QUESTIONS & ANSWERS:

INCLUSIVE PRACTICE IN THE PREVENTION OF SEXUALLY TRANSMITTED AND BLOOD BORNE INFECTIONS AMONG ETHNOCULTURAL MINORITIES

PROTECTING CANADIANS FROM ILLNESS

Public Health Agency of Canada
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Centre for Communicable Diseases and Infection Control
Public Health Agency of Canada
Ottawa, ON K1A 0K9
Email: ccdic-clmti@phac-aspc.gc.ca

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PREFACE

Questions & Answers: Inclusive practice in the prevention of sexually transmitted and blood borne infections among ethnocultural minorities is intended to address the most commonly asked questions about the prevention of sexually transmitted and blood borne infections (STBBIs)[i] in diverse ethnocultural environments. The goal of this resource is to help community organizations, health professionals, educators and others to develop and implement STBBI prevention interventions and programs that address the needs of ethnocultural minorities. This document examines factors which impact vulnerability to and resilience against STBBIs and provides an evidence base to address disparities in health.

The Public Health Agency of Canada's (the Agency's) *Canadian Guidelines for Sexual Health Education (Guidelines)*,[1] first published in 1994, and most recently revised in 2008, were developed to help professionals and educators in their efforts to provide broadly-based sexual health education for the prevention of STBBIs. Feedback from a national evaluation of the *Guidelines* indicated the need for companion documents to provide more detailed information, evidence and resources on specific populations mentioned in the *Guidelines*. In response, the Agency identified a 'question and answer' format as a means to provide information, resources and promising practices to community organizations, health professionals, and educators to assist in the development of prevention programs among diverse populations. These documents are evidence-informed, use inclusive language and are intended to cover a range of topics that reflect key issues for the prevention of STBBIs among diverse populations. This resource is the fourth in the series of *Questions & Answers* documents, preceded by documents on sexual orientation, gender identity and sexual health education for youth with physical disabilities.[2]

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[i] Sexually transmitted and blood borne infections (STBBIs) refer to infectious diseases that are transmitted through bodily fluids such as blood, vaginal fluids and semen. They include: chlamydia, gonorrhea, hepatitis B, hepatitis C, syphilis, human immunodeficiency virus (HIV), human papillomavirus (HPV), genital herpes, lymphogranuloma venereum (LGV), and trichomoniasis.

INTRODUCTION

The term 'culture' can refer to shared symbols, beliefs, attitudes, practices and values that are created and negotiated through interactions among people.[3] Culture is shaped by historical, socioeconomic and political contexts, by relationships both among and between cultural groups, and by the institutionalized attitudes and practices that result.

Culture is one of the primary sources of personal identity and is the foundation upon which people define and express themselves. Cultural diversity results from the influence of many different elements of a person's identity, including gender, race, ethnicity, occupation, geography, class, ability or sexual orientation. It is also shaped by "interculturation", which occurs among and between cultural groups when they interact, learn from, transform, shape and mould each other.[4]

Culture: 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.

Culture is dynamic and continuously changing. It plays an important role in influencing knowledge, skills and attitudes towards sexuality, as well as sexual behaviours and health outcomes of individuals. For example, cultural factors may influence what is considered to be acceptable and unacceptable sexual behaviour and expression in society.[5] Culture may also influence attitudes towards marriage, sexual orientation, gender identity and expression, sexual health education, and sexual relationships.

Interculturation: The process of exchange among and between cultural groups, including the negotiation of differences and similarities of different cultural elements.

Disparities in health and illness in Canada across cultural groups emphasize the need to adopt culturally-based illness prevention and health promotion approaches. "Inclusive practice" is a culturally-based approach that aims to address disparities in health and illness experienced by specific cultural groups. It recognizes differences both within and between cultural groups and aims to provide programs that better meet the needs of all individuals. Inclusive practice examines the historical, cultural, socioeconomic and political contexts that shape people's lives. These include structural barriers and social environments that contribute to disparities in accessing and using information and services.

Inclusive practice: A culturally-based approach that acknowledges differences within and between cultural groups, as well as the intersection of identities that create individual experiences and needs. Inclusive practice emphasizes the importance of self-determination, social justice, and capacity building in addressing determinants of health disparities.

