

# AT A GLANCE:

## PREVENTION OF SEXUALLY TRANSMITTED AND BLOOD BORNE INFECTIONS AMONG ETHNOCULTURAL COMMUNITIES

PROTECTING CANADIANS FROM ILLNESS



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To obtain additional information, please contact:

Public Health Agency of Canada  
Address Locator 0900C2  
Ottawa, ON K1A 0K9  
Tel.: 613-957-2991  
Toll free: 1-866-225-0709  
Fax: 613-941-5366  
TTY: 1-800-465-7735  
E-mail: [publications@hc-sc.gc.ca](mailto:publications@hc-sc.gc.ca)

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## FOREWORD

Sexually transmitted and blood borne infections (STBBIs) are an important public health issue that require attention and action. These are infections that are spread primarily through person-to-person sexual contact (e.g. chlamydia) or blood-to-blood contact (e.g., hepatitis C). Despite the progress made in preventing and controlling infectious diseases, increasing rates of STBBIs underline the need for continued public health vigilance in Canada. In particular, members of ethnocultural communities in Canada, which include individuals (other than Aboriginal people) who are non-Caucasian in race or non-white in colour, are disproportionately affected by many social, structural and economic factors which contribute to poor health outcomes including STBBIs. Since STBBIs are preventable, public health plays an important role in reducing and managing the transmission of infection. In order to be effective, it is important for STBBI prevention, screening and treatment programs to consider the determinants of health and other related health factors.

This “at-a-glance” document builds on the findings of the *Population-specific HIV/AIDS Status Report: People from Countries where HIV is Endemic- Black people of African and Caribbean descent living in Canada* published in 2009. The document expands the focus of the status report to a consideration of the factors that influence vulnerability to and resilience against all STBBIs. HIV and other STBBIs (e.g., chlamydia, gonorrhoea, syphilis, hepatitis C) share common routes of transmission (e.g., blood, semen and other bodily fluids), common risk behaviours (e.g., unprotected sex, sharing contaminated drug equipment), and common social and structural factors (e.g., poverty, homelessness, mental illness and stigma and discrimination). Addressing STBBIs is an important upstream approach to HIV prevention as the presence of certain STBBIs can facilitate the transmission and acquisition of HIV.

This document summarizes current research evidence and gaps related to prevention and the determinants of vulnerability to and resilience against STBBIs among ethnocultural minorities. It is intended to provide public health professionals, researchers, staff in provincial/territorial governments and community organizations with evidence and areas for action to inform STBBI prevention programming, policy and research that address STBBIs among diverse ethnocultural communities across Canada. Comparing ethnocultural groups remains a challenge not only due to incomplete reporting of race/ethnicity data but also due to the diversity between subgroups. The focus of this document is to address those individuals most vulnerable to STBBIs while acknowledging that there is no one size fits all approach given the wide diversity among subgroups and the unique life experiences of individuals.

## ACKNOWLEDGEMENTS

The Agency would like to thank the many contributors whose feedback and guidance ensured that this resource contains current and relevant evidence about STBBIs among ethnocultural communities. In addition, the Agency would like to acknowledge the staff of the Centre for Communicable Diseases and Infection Control for their contributions to this document.

## WHAT WE FOUND

Canada's ethnocultural communities are ethnically, culturally, linguistically and spiritually diverse, and are impacted by determinants of health in various ways. Members of these communities include both individuals who have lived in Canada for many generations, as well as recent immigrants or newcomers. Acknowledging diversity, including the differences within and between cultural groups and the intersection of social identities such as race, class, sexual orientation, gender and gender identity, is important in understanding stigma and discrimination and addressing factors that contribute to poor health outcomes including vulnerability to STBBIs.

According to the 2011 National Household Survey, nearly 6.3 million people self-identified as a member of a visible minority group, representing 19.1% of the total population.

### Demographic profile (2011 National Household Survey)<sup>1</sup>

- Over 200 different ethnic origins were reported among the population in Canada.
- The three largest visible minority groups – South Asian, Chinese and Black accounted for 61.3% of the visible minority population.
- 33.4 years was the median age of the visible minority population.
- 78.0% of all immigrants who arrived in Canada between 2006 and 2011 were visible minorities.
- 13.1% of all recent immigrants were born in the Philippines, followed by China (10.5%) and India (10.4%).
- 22.0% of the total population was first generation (born outside Canada), compared to 17.4% who was second generation (born in Canada and had at least one parent born outside Canada) and 60.7% who was third generation (born in Canada with both parents born in Canada).
- 72.8% of immigrants reported a mother tongue language other than English or French. The most common languages other than Canada's two official languages were Chinese, Tagalog, Spanish and Punjabi.
- 94.8% of immigrants lived in four provinces: Ontario, British Columbia, Quebec and Alberta; 63.4% lived in the Toronto, Vancouver or Montreal areas.

## STBBIs among ethnocultural communities

In Canada, ethnocultural communities remain disproportionately affected by STBBIs. However, it is important to note that STBBI data for sub-populations, including ethnocultural communities, are limited and underreported making it more challenging to identify and address health issues associated with STBBIs. There can also be considerable differences in STBBI rates within and between different ethnocultural communities. As a result of the diversity of these communities and the variation in reporting race/ethnicity information, it is important to recognize that STBBI data are not representative of all ethnocultural minorities in Canada. Available epidemiological data and research suggest that:

- People born in countries where HIV is endemic<sup>1</sup> account for 16.9% of new HIV infections and 14.9% of those living with HIV in Canada, despite making up just 2.2% of the Canadian population.<sup>2</sup>
- The estimated new infection rate among people from countries where HIV is endemic is 9.0 times higher than among other Canadians.<sup>3</sup>
- The majority of HIV-positive test reports among individuals from countries where HIV is endemic and who were exposed to HIV through heterosexual contact are those who self-identify as Black.<sup>4</sup>
- In 2012, of the 534 HIV-positive test results from the Immigration Medical Exam, 58.4% were born in Africa and the Middle East.<sup>5</sup>
- Many immigrants come to Canada from countries with a high prevalence of hepatitis C virus; an estimated 35% of hepatitis C infections in Canada are among the foreign-born population.<sup>6</sup>
- Human papillomavirus (HPV) is the most common STBBI and is a causal factor in the majority of cases of cervical cancer. HPV also causes most anal cancers and some vaginal, vulvar, penile and oropharyngeal cancers. Some groups of immigrants, including South Asian and Southeast Asian women, have lower rates of cervical cancer screening than Canadian-born women.<sup>7</sup>
- The prevalence of genital herpes is high among African/Caribbean women compared to the general Canadian population.<sup>8</sup>
- Among a sample of street-involved youth in Canada, 27.2% of participants who self-identified as an ethnocultural minority tested positive for an STBBI, compared to 19.7% of Caucasian street-involved youth.<sup>9</sup> In particular, the prevalence of hepatitis B virus seropositivity (8.4%) was significantly higher for ethnocultural street-involved youth compared to Caucasian and Aboriginal street-involved youth. The prevalence of chlamydia was also higher among ethnocultural street-involved youth (9.5%) compared to Caucasian street-involved youth (7.1%).

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<sup>1</sup> The term “people from countries where HIV is endemic” is an epidemiologic term often used in HIV/AIDS surveillance and research activities, and refers to a population that is largely composed of Black people of African and Caribbean descent. Countries where HIV is endemic are defined as those where the prevalence of HIV among people ages 15 to 49 years is 1.0% or greater and one of the following: 50% or more of HIV cases are attributed to heterosexual transmission; a male to female ratio of 2:1 or less among prevalent infections; or HIV prevalence greater than or equal to 2% among women receiving prenatal care. There are currently 71 countries that comprise the list of countries in which HIV is endemic. Among these, 42 are in Africa (mostly Sub-Saharan Africa), 26 are in the Caribbean and Central/South Central America, and 3 are in Asia.

## Determinants of vulnerability to and resilience against STBBIs

While being from an ethnocultural community in and of itself is not a risk factor for STBBIs, there are multiple factors that shape individual experiences of health and illness. Among ethnocultural communities, these factors can include varying degrees and impacts of racism, discrimination, homophobia, culture, social support networks, socioeconomic status, sex and gender, sexual orientation, gender identity, immigration, health beliefs and personal health practices. Depending on individual life circumstances, some of these factors impact individuals and communities in different ways and may not be the same for all STBBIs or ethnocultural communities. These are factors to consider when developing and tailoring STBBI prevention programs to specific audiences.

### *Racism, discrimination and homophobia*

- Racism (belief that one group is superior to others and the specific actions that result from this belief), discrimination (unfair and unjust treatment based on the group, class or category to which a person identifies with or belongs to) and homophobia (fear and/or hatred of homosexuality in others, often exhibited by prejudice, discrimination, intimidation, or acts of violence) that occur both among and within ethnocultural groups can increase vulnerability to STBBIs by impacting access to STBBI prevention, testing, treatment, care and support.<sup>10,11,12,13</sup>
- Racism and discrimination can lead to long term health consequences and inequities through multiple pathways. Racism and discrimination may result in increased psychological stress and physiological effects, unequal economic opportunities, inequitable access to education, housing and social resources, engagement in risky health behaviours, and victimization and violence.<sup>14,15</sup>
- Experiences of homophobia and transphobia (fear and/or hatred of transgender individuals, often exhibited by prejudice, discrimination, intimidation, or acts of violence) can lead to depression, anxiety and suicidal thoughts.<sup>16</sup> The interaction of racism, homophobia and transphobia can lead to increased STBBI-related sexual risk behaviour and therefore increased vulnerability to STBBIs.<sup>17</sup>
- Some members of ethnocultural communities face multiple forms of discrimination as a result of intersecting identities, including race, class, ethnicity, gender identity, age, ability or sexual orientation. This can have serious and long-lasting effects on an individual's identity and mental health and can also increase vulnerability to STBBIs.<sup>18,19,20</sup>
- HIV-related stigma (negative beliefs, feelings or attitudes towards people living with or associated with HIV/AIDS) often stems from fear and ignorance of HIV and its transmission. HIV-related stigma can reinforce existing inequalities and can lead to shame, social isolation, depression and internalized stigma and can impact access to health services and support.<sup>21</sup>
- Studies of East and South Asian men who have sex with men show that experiences of racism from within the gay community and homophobia within their ethnocultural community can lead to isolation, low self-esteem and increased vulnerability to STBBIs.<sup>22,23</sup>
- Many Black, African and Caribbean youth report racism as a key barrier to accessing sexual health services. Results from the *Toronto Teen Survey* show that this population reported the lowest (34%) sexual health clinic attendance.<sup>24,25</sup>

- A history of discrimination may lead to ethnocultural communities' mistrust of public health professionals, institutions and STBBI prevention services.<sup>26,27,28</sup> Identifying ethnocultural community leaders to champion STBBI issues can help to address stigma and isolation and strengthen existing STBBI prevention efforts.<sup>29</sup>

## Culture

- Culture is an important element of our identity that goes beyond shared symbols, behaviours, practices, values and attitudes. It is shaped by historical, socioeconomic and political contexts, by relationships among and between groups and by institutionalized attitudes and practices that result.<sup>30</sup>
- Culture is dynamic and continuous. It can change and adapt to internal and external forces including immigration. It can also influence knowledge, skills and attitudes towards sexuality, sexual behaviours, and health outcomes. For many groups, culture is a source of strength and resilience.<sup>31,32</sup> Cultural values and beliefs can provide support to overcome barriers and guide individuals to improved health and wellness.<sup>33</sup>
- Cultural beliefs influence how health and illness are perceived, experienced and expressed. This can include views on the causes of illness,<sup>34</sup> acceptable preventive or health promotion measures (e.g., vaccines, condoms, birth control)<sup>35</sup> and willingness or (dis)comfort in discussing health issues with partners, family, friends or health care providers.<sup>36</sup>
- In some cultures, sex-related issues are considered taboo, making it difficult to discuss and acknowledge STBBIs both within and outside of different cultural communities. This can result in individuals avoiding or delaying access to STBBI prevention, testing and treatment.<sup>37,38,39,40</sup>
- Traditional and cultural practices such as cleansing rituals, male circumcision and female genital cutting (FGC) may increase individual vulnerability to STBBIs.<sup>41</sup> FGC, for example, can cause scarring of a woman's genital tract which increases the likelihood of tearing during intercourse, which can facilitate STBBI transmission from an infected partner.<sup>42</sup>
- Cultural differences related to how mental health, mental illness and substance use are perceived may contribute to stigma and impact individuals' access to treatment, care and support.<sup>43,44,45</sup>
- Religion can play an important role in shaping individual values, beliefs and practices concerning sexuality including access to STBBI information and services and use of contraception or condoms.<sup>46</sup>
- Inclusive and culturally safe health services (services that recognize relationships of power and trust between the health care provider and the patient) can build resilience against STBBIs by improving ethnocultural minorities' access to services.<sup>47</sup>

### **Social support networks**

- Social support can play a protective role in reducing the health impacts (e.g., stress) of stigma and discrimination.<sup>48,49</sup>
- Some immigrants experience a loss of social support networks when they arrive in a new country like Canada, including separation from partners, extended families and children.<sup>50</sup>
- Social support influences how individuals approach disclosure of STBBIs, including their fear of stigma and discrimination and lack of confidentiality and privacy.<sup>51,52,53</sup>
- Social isolation is a predictor of unprotected sex and is associated with depression and substance use, all of which increase vulnerability to STBBIs.<sup>54,55,56,57</sup>
- The availability of culturally safe spaces where these support networks can be formed can help to build resilience against STBBIs.

### **Socioeconomic status**

- Ethnocultural communities are disproportionately represented in the lower socioeconomic categories in Canada due to multiple social, structural and economic factors. In 2011, 40.8% of the population living in low-income neighbourhoods belonged to a visible minority group compared to other neighbourhoods where 24.2% of the population belonged to a visible minority group.<sup>58</sup>
- Limited opportunities for employment and higher income (e.g., non-recognition of foreign credentials or work experience) create disparities in access to STBBI prevention and treatment information and services, which directly impact an individual's ability to protect themselves from STBBIs (e.g., through condom use), communicate STBBI disclosure, and be treated for STBBIs.<sup>59,60,61,62</sup>
- Poverty and economic dependency may influence women, regardless of their ethnocultural background, to remain in relationships that may increase their vulnerability to STBBIs, for the sake of meeting basic needs (e.g., housing, income).<sup>63,64</sup>

### **Sex and gender**

- Culturally-defined gender norms and roles impact STBBI vulnerability, including gender-based violence, condom negotiation with partners and expectations surrounding relationships, marriage and reproduction.<sup>65,66,67</sup>
- Gender inequalities vary between and within cultures and can impact women's access to STBBI screening, prevention and treatment services.<sup>68</sup>
- Studies have shown that female immigrants experience a greater rate of poorer physical and mental health, and are more vulnerable to social changes compared to their male counterparts.<sup>69,70</sup>
- Cultural norms related to masculinity and femininity, including homophobia, transphobia and the stigmatization of gay men and other men who have sex with men, may lead to individuals hiding their sexuality and sexual behaviour which increases not only their own vulnerability to STBBIs but also that of their partners.<sup>71,72,73,74</sup>

- Increasing cultural competency and language about gender identity, including transgender and gender-nonconforming populations within ethnocultural communities can help reduce barriers to access to health and social services and experiences of discrimination.

### *Immigration*

- Immigrants and refugees may be more vulnerable to poor mental health and mental illness as they cope with stress both before (e.g., pre-migration trauma) and after moving to a new country, such as navigating the immigration and refugee system, post-traumatic stress, poverty, racism, unemployment and loss of social support networks.<sup>75,76,77,78</sup>
- Competing demands such as housing and employment may place health and self-care, including STBBI prevention, treatment and care, as a lower priority. Without adequate supports in place, these individuals may be at increased risk for STBBIs.<sup>79</sup>
- Recent immigrants may have limited or delayed access to health services, including STBBI testing and treatment. This is particularly true if they are not yet eligible for health insurance, do not have proper documentation or lack familiarity with the Canadian health care system.<sup>80</sup> They may also be unwilling to access testing due to discrimination or fear of disclosure.<sup>81</sup>
- Among some immigrants there is a perception of lower STBBI risk in Canada, especially when compared to their country of origin.<sup>82</sup> A false perception that the Canadian immigration process only gives visas to immigrants who do not have HIV may create a false sense of safety and lead to higher risk behaviours such as unprotected sex.<sup>83</sup>

### *Health beliefs and personal health practices*

- Different cultural groups may have different beliefs about health and illness, including causes of disease, perceptions of risk, how illness and pain are experienced and expressed, and where and how individuals seek help and interact with health care providers.<sup>84,85</sup>
- Women from ethnocultural communities have a higher risk of cervical cancer due to lower screening rates and higher rates of HPV infection.<sup>86,87,88,89</sup> Pap tests screen for and help diagnose precancerous conditions of the cervix and cervical cancer, which is commonly caused by HPV.
- Different attitudes towards and experiences related to health care may include reliance on traditional healers or self-diagnosis over accessing primary care providers in clinical settings.<sup>90,91</sup>
- Cultural beliefs about condom use can influence preventive measures against STBBIs and attitudes towards other contraceptives.<sup>92,93</sup>
- Health inequities (disparities in the social determinants of health among groups with different levels of social advantage) impact ethnocultural minorities' vulnerability to STBBIs. For example, low income and education levels can limit an individual's access to STBBI testing services and ability to maintain good health.<sup>94</sup>

## WHY IT MATTERS

In Canada, visible minorities account for 19.1% of the population, with 20.6% of the population being born outside of Canada. According to demographic projections, within the next two decades, more than one out of every four Canadians could be foreign-born. As cultural diversity continues to increase, it is important to be prepared and provide appropriate STBBI prevention and control that speaks to the health context of new Canadians. Across Canada, individuals, organizations and communities have engaged in increasing awareness of STBBIs and addressing the health needs of ethnocultural communities. The following areas are important to consider as part of a comprehensive approach to preventing STBBIs among these diverse communities.

### Promoting health and wellbeing

Preventing STBBIs among ethnocultural minorities requires looking at the factors that influence their day to day life. Due to the complex and intersecting nature of many health needs, it is often difficult to separate STBBI concerns from other competing health needs such as mental health and basic survival (e.g., food, shelter). A comprehensive and holistic approach to STBBI prevention includes promoting healthy attitudes and behaviours that support overall health and wellbeing, including healthy relationships, inclusion, social support, and self-efficacy (the measure of one's own ability to complete tasks and reach goals).

### Promoting social and cultural connectedness

Being socially connected to and receiving support from family, friends and communities is important in helping ethnocultural minorities deal with adversity and is associated with better health outcomes. Social support is a strong source of resilience, and can influence access to STBBI information and services, disclosure of an STBBI to partners and health care providers, and adherence to STBBI medication. In particular, peer-based programming for the delivery of STBBI prevention services has been shown to be effective.<sup>95</sup> Social and cultural connectedness can reduce and mediate the effects of STBBI stigma and can also protect individuals from poor mental health and mental illness by fostering a sense of belonging, sense of worth, and satisfaction with life.

### Preventing poor mental health and mental illness

Poor mental health and mental illness, including depression and low self-esteem can lead to sexual risk behaviours which increase vulnerability to STBBIs. For example, experiences of racism and homophobia and stressful life events such as immigration have been associated with anxiety, depression or problematic substance use which can lead to sexual risk behaviours such as unprotected sex.<sup>96,97</sup> Protective factors such as social support from family and friends, school connectedness, community engagement and self-efficacy can improve mental health and reduce STBBI risk.<sup>98</sup> Addressing mental health and STBBIs as part of a comprehensive approach to health can help to improve individual capacity to adopt healthy behaviours and reduce STBBI risk.

## Increasing access to health care and services

Members of ethnocultural minorities can experience multiple barriers to accessing STBBI information and services, including stigma and discrimination, low socioeconomic status, language barriers and lack of culturally competent health care providers. Not being familiar with the Canadian healthcare system, being unaware of available community health resources, or having little experience in accessing STBBI services such as Pap tests or screening for STBBIs may contribute to increased STBBI risk. Improving individual health literacy, self-advocacy and ability to communicate health needs or ask for support can increase access to health care and services. Tailoring STBBI prevention programs to address context-specific barriers and the unique needs of diverse ethnocultural groups can effectively reduce STBBI related risk behaviours.

## Building resilience

Despite facing various social, structural and economic barriers, in many cases members of ethnocultural communities balance stress and adversity with the ability to cope and develop resilient behaviour. Empowering both individuals and communities to take care of their own health, address stigma and make healthy decisions can build resilience against STBBIs. Access to culturally safe and inclusive services can help to foster healthy behaviours and positive coping mechanisms which can decrease vulnerability to STBBIs. Building resilience has positive benefits that extend to all aspect of an individual's life.

## AREAS FOR ACTION

The following are action areas for STBBI prevention among ethnocultural communities:

- **Fostering inclusion and engagement of ethnocultural communities in addressing STBBIs including STBBI-related stigma**

Community institutions such as schools and health centres, and faith-based communities can have an important role in promoting healthy behaviours and facilitating opportunities for dialogue on STBBI-related stigma. These organizations can engage community leaders in the development, implementation, delivery and evaluation of STBBI prevention programs and services through community consultations and needs assessments.

- **Tailoring STBBI prevention programs and services to the unique needs of diverse ethnocultural groups**

Ethnocultural communities are very diverse. STBBI prevention programming that is tailored to specific ethnocultural groups, adopts a health equity lens and accounts for intersecting identities (e.g., race, class, gender, sexual orientation, disability) will respond to this diversity. Peer-based approaches to programming that build on the lived and shared experiences of people infected or affected by STBBIs can strengthen STBBI prevention.

- **Strengthening networks and knowledge sharing**

Personal and community networks are key agents in sharing health information and supporting healthy behaviours. Strong and inclusive networks within ethnocultural communities where individuals do not face exclusion based on their sexual orientation, gender identity or STBBI status, for example, are important for facilitating knowledge translation across health and social issues and for learning from promising practices to inform effective STBBI prevention programming.

- **Building capacity to foster healthy and inclusive environments**

Safe, healthy and inclusive environments that promote health equity and support the diverse needs of ethnocultural communities are fundamental to positive health outcomes. Building capacity among health care providers to increase understanding of the impact of determinants of health on the health and wellbeing of ethnocultural groups can improve their ability to manage and staff programs in ways that are reflective of the communities they are working with, create culturally safe environments and deliver inclusive STBBI programming. Likewise, building capacity to promote leadership of affected populations to be visible champions in advancing education, harnessing skills and resilience can inform the development of culturally responsive and competent programs and services.

- **Increasing intersectoral collaboration across levels of government and within communities**

Federal/provincial/territorial governments, frontline providers (e.g., primary care providers, social workers, mental health workers) and stakeholders across multiple sectors (e.g., mental health agencies, immigration and settlement services, AIDS service organizations) all play a role in addressing the wide range of health and social issues (e.g., housing, mental health, addictions) that impact vulnerability to STBBIs. Partnerships and collaboration with diverse stakeholders can allow individuals and organizations to build on each other's efforts through better communication and coordination.

- **Building awareness and understanding of STBBIs as an important issue and health concern for ethnocultural communities in Canada**

Many individuals remain unaware of their STBBI status and their personal risk for infection. Individuals who are unaware that they are infected with an STBBI may be more likely to infect others. Culturally inclusive information on STBBI risk behaviours and risk reduction that is available in multiple languages, formats and in locations where ethnocultural communities and recent immigrants frequently access will increase awareness and understanding of STBBI-related issues within ethnocultural communities.

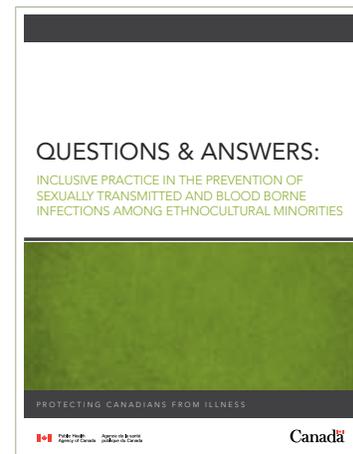
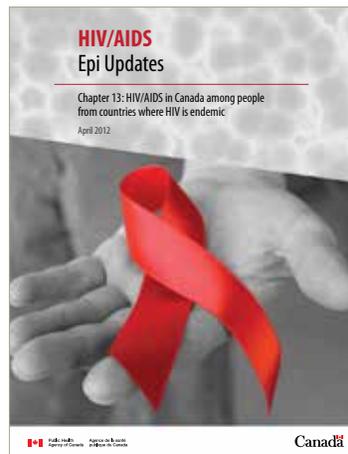
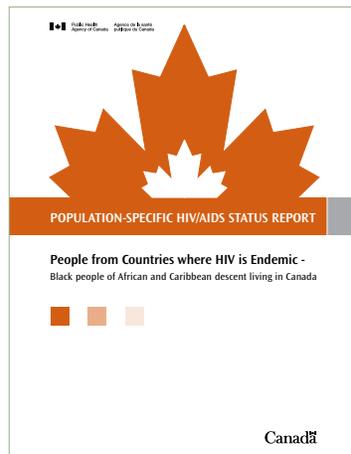
## WHAT MORE CAN WE DO

Reported rates of STBBIs and their long-term impacts continue to be a health concern for public health professionals and health care providers working with ethnocultural communities in Canada. However, there is considerable diversity within and between ethnocultural groups. Examining the underlying factors that increase vulnerability to and resilience against STBBIs among specific ethnocultural groups and communities is key to developing an effective response. Moving forward, culturally safe, inclusive and upstream approaches to STBBI prevention require a collaborative and sustained effort. In order to build capacity among ethnocultural communities and to have a healthy impact on STBBI-related attitudes and behaviours, future strategies for STBBI prevention can build on lessons learned by:

- Increasing visibility and engagement of ethnocultural communities in the development, implementation, delivery and evaluation of STBBI prevention projects.
- Tailoring STBBI-related programs and services for diverse ethnocultural groups to reflect their lived experiences, cultural contexts and unique health needs.
- Improving knowledge use and translation to assess and evaluate the effectiveness of existing STBBI prevention programs in reducing STBBIs and addressing the needs of ethnocultural communities to inform future STBBI prevention programs and policies.
- Providing capacity building opportunities such as health equity and anti-racism/anti-oppression training for health service providers to increase cultural competency and to address common myths and stereotypes concerning ethnocultural communities, STBBIs and mental illness.
- Collaborating across sectors to increase access to health and social services among ethnocultural communities at primary access points (e.g., clinics, ethnocultural associations, newcomer organizations, community centres, youth drop-in centres).
- Engaging ethnocultural communities through public awareness campaigns, education and outreach to challenge social norms and values surrounding STBBI stigma, discrimination, racism and homophobia.

## FIND OUT MORE

Regional and local networks across the country have developed a variety of resources related to the prevention of STBBIs among ethnocultural communities. To read more, visit the CATIE website ([www.catie.ca](http://www.catie.ca)). Select Agency resources include:



Population-specific HIV/AIDS status report: People from countries where HIV is endemic—Black people of African and Caribbean descent living in Canada ([www.catie.ca/en/resources/population-specific-hiv-aids-status-report-people-countries-where-hiv-endemic-black-people-0](http://www.catie.ca/en/resources/population-specific-hiv-aids-status-report-people-countries-where-hiv-endemic-black-people-0))

HIV/AIDS Epi Update—Chapter 13: HIV/AIDS in Canada among people from countries where HIV is endemic ([www.catie.ca/en/resources/hiv-aids-epi-updates-chapter-13-hiv-aids-canada-among-people-countries-where-hiv-endemic](http://www.catie.ca/en/resources/hiv-aids-epi-updates-chapter-13-hiv-aids-canada-among-people-countries-where-hiv-endemic))

Questions & Answers: Inclusive practice in the prevention of sexually transmitted and blood borne infections among ethnocultural minorities ([www.catie.ca/en/resources/questions-and-answers-inclusive-practice-prevention-sexually-transmitted-and-blood-borne-i](http://www.catie.ca/en/resources/questions-and-answers-inclusive-practice-prevention-sexually-transmitted-and-blood-borne-i))

To learn more about sexually transmitted and blood borne infections and the work of the Agency, visit: [www.healthy Canadaians.gc.ca/health-sante/sexual-sexuelle/index-eng.php](http://www.healthy Canadians.gc.ca/health-sante/sexual-sexuelle/index-eng.php)

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