeans carried a certain amount of

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[2] The term 'Indigenous peoples' is used throughout this paper to refer collectively to the original inhabitants of Canada, including First Nation, Inuit, and Métis. Where possible and appropriate, we distinguish between First Nations, Inuit and Métis.

immunity to these diseases, Indigenous Peoples were left completely vulnerable to the devastating effects of these diseases. The Haida First Nation in Northwestern British Columbia is an example of the complete devastation European diseases brought. As recounted by a Haida Elder, the Haida Nation had over 80,000 members before contact, but was decimated to less than 600 by epidemics like smallpox (Wesley-Esquimaux et al., 2004). Infectious diseases have resulted in immense loss and devastation of not only people, but also culture, language and knowledge, which has contributed to the intergenerational traumas experienced in many Indigenous communities. More recent infectious disease outbreaks, such as the H1N1 influenza in 2009, have also disproportionately impacted Indigenous communities in Canada, highlighting the potentially disproportionate impacts that COVID-19 may also have on this population.

While 1 in 10 deaths from the H1N1 influenza in Canada were among Indigenous Peoples (Driedger et al., 2013; Kermode-Scott, 2009; National Collaborating Centre for Aboriginal Health [NCCAH], 2016b), Indigenous communities also faced systemic racism and discrimination when trying to protect their communities. Many lessons were learned from this outbreak that may be beneficial in understanding the trauma experienced in many of these communities, the vulnerabilities of Indigenous communities living in rural, remote and northern communities, and also in grounding our discussion of stigma in the face of COVID-19. Indigenous communities were at higher risk of infection due to the increased likelihood of having underlying health conditions, overwhelmed and underfunded health services, and human resources challenges (Moghadas, Pizzi, Wu, Tamblyn, & Fisman, 2011; NCCAH, 2016b). Research emerged post-H1N1 discussing implications of pandemics on northern and rural Indigenous communities, the complexities involved in pandemic responses for geographically isolated communities, and inappropriate responses from governments. For example, instead of sending needed supplies and resources to Indigenous communities to address the spread of the virus and lessen impacts in the community, body bags were sent instead. Furthermore, the federal government delayed sending hand sanitizer in a timely manner to some Indigenous communities due to fears it might be ingested (Spence & White, 2010). These two instances point to structural racism and stigmatizing practices entrenched in government and health sector practices (Spence & White, 2010). Preventive planning, effective emergency responses, and better communication strategies were indicated as broad areas needing attention in response to the H1N1 pandemic outcomes in Indigenous communities (NCCAH, 2016a). Additional recommendations included the need to identify those more susceptible to infectious diseases, address social and economic disparities, ensure communities have adequate and timely access to resources and supplies, ensure access to appropriate healthcare, and implement better surveillance strategies and rapid diagnosis, early treatment, and aggressive mitigation. Furthermore, as rural, remote, and northern communities are more vulnerable to the devastating impacts of pandemics, they require effective emergency measures to prevent community members from becoming ill in the first place, and ultimately taking swift efforts to slow the spread of infection (NCCAH, 2016a). Finally, effective, clear, and consistent communication and messaging was noted as an important recommendation for future pandemic planning, especially culturally specific information and messaging (NCCAH, 2016a). We anticipate that these broad recommendations are useful in informing responses to COVID-19 by Indigenous communities in rural, remote and northern communities, and are necessary to avoid repeating historical outcomes and preventable losses.

It is with this context in mind that we undertook a rapid evidence review to understand the best practices for preventing and mitigating COVID-19 related stigma in Indigenous, rural, remote and northern communities within Canada. To undertake this work, we drew on learnings from previous infectious disease outbreaks faced by Indigenous communities, including H1N1 influenza, tuberculosis and HIV/AIDS. A synthesis of findings is provided below.

More recent infectious disease outbreaks, such as the H1N1 influenza in 2009, have disproportionately impacted Indigenous communities in Canada, highlighting the potentially disproportionate impacts that COVID-19 may also have on this population.

SYNTHESIS OF FINDINGS

This rapid review identified six broad themes which explore the topic of best practices for stigma mitigation among Indigenous, rural, remote and northern communities in the face of an infectious disease outbreak such as COVID-19. The themes include: 1) pathogen factors; 2) fear, anxiety and misinformation; 3) stigmatised identities; 4) structural and systemic drivers; 5) culture and community; and 6) public health and media.

Pathogen factors

Method of transmission, infection rates, and mortality rates are among some of the pathogen-specific factors that can drive stigma related to a novel virus such as COVID-19 (Bruns et al., 2020). These pathogen specific factors are discussed in three papers included in this review (Bruns et al., 2020a; Logie, 2020; Logie et al., 2011). For example, one way a pathogen can drive stigma is through its method of transmission. Method of transmission can result in the labeling of certain behaviors as 'high risk' for infection, and subsequently result in stigma. In the case of HIV/AIDS, one of the methods of transmission involves unprotected sex with an infected individual, which quickly resulted in stigma towards individuals participating in these behaviors, especially towards men who have sex with men (Logie, 2020). Similarly, in COVID-19, the arrests of people for breaching COVID-19 public health measures and subsequent labeling as 'super spreaders' results in the creation of the 'immoral' other (Logie, 2020). This contributes to stigma towards individuals, groups and communities. Learning and researching about a pathogen generally does not allow us to change the pathogen; however, pathogen-specific factors, such as method of transmission, can create intended or unintended stigma towards groups of people. The ways in which these pathogen factors can contribute to stigma warrants further discussion and exploration.

Fear, anxiety and misinformation

Six of the 25 articles in this review highlight the role of fear and anxiety as a driver for stigma associated with infectious diseases outbreaks (Bruns et al., 2020; Cain et al., 2013; Centre for Disease Control, 2020; IFRC et al., 2020; Kane et al., 2019; PHAC, 2019a; Woodgate et al., 2017). COVID-19 can result in fear due to the novelty of the virus, worries of contracting the virus, uncertainty about how the virus spreads, natural history of the virus, disruption of normal routines, or not knowing how to keep oneself and one's family safe (Centre for Disease Control, 2020; IFRC, UNICEF, & WHO, 2020). Fear of contagion is a unique aspect of infectious disease stigma, perhaps more so than other health-related stigma (i.e. mental health). Misinformation and lack of information can add to the fear and anxiety that exists during an infectious disease outbreak, as identified in this evidence review (Donnelly et al., 2016; Woodgate et al., 2017). For example, in a study by Woodgate et al. (2017), Indigenous participants with an HIV positive status expressed feeling stigmatized and discriminated against by family members and friends due to their not knowing about or misunderstanding the disease and how it is transmitted. This stigmatization resulted in a loss of connections with their communities and psychological distress among participants with HIV positive status. Similarly, in another study of 33 Aboriginal, Latino, Asian and African participants, all of whom had positive HIV diagnoses, misinformation

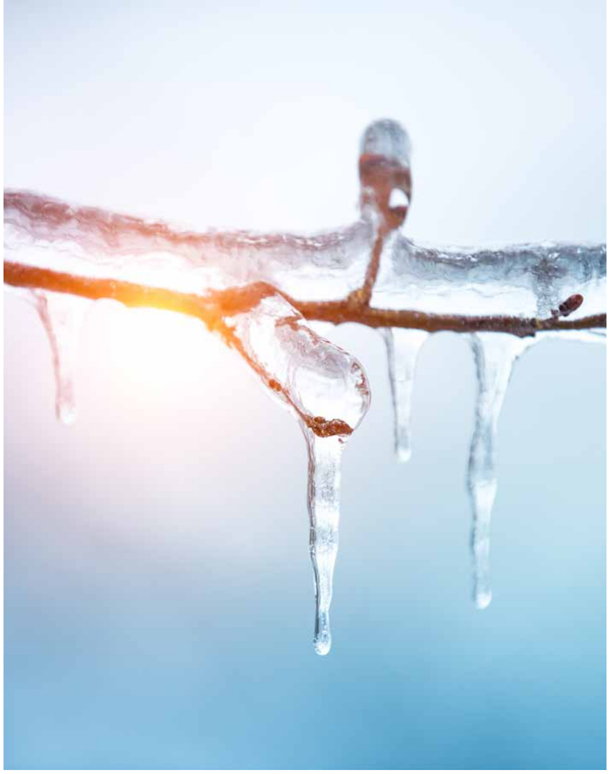
and fear amongst their peers and families resulted in stigma and discrimination for several participants (Donnelly et al., 2016). What is known about COVID-19 is rapidly evolving and new evidence is emerging daily, adding to fear and anxiety about this pandemic. To date, there is no research which explores the fears, anxieties, and knowledge of COVID-19 among northern, rural, remote and Indigenous communities in Canada. More research is also needed to explore the link between fear, anxiety and knowledge of COVID-19 and experiences of stigma within these communities.

Interestingly, those with increased personal resources, such as education, income, and social support, reported less fear and worry around HIV and SARS, and were less likely to stigmatize those with the diseases (Des Jarlais et al., 2006). Addressing fear, misinformation and knowledge gaps through education has been suggested as a useful practice for combating HIV-related stigma (Woodgate et al., 2017). While education can be useful in addressing knowledge gaps and misinformation and reducing anxiety, it has been suggested that education should not be used alone for stigma mitigation. This was demonstrated by Rao et al. (2019), who found that education-based strategies alone are ineffective at addressing stigma as they do not lead to people rejecting stereotyped beliefs but rather suppressing these beliefs. Within the mental health literature, this sentiment is echoed in other brief educational campaigns that did not have lasting effects on behavioral change (Livingston et al., 2014; National Academies of Sciences, Engineering, and Medicine, 2016). There remains limited information about the role and efficacy of either isolated education campaigns or education campaigns as part of a larger stigma mitigation strategy as it relates to COVID-19 and Indigenous populations. It is likely to be a useful tool in stigma mitigation; however, it should not be used in isolation and should be anchored in critical self-reflection. We argue that education programs should be designed to increase knowledge and challenge individuals to critically reflect on their behaviour, assumptions, and biases, with the goal of changing people's behaviours and stigmatizing practices.

Stigmatised identities

More than half of the papers (n=13/25) in this rapid evidence review highlighted the intersectionality of stigma, as well as its negative impacts on seeking care for infectious diseases (Bucharski, Reutter, & Ogilvie, 2006; Cain et al., 2013; Des Jarlais et al., 2006; Donnelly et al., 2016; Jongbloed et al., 2019; Kane et al., 2019; Logie, 2020; Logie et al., 2011; Loutfy et al., 2012; Marziali et al., 2020; Mill et al., 2010; Saewyc, Clark, Barney, Brunanski, & Homma, 2014; Woodgate et al., 2017). One of the articles identified was a systematic review on Indigenous Peoples' experiences of HIV care and summarized

93 qualitative and quantitative articles published between 1996 and 2017. This review found that some participants felt discrimination based on HIV status, and identified its intersection with their race, substance use, sexual or gender identity, and spirituality (Jongbloed et al., 2019). Some of these individuals sought out Indigenous-specific, gender-specific, or HIV-specific services in an effort to avoid feeling stigmatised or discriminated against, a challenge in rural and remote areas (Jongbloed et al., 2019). For already stigmatised populations, internalized stigma, that is negative feelings and thoughts about oneself due to experiencing stigma, may prevent some individuals from seeking medical care if they are COVID-19 symptomatic, which is a common trend seen with those diagnosed with HIV and TB (Jetty, 2020; Pantelic, Steinert, Park, Mellors, & Murau, 2019; Woodgate et al., 2017). Although several commentaries highlight the potential for COVID-19 stigma to intersect with other stigmatised aspects of one's identity (Dunlop et al., 2020; Eaton & Kalichman, 2020; Jenkins et al., 2020; Logie, 2020; Logie & Turan, 2020), there is a lack of primary literature which explores this.



Several papers identified in this review (n=6/25) found that sharing personal stories can be an effective tool for stigma mitigation among people living with HIV (Logie & Turan, 2020), and for generating solidarity and reclaiming identities (IFRC et al., 2020; Hatala et al., 2018; Logie et al., 2011; Logie, 2020; UNAIDS, 2020). Hiring people with lived experiences within community organizations can also help reduce stigma as a barrier for those accessing community services. For example, one study by Hatala et al., (2018) interviewed 21 Indigenous people living with HIV/AIDS in Saskatoon. Several participants highlighted the "important identity transformation and role of being and becoming a 'helper' in the community" (Hatala et al., 2018, p.1099). Being a 'helper' for others within their community allowed these participants to reclaim and transform their identity from a strengths-based perspective. This is consistent with the literature showing that sharing stories and hearing from people with lived experiences with an illness (such as HIV or mental illness) has been one of the best documented methods to reduce stigma among healthcare providers (Nyblade et al., 2019; UNAIDS, 2020). Methods of sharing stories may involve interaction, discussions, games, and role play to share information, share how stigma affects communities, encourage reflection on personal biases, and ensure institutional support for stigma mitigation (Nyblade et al., 2019; UNAIDS, 2020). During the COVID-19 pandemic, individuals, communities and media outlets are sharing stories of people impacted by COVID-19 to try and reduce the fear and stigma around the disease (IFRC et al., 2020; Nyblade et al., 2019). It is reasonable to infer that sharing stories of people impacted by COVID-19 may help to build connections via kindness and caring and allow listeners/viewers to engage with empathy to the story being told, thereby reducing othering and stigmatizing practices (UNAIDS, 2020; WHO, 2020). However, the impact of sharing stories and personal experiences of COVID-19 on reducing stigma remains unknown and should be further researched, especially among those living in rural, remote and First Nations, Métis and Inuit communities.

Understanding our shared humanity and collective experiences on the pandemic may be a step towards fostering solidarity during COVID-19. Logie (2020) argues that while it is important to focus on stories of individuals with lived experience during the epidemic, it is equally important to remember the complexity and fullness of people's lives and share the collective experiences too. For example, the videos of people singing from their balconies while quarantined in Italy during COVID-19 serves to highlight the unity that can evolve in the face of hardship, creating a new community among those affected. Similarly, the message from British Columbia's Medical Health Officer during the COVID-19 pandemic has been "Be Kind, Be Calm, Be Safe," a reminder that we are all in this together and interconnected in our vulnerability to sickness. Creating a sense of togetherness in the face of adversity may be useful for reducing stigma; this is an area that has not been well researched as it relates to COVID-19 but deserves further attention.

Structural and systemic drivers

Nearly half of the papers (n=11/25) in this review identified structural and systemic factors as drivers of infectious disease related stigma relevant to Indigenous Peoples (Bucharski et al., 2006; Cain et al., 2013; Charania & Tsuji, 2012; Donnelly et al., 2016; Jongbloed et al., 2019; Logie & Turan, 2020; Loutfy et al., 2012; Mill et al., 2010; Newman, Woodford, & Logie, 2012; Saewyc et al., 2014; Woodgate et al., 2017). For example, one paper by Mill et al. (2010) describes how stigma related to HIV/AIDS has been used as a means of social control through shunning, ostracizing, labeling, and disempowering healthcare practices to separate the sick from the not-sick. Indigenous and non-Indigenous participants in their study shared experiences of being treated differently after they disclosed their HIV status, resulting in decreased social supports, precarious living situations, and lack of access to appropriate care (Mill et al., 2010). When organizations demonstrate their commitment to responding appropriately to COVID-19 and systemic stigma such as racism and discrimination, it can influence the people who work there as well as those who receive support from these organizations. This can be undertaken through setting aside adequate resources, developing safety policies, using trauma informed approaches, and increasing choice and control for employees. More research is needed which looks at the role of organizational and institutional level interventions to mitigate COVID-19 associated stigma.

Tackling stigma requires a multi-factorial, multi-systems, and multi-layered approach given the complex ways stigma interfaces with various identities, structures, and systems (Bruns et al., 2020; Logie, 2020; Logie & Turan, 2020). Greenwood (2019) argues that change at service delivery, systemic, and structural levels is critical for addressing ongoing racism and discrimination directed towards Indigenous Peoples within healthcare systems in Canada. Throughout the article, she draws examples from work and partnerships within the Northern Health Authority region of British Columbia to address racism at multiple levels, including service delivery, systemic, and structural levels of health care. Structural 'enablers' (i.e. change at the structural level) included agreements and accords in British Columbia between First Nations and the provincial and federal governments, including the creation of the First Nations Health Authority (FNHA), the first health authority of its kind in the country. Systemic level change has included conception of the First Nations Health and Wellness Plan, jointly developed by First Nations communities and leadership, the FNHA, and Northern Health. Supported by working groups comprised of individuals from Northern Health, FNHA and northern First Nations, this plan outlines priority areas important for increasing health and wellness of Indigenous Peoples in the north. Finally, change at a service delivery level has been enacted

through local committees that meet to collaborate and address local health needs of First Nations and Métis communities within the northern region of BC, a region which comprises almost two-thirds of the geographic area of the province. In tandem, these strategies include opportunities and strategies to educate Northern Health staff through the development of local cultural resources and learning about the important components of cultural safety and humility. These partnerships and work between Indigenous and non-Indigenous leaders are paving the way to decreased racism within the healthcare system through multi-layered approaches that result in service delivery, systemic, and structural change. At this time, there is no precedent to reference for stigma mitigation, however much can be learned from previous outbreaks, pandemics, and other research. It is possible that using a model such as the one posited by Greenwood (2019) could be an actionable way to address stigma around COVID-19 (i.e. through service delivery, systemic, and structural changes). In developing stigma mitigation strategies, decision-makers must also consider unique realities of COVID-19, as well as unique contexts in which they are working (i.e. Indigenous sovereignty vs. public health).

Culture

The impact of culture[3] is referenced in 15 of the 25 papers identified in this review (Bucharski et al., 2006; Cain et al., 2013; Charania & Tsuji, 2012; Donnelly et al., 2016; Driedger et al., 2013; Hatala, Desjardins, & Bombay, 2016; Jongbloed et al., 2019; Larcombe et al., 2019; Loutfy et al., 2012; Marziali et al., 2020; Mill et al., 2010; Newman et al., 2012; Saewyc et al., 2014; Woodgate et al., 2017; Worthington et al., 2020). One paper, written by Bruns et al. (2020), points out that culture can influence how people perceive and respond to new diseases, epidemics, and pandemics. Culture can also influence understandings of illness, access to care, treatment options, and fear of stigmatization. Public health interventions should assess cultural beliefs and assumptions (Bucharski et al., 2006; Cain et al., 2013; Donnelly et al., 2016; Jongbloed et al., 2019; Larcombe et al., 2019; Worthington et al., 2020). These interventions should be addressed at the local level to encourage education and participation, and ensure that interventions are culturally appropriate for the community (Bucharski et al., 2006; Cain et al., 2013; Donnelly et al., 2016; Jongbloed et al., 2019; Larcombe et al., 2019; Worthington et al., 2020).

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[3] We would like to acknowledge the complexities that exist around definitions of 'culture,' as our discussion does not delve deeply into this. It is important to note that culture is dynamic, ever-changing, and intimately linked with health (Napier et al., 2014). As stated by Napier et al (2014), culture "can be thought of as a set of practices and behaviours defined by customs, habits, language and geography that groups of individuals share" (p. 1609).

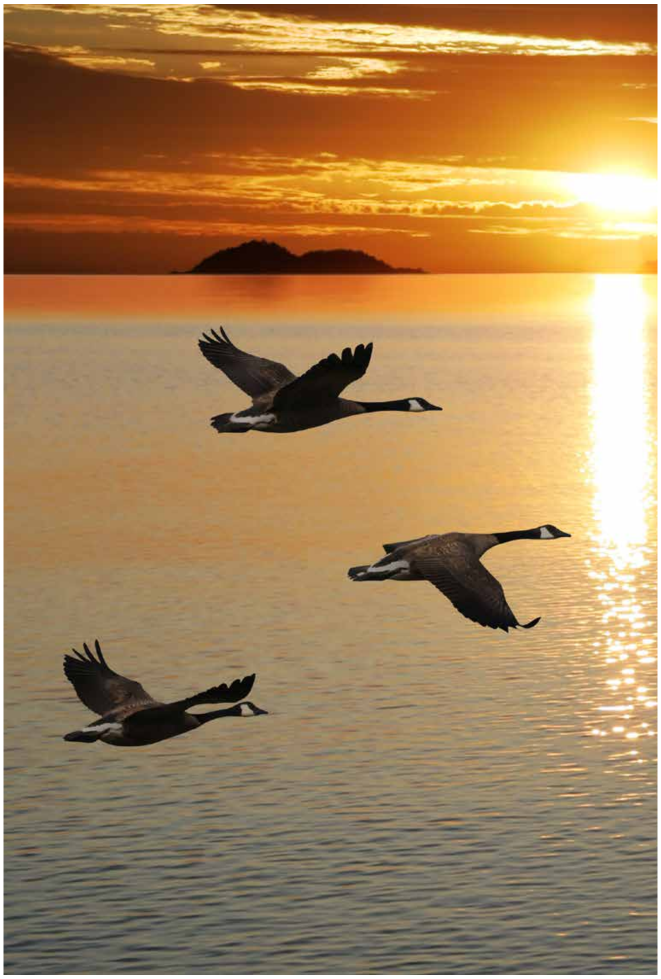
Culture or religion can be protective factors when it comes to stigma and COVID-19. In efforts to support physical distancing and discourage large gatherings, community leaders and religious groups can postpone religious or cultural celebrations and encourage gathering in smaller numbers (Bruns et al., 2020). Not long after COVID-19 was declared a pandemic, Dr. Evan Adams, the Chief Medical Officer of the First Nations Health Authority in British Columbia, issued a statement cautioning against First Nations ceremonies such as sweat lodges (Sterritt, 2020). Several other First Nations doctors echoed this sentiment, reminding First Nations Peoples of their ancestors' experiences through social distancing during past pandemics, and framing public health efforts to slow the spread of COVID-19 in a culturally relevant way (Sterritt, 2020). In these ways, cultural factors and practices can be seen to potentially reduce stigma, taking efforts to collectively influence the behavior of groups, potentially reducing the spread of COVID among populations, and potentially reducing the risk of COVID stigma. However, the reverse can also occur, as those who do continue to practice in larger groups may in turn be stigmatized by those adhering to public health recommendations. It is important to consider, however, that some of these groups remain the subject of stigma in mainstream society regardless of COVID efforts. Applying cultural values, such as promoting care for one's family and community, might also be protective factors against stigma.

Encouraging and promoting healthcare systems that embrace and promote cultural safety may help mitigate stigma, promote relationship building, decrease racism and discrimination, and foster safe and equitable care for everyone. In 1992, cultural safety became a mandatory component of nursing education in New Zealand through the Nursing Council of New Zealand (Papps & Ramsden, 1996). At that time, cultural safety was defined as: "the effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on own cultural identity and recognizes the impact of the nurses' culture on own nursing practices" (Papps & Ramsden, 1996, p. 491). Cultural safety emerged as a component of nursing education to bring to light that differences exist in the ways people experience and view the world. In nursing education, cultural safety calls upon students to reflect on their own culture, beliefs, values, and assumptions about others. Cultural safety also calls into account inherent power imbalances that exist between healthcare providers and patients (Papps & Ramsden, 1996). Along with cultural safety is cultural humility, a practice based in principles of self-reflection, evaluation and critique, as well as being a learner first and foremost from one's clients and patients (Nguyen, Naleppa, & Lopez, 2020). Furthermore, cultural safety and humility act to address power imbalances that exist between practitioner-patient. We draw from examples in British Columbia, where efforts to 'hardwire' cultural safety into the healthcare system have been ongoing.

The First Nations Health Authority in British Columbia has been instrumental in promoting cultural safety in the health system across the province. Their "it starts with me" campaign promotes action from everyone, voicing that we all have a role to play in creating a culturally safe system. In addition, the FNHA's Policy Statement on Cultural Safety and Humility provides recommendations on policy and programming related to cultural safety and may be relevant to strategies aimed at addressing stigma. These recommendations include: implementing cultural safety and humility training, changing policies to incorporate cultural safety and humility into all aspects of organizational policies, implementing a complaints process and evaluation to ensure First Nations' voices are heard and their experiences are taken sincerely, increasing health human resources to include more First Nations leaders and staff visible across all levels of an organization, creating culturally safe spaces, changing leadership so as to model culturally safe practices and attitudes, and building meaningful partnerships with First Nations communities and leaders.

Other organizations in northern British Columbia have also worked towards transforming healthcare spaces to be more accessible, safe, and healing for Indigenous Peoples and communities. In one article, the authors discuss two organizations within the Northern Health region of British Columbia that are working to "create ethical space and cultural safety at the intersections of Indigenous knowledge about health and wellness, Western medicine, and healthcare services for Indigenous Peoples in Canada" (Greenwood, Lindsay, King, & Loewen, 2017, p. 179). Using the principles of cultural safety, ethical space, and Two-Eyed Seeing (from Mi'Kmaw Elders Murdena and Albert Marshall), all anchored in Indigenous knowledges, the authors offer these principles as ways to lead transformations taking place within healthcare spaces. Indeed, they "offer many ways for health organizations to address…[a] history of distrust and repair relationships with the Indigenous communities they serve by understanding, respecting, and honoring the diverse and situated knowledges Indigenous Peoples bring to their own health and wellness" (p. 182).

The authors describe cultural safety as a self-reflexive practice where healthcare practitioners acknowledge and address the power imbalances in patient-provider encounters, as well as address individual, organizational, and systemic barriers that exist to building trusting, respectful, relationships. The concept of ethical space comes from First Nation scholar, Willie Ermine. 'Ethical space' is created when two worldviews and schools of thought can come together in a respectful and cooperative interaction. Rather than a 'physical space,' it is an 'active space' that promotes dialogue and mutual agreement of each party. Finally, Two-Eyed Seeing encourages us to see with one eye the strengths and teachings of Indigenous knowledges and ways of being, and with the other eye the knowledge and strengths from Western cultures (Bartlett, Marshall & Marshall, 2012). Together, cultural safety, ethical space, and Two-Eyed Seeing offer a foundation and guide from which we can begin to transform health care at the individual, organizational, and systemic levels. This transformation will not come from Western or Indigenous knowledge alone, but requires both (Greenwood et al., 2017).

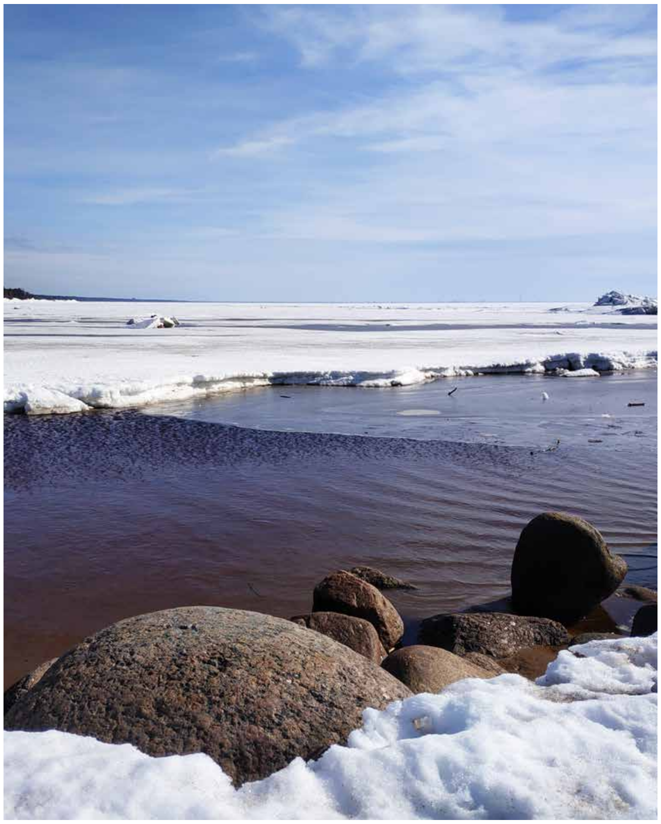


Although cultural safety is not directly suggested in the literature as a way to mitigate stigma, we suggest that the same principles of cultural safety, including self-reflection, learning, humility, respect, and dignity in relationships, can be used as part of a strategy to tackle stigma related to COVID-19 within healthcare systems and facilities. Knowing that stigma may disproportionately impact Indigenous Peoples, it is our recommendation that any future strategies centre Indigenous ways of knowing and experiences of stigma.

Public health measures

While intended to keep the public safe, public health responses to an infectious disease can contribute to or mitigate stigma. One paper in this review identified something as simple as the name and how this can have unintended effects. Historically, it was common for viruses to be named after the landscapes, places or regions where the first outbreaks occurred, for example, the Spanish flu and Middle East Respiratory Syndrome. However, in 2015 the World Health Organization introduced guidelines to halt these practices, thereby reducing stigma and negative impacts such as fear or anger directed towards those regions or their people (Bruns et al., 2020). Certain disease names can provoke a backlash against members of particular religious or ethnic communities, create unjustified barriers to travel, commerce and trade, and trigger needless slaughtering of food animals. This can have serious consequences for people's livelihoods (WHO, 2005). It is important to keep in mind, however, that stigma can be thought of as an evolutionary process. That is, we are somewhat 'hardwired' to distance ourselves from those who present a threat to us (i.e. infect us). This relates back to fear and misinformation. Physical distancing and naming the virus are two public health measures discussed in the literature; however, more public health measures are being implemented. At this time, we do not have enough information to comment on the degree to which specific public health measures can drive stigma.

Other public health responses, such as physical distancing and quarantining, can produce fear and promote avoidance. The experience of being quarantined has been highlighted in one paper as a driver of stigma in previous outbreaks, often lasting even after people have completed recommended quarantine periods (Bruns et al., 2020). This stigma can persist past the containment of the outbreak (Brooks et al., 2020). Quarantined individuals are more likely to report stigmatization and social rejection including avoidance, withdrawal of social invitations, being treated with fear and suspicion, and having critical comments made to them (Cava et al., 2005; Desclaux, Badji, Ndione, & Sow, 2017; DiGiovanni, Conley, Chiu, & Zaborski, 2004; Lee, Chan, Chau, Kwok, &Kleinman, 2005; Maunder et al., 2003; Pan, Chang, & Yu, 2005). In a comparison of healthcare workers quarantined vs. those not quarantined (Bai et al., 2004), quarantined participants were significantly more likely to report stigmatisation and rejection from people in their local neighborhoods. This suggests stigma may specifically affect people who are quarantined (Brooks et al., 2020). This experience of quarantine and other public health measures are not well researched as it relates to COVID-19 within Indigenous, northern, rural and remote communities. There have been case reports of rural and Indigenous communities denying community members from returning home because of public health implications (Scott, 2020). The impact of this on the individual and the community should be further explored.



Many of the public health measures have been driven from the top down, with little input and consultation from Indigenous communities. For this reason, the current COVID-19 pandemic has implications for potentially re-igniting the trauma experienced by Indigenous Peoples and communities. For example, as part of policies and recommendations from the Federal Government and Chief Medical Health Officers in the country, First Nations doctors have been asking communities to place a hold on traditional practices, such as sweat lodges and pipe ceremonies, that might put people at increased risk of spreading COVID-19 (Sterritt, 2020). Although these precautions are necessary to limit the spread of COVID-19, they are a stark reminder for communities of previous colonial policies that banned cultural activities (Indigenous Corporate Training Inc., 2020; Sterritt, 2020). Discussions focused on banning cultural and traditional practices within Indigenous communities, including disruption of a sun dance ceremony by RCMP over concerns that attendees were not abiding by physical distancing recommendations, have sparked Canadian leaders such as Prime Minister Justin Trudeau and Indigenous Services Minister, Marc Miller to state that the government would not step in on decisions regarding Indigenous cultural and traditional practices. He explained these decisions lie solely in the hands of community leadership (Bridges, 2020). In 2020, these declarations are a reminder of the colonial policies that continue to control and regulate Indigenous Peoples in Canada, and of previous colonial policies which banned cultural activities. Indigenous Peoples continue to not be adequately consulted in many public health decisions related to COVID-19 that impact themselves and their communities.

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IMPLICATIONS AND CONCLUSIONS

As COVID-19 rapidly evolves, much is to be learned from how stigma has manifest and played out for Indigenous communities, as well as in northern, rural and remote places across Canada. The results of this Rapid Evidence Review highlight that there exists a dearth of literature with regards to stigma, COVID-19, and Indigenous communities. However, drawing from existing literature related to other infectious diseases (e.g. TB/HIV), and previous epidemics (MERS-CoV, H1N1, SARS), there is much to be learned related to what drives stigma, the impacts of stigma, and strategies to mitigate stigma. As is clear from the literature, stigma manifests in many different ways and intersects with many different identities (e.g. racial, gender, religious etc.). Stigma also exists on many different 'levels,' such as intrapersonal, interpersonal, social, and structural. Recent research has highlighted the importance of tackling stigma at these different levels, and going beyond education strategies to mitigate stigma (Livingston, Cianfrone, Korf-Uzan, & Coniglio, 2014; National Academies of Sciences, Engineering, and Medicine, 2016; Rao et al., 2019). At this time, evidence on stigma mitigation strategies is limited, poorly understood, and not well evaluated, especially when it comes to COVID-19. However, based on limited research, we recommend the following broad recommendations for stigma mitigation.

1. Context specific strategies: there is no one-size-fits all stigma mitigation strategy. Stigma mitigation strategies should be context and community specific. Stigma mitigation strategies should be allowed to evolve in response to community needs and changing circumstances. They should be based on the wishes and needs of the community and reflect the culture and values of a community. What works in one community should not be assumed to work in all communities.

2. Strengths-based and resilience focused: Mitigation strategies directed at stigma and COVID-19 among Indigenous populations should acknowledge the resilience and strengths that exist within Indigenous communities and have existed for centuries. We recommend working with community to draw on local knowledge and stories, and move away from a disease-centered and deficit-based lens.

3. Recognize the sovereign rights of First Nations, Inuit, and Metis Peoples: Decision makers must be familiar with, and acknowledge, the harmful experiences of colonial policies, as well as the ongoing impacts of these colonial practices toward First Nations/Inuit/Métis. In addition, decision makers should honour these communities as sovereign nations that need to be consulted and empower them to be decision makers for their own communities.

4. Multi-faceted: Like layers of an onion, we need multiple strategies which address multiple systems concurrently. Stigma is a complex, multi-faceted, construct that is enforced at individual, community, and organizational/systemic levels; stigma mitigation strategies should reflect this reality and in turn be multi-layered and focused on multiple systems (more than just educating the individual). Strategies may include education, sharing stories, group discussions,

decriminalization of COVID-19, organizational commitment to tackling stigma, and more.

5. Dynamic strategies: COVID-19 is a rapidly unfolding situation and strategies must incorporate and respond to new issues as they arise. Stigma mitigation strategies must be permitted to change/evolve depending on new information and progression of the pandemic.

6. Humility: Decision makers should be humble while working with stakeholders and other decision makers. They should entertain a willingness to work together and listen to each other, regardless of culture, ethnicity, gender, and race, and honor each other's stories. They should be willing to be empathetic to themselves and each other and reflect on their biases and assumptions. They should be inclusive and encourage and embrace diversity in order to celebrate our shared humanity and what unites us.

7. Partnered approach: In order to prioritize and create culturally specific strategies for stigma mitigation, decision makers should partner with community champions and leaders. It may be beneficial to draw on community knowledge when developing these strategies.

8. Methodical, rigorous and aware of gaps in the literature: We recommend that when doing a Rapid Evidence review on Indigenous topics, which are under-researched/under-represented in academic literature, it is of value to include grey literature sources, such as news articles, oral accounts, and stories to better represent a more wholesome account. This can be done in a methodical and rigorous way, as demonstrated in this paper.

Furthermore, it is imperative that we acknowledge the resilience and strengths within Indigenous communities and recognize the need for strategies and solutions based in Indigenous knowledge and ways of being. As such, this work is not done. The next phase will require imagining and developing strategies informed by this work that are community-based, Indigenous-led, and address the multitude of cultural, social, and geographic realities in which Indigenous Peoples across Canada live.

Limitations

This Rapid Evidence Review has several limitations. First, due to the rapidly evolving nature of COVID-19, research is constantly evolving, and new literature is constantly being produced. This review only captures research outlined in literature collected at a specific point in time. Therefore, any literature that has been released since then is not included here. Secondly, and similarly to the above, limited research exists related to COVID-19 and First Nations, Inuit, Métis or Aboriginal/Indigenous Peoples. More research is needed to understand the distinct and unique experiences of First Nations, Inuit and Métis Peoples and stigma related to COVID-19. The research approach for such work should centre on Indigenous ways of knowing and being, as well as include Indigenous scholars, community leaders, and communities. Third, our search was limited to articles in the English language only, thus excluding research in other languages. Finally, academic literature often fails to capture the true experiences of Indigenous Peoples as their voices are often absent from academia. We tried to mitigate this by drawing on gray literature, as well as stories from the Task Group on Stigma. However, the stories we included may not offer accurate reflections of the various realities, nor capture the full picture of experiences of stigma with COVID-19.

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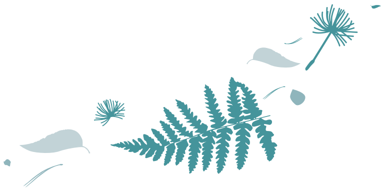

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APPENDIX 1:
LITERATURE SEARCH

We undertook a Rapid Evidence Review, guided by the National Collaborating Centre of Methods and Tools Rapid Review Guide (Dobbins, 2017), to gather existing evidence to answer the following research question: **What are the best practices for preventing and mitigating COVID-19 related stigma in Indigenous, rural, remote and northern communities within Canada?** In order to answer this question, we asked:

1. What stigma mitigation strategies have been used by Indigenous communities in Canada during previous epidemics, pandemics, or infectious disease outbreaks (i.e. COVID-19, HIV/AIDS, Tuberculosis, H1N1 influenza)?

2. What factors need to be considered when undertaking stigma mitigation related to infectious diseases within rural, remote, northern, and Indigenous communities within Canada?

Rapid Evidence Reviews are a "type of knowledge synthesis in which systematic review processes are accelerated and methods are streamlined to complete the review more quickly than is the case for typical systematic reviews" (Tricco, Langlois, & Straus, 2017, p. 3). Typically, in a full systematic review, an exhaustive search for all available evidence on this issue would be undertaken (Dobbins, 2017). Since COVID-19 is a new and emerging topic, and decision makers are having to act quickly on evolving evidence, we worked with an academic librarian to develop an efficient and effective search strategy to gather relevant results in a timely manner (Dobbins, 2017). Rapid Evidence Reviews are useful for policy makers when trying to make time-sensitive decisions based on high quality evidence (Tricco et al., 2017).

The literature search was conducted in May 2020 and repeated in October 2020. Six databases were systematically searched, including: Pubmed, CINAHL, PsychInfo, OVID Medline, Web of Science and Native Health Database. The following search terms were used, including relevant MeSH headings:

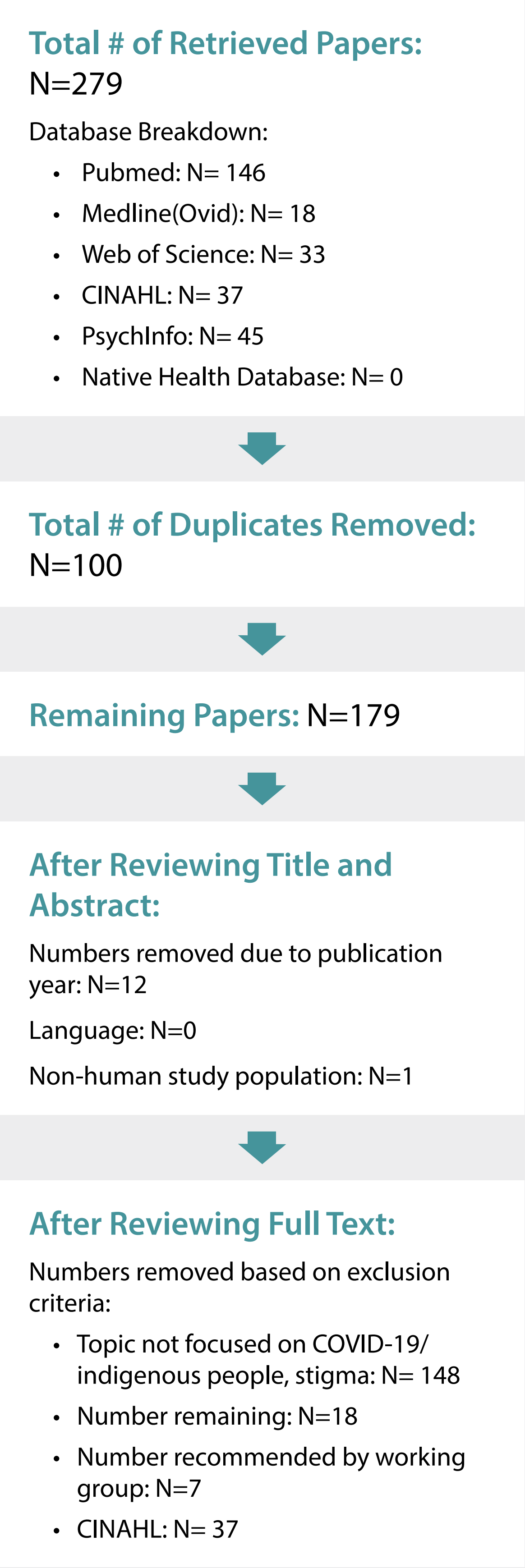
1) Coronavirus/COVID-19 OR Outbreak OR epidemic OR pandemic OR tuberculosis/TB OR HIV OR Human Immunodeficiency Virus/HIV/AIDS OR H1N1 OR SARS OR MERS
2) First Nations, Inuit, Metis, Indigenous, Aboriginal
3) Stigma, attitude, discrimination, inequity, prejudice, shame
4) Canada

A total of 279 papers were identified through this search strategy. Of these, 100 duplicates were removed and 179 papers remained. Papers were excluded if they were not written in English (n=0), did not include a human study population (n=1), or were published before 2000 (n=12). The year 2000 was selected, as Dr. Linda Tuhiwai Smith's work on decolonizing methodologies had recently been published in 1999, setting a new standard for research with Indigenous Peoples (Smith, 1999). As well, 2000 was a turning point from a technical and health care standpoint, with more widespread access to technology and social media, and a shift towards patient safety and increased attention towards patient experiences within the healthcare system (Health Canada, 2019). This is relevant in that health information was becoming more accessible to all people, and also because more conversations were being had about stigma, discrimination, and racism within the healthcare system. Of the remaining 179 papers, abstracts and titles were reviewed and papers which were not relevant to the research question were removed. After reviewing the titles and abstracts, 148 papers were excluded as their topic did not align with the research questions or the paper could not be accessed. As a result, 18 papers remained (See Figure 1). Seven additional papers were included based on a review of reference lists or recommendations by the Working Group as being relevant to the topic, for a total of 25 papers (see Figure 1).

The 25 retrieved papers were reviewed and critically appraised by two independent assessors and the evidence was synthesized below.

Results of the search

Our search strategy yielded 25 papers. Of those papers, three were published before 2010 (Bucharski et al., 2006; Des Jarlais et al., 2006; Newman et al., 2012) and the remaining 23 papers were published between 2010-2020. Most of the papers were published in Canada (n=19/25), with five papers being published in the United States (n=5/25) (Bruns et al., 2020; Centre for Disease Control, 2020; Des Jarlais et al., 2006; Kane et al., 2019; Rao et al., 2019) and one being published by the World Health Organization based out of Geneva (IFRC et al., 2020). Of the 25 articles, six were collaborations between researchers from different provinces (Cain et al., 2013; Hatala et al., 2018; Mill et al., 2010; Newman et al., 2012; Saewyc et al., 2014; Worthington et al., 2020).



Total # of Retrieved Papers:
N=279

Database Breakdown:

- Pubmed: N= 146
- Medline(Ovid): N= 18
- Web of Science: N= 33
- CINAHL: N= 37
- PsychInfo: N= 45
- Native Health Database: N= 0

Total # of Duplicates Removed:
N=100

Remaining Papers: N=179

After Reviewing Title and Abstract:

Numbers removed due to publication year: N=12

Language: N=0

Non-human study population: N=1

After Reviewing Full Text:

Numbers removed based on exclusion criteria:

- Topic not focused on COVID-19/ indigenous people, stigma: N= 148
- Number remaining: N=18
- Number recommended by working group: N=7
- CINAHL: N= 37

Figure 1. Search strategy for Rapid Evidence Review.

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