While culture can refer to other social groups that are characterized by age, sexual orientation or disability, the focus of this document is on ethnocultural minorities.[ii] This resource is intended to help community organizations, health professionals, and educators develop and implement inclusive programs and interventions for the prevention of sexually transmitted and blood borne infections (STBBIs) to ensure that:

1. programming is inclusive of the needs of ethnocultural minorities;
2. the experiences of ethnocultural minorities are reflected in all facets of prevention programming;
3. professionals working with ethnocultural minorities are familiar with the concept, elements and benefits of inclusive practice; and
4. professionals working in STBBI prevention are aware of key issues and determinants of vulnerability among ethnocultural minorities and have the necessary tools to address these issues.

Ethnocultural minorities: Individuals whose origin, culture and language differ from the numeric and/or social majority.

WHAT DO WE KNOW ABOUT SEXUALLY TRANSMITTED AND BLOOD BORNE INFECTIONS (STBBIs) AMONG ETHNOCULTURAL MINORITIES IN CANADA?

Canada is an ethnoculturally diverse country, with over 200 ethnic origins reported by the total population.[6] The ethnocultural diversity of Canada's population continues to increase due to immigration and a growing visible minority population. In 2011, visible minorities comprised 19.1% of the population in Canada, compared to 16.2% in 2006.[7] Much of this increase can be attributed to the large proportion of visible minority immigrants to Canada. In 2011, 60.2% of all immigrants to Canada were visible minorities.[8] In 2011, the 72.8% of the immigrant population reported a mother tongue language other than English or French, and settled in large metropolitan areas.[9] Furthermore, the majority of new immigrants were under 44 years of age (81.5%), with approximately two-thirds (62.4%) in their reproductive years (15 to 44 years).[10]

Visible minorities: Persons who are non-Caucasian in race or non-white in colour and who do not report being Aboriginal.

[ii] For consistency in this document, we use the term "ethnocultural minority" to refer to all racialized and ethnic groups.

Epidemiological data suggest that STBBIs are not equally distributed among ethnocultural groups in Canada. For example, in 2011 people born in countries where HIV is endemic[iii] made up only 2.2% of the Canadian population, but they accounted for 16.9% of new HIV infections.[11] While data on ethnic identity are not typically included in case reports submitted to the Public Health Agency of Canada for nationally reportable STBBIs other than HIV (e.g. chlamydia, gonorrhea), there is a possibility that there are ethnocultural differences in reported rates of these STBBIs. In a parallel example that helps us understand differences in STBBIs among ethnocultural groups, we can look at rates of STBBIs in the Northwest Territories and Nunavut, where Aboriginal people make up a large proportion of the population.[12] In 2010, reported rates of chlamydia and gonorrhea in the Northwest Territories were 7.5 and 15 times higher than the national average, respectively. In Nunavut that same year, rates of chlamydia and gonorrhea were 15 and 58 times higher than the national average, respectively. Furthermore, among a sample of street-involved youth in Canada aged 15 to 24 years between 2001 and 2005, Aboriginal youth had higher rates of chlamydia and gonorrhea compared to Caucasian youth and youth of other ethnic origins.[iv,13]

Newcomers: Landed immigrants who came to Canada up to five years prior to a given census year.

[iii] 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. 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 three are in Asia.

[iv] Other ethnic origins include Hispanic, East Asian, Middle Eastern, and South East Asian. There were no significant differences between Aboriginal and Black, African or Caribbean street youth.

Individual behaviours, such as inconsistent condom use, multiple sexual partners or sharing of drug equipment do not account for all of the ethnocultural differences in health outcomes.[14] Data from Statistics Canada and several local surveys suggest that newcomers and longer-term immigrants are less likely to access sexual health services compared to the Canadian-born population.[15] Difficulty locating services, time and transportation to access services, and inconvenient hours of service are common barriers experienced by both immigrant and non-immigrant populations. Additional barriers to accessing services among immigrant populations include lack of services in their first language and lack of culturally appropriate health services.[16] These barriers are often compounded by the stress of immigration, resettlement and being separated from family.[17]

Immigrants: Persons residing in Canada who were born outside of Canada, excluding temporary foreign workers, Canadian citizens born outside of Canada and those with student or working visas.

Research also points to differences in awareness of sexual health services and access to sexual health information among ethnocultural minorities. For example, results from the Toronto Teen Survey showed that newcomer and immigrant youth in Canada reported a lack of awareness of sexual health services compared to longer term immigrants[v] and second generation[vi] Canadian youth.[18] The survey also found that newcomer youth who had arrived in Canada within the past

[v] Refers to youth whose parent(s) are immigrants and who have been in Canada for at least four years.

[vi] Refers to youth who were born in Canada and had parents who were also born in Canada.

three years were the least likely to have received any formal sexual health education compared to longer-term immigrant and second generation Canadian youth.[19]

Refugee: A person who has left their country of origin or residence because they have suffered persecution on account of race, religion, nationality, political opinion, or because they are a member of a persecuted cultural group in that country.

The differential distribution of health and illness among the general Canadian population and ethnocultural minorities emphasizes the need for culturally-based approaches to reduce these disparities.

WHAT APPROACHES HAVE BEEN USED TO SUPPORT THE HEALTH OF ETHNOCULTURAL MINORITIES?

For decades, scholars and health practitioners have recognized the need for culturally-based approaches to support the health and well-being of ethnocultural minorities. Models of practice presented in the health literature represent a continuum of culturally-based approaches that include cultural awareness, cultural sensitivity, cultural competence, cultural safety, and inclusive practice.[20]

On one end of the continuum, cultural awareness involves acknowledgement of similarities and differences between cultural groups. It requires an understanding that the characteristics, behaviours and practices that constitute a cultural group are shaped by cultural identities.[21] Cultural awareness does not involve reflection on the impact that one's own cultural identity has on how others are perceived or interacted with. While approaches to illness prevention or health promotion based on cultural awareness acknowledge differences between cultural groups, they remain grounded in the dominant culture and are not tailored to specific cultural groups.

Cultural awareness: Observing and being conscious of similarities and differences between cultural groups.

Cultural sensitivity moves beyond simply recognizing, accepting and understanding that cultural differences and similarities exist. It involves understanding how personal attitudes, experiences and actions affect other people. While approaches to illness prevention or health promotion based on cultural sensitivity are respectful of individual cultural identities, the information is grounded in the dominant culture and targeted to specific cultural groups. For example, culturally sensitive programming may consist of providing information to specific cultural groups in their mother tongue.

Cultural sensitivity: The process of understanding how personal attitudes, experiences and actions shape an individual's approach to people from other cultures.

Cultural competence includes the knowledge, skills and attitudes health professionals and educators need to provide health information, education and services to diverse ethnocultural groups. Culturally competent educators recognize that a "one size fits all" approach grounded in the dominant culture is not sufficient to meet the diverse needs of specific cultural groups.[22] Cultural competence in illness prevention, for example, may involve recruiting minority staff to assist in the delivery of programs, collaborating with traditional healers, or incorporating culture-specific values and attitudes into health promotion materials.[23]

"Cultural safety" as an approach was developed by nurses to improve the health status of Indigenous people in New Zealand. The approach emphasizes the need for programming to be shaped in collaboration with members of the specific cultural group being served. Cultural safety addresses the social, cultural, political and structural conditions that shape sexual health outcomes and access to sexual health information and services.[26] The cultural safety model builds on the idea of cultural competence but shifts its focus from building the capacity of the health professional to that of the cultural community itself.

Cultural competence: The knowledge, skills and attitudes of health educators that are necessary for providing health information, education, and services among diverse groups.

Cultural safety: Emphasizes the social, cultural, political and structural conditions that shape health outcomes and focuses on building capacity of the cultural community.

Despite its widespread use and acceptance in the literature, cultural competence in public health programming has been criticized. This approach treats cultural groups as homogenous and ignores differences within cultural groups.[24] Furthermore, the focus of the approach is limited to technical skills developed and acquired by health professionals and educators rather than on building community capacity. Focusing on the health professional or educator takes away the opportunity to build the capacity of individuals and communities to protect their health. It can also reinforce imbalanced relationships that favour health professionals as bearers of specialized knowledge and create barriers to accessing programs or services among ethnocultural minorities.[25]

While these approaches aim to support health professionals in meeting the challenges of cultural diversity, many are limited by narrow definitions of culture or stereotypes of characteristics based on cultural background such as values, attitudes and physical appearances. These assumptions can lead to a focus on cultural groups as a whole and characteristics of the cultural group as an explanation for health outcomes. They can reinforce negative stereotypes and ignore the multiple social, historical and economic contexts within which *individuals* are situated based on multiple elements of their identity (e.g., race, ethnicity, sexual orientation, ability, age).[27]

Inclusive practice builds on cultural safety and acknowledges differences within and between cultural groups, as well as the intersection of identities that create individual experiences and needs. Inclusive practice emphasizes the importance of self-determination, social justice, and capacity building in addressing determinants of health disparities, such as racism, sexism, or homophobia. Adopting inclusive practice can help public health professionals address disparities in health among ethnocultural minorities, including their vulnerabilities to and resilience against sexually transmitted and blood borne infections.

WHAT IS THE BENEFIT OF INCLUSIVE PRACTICE IN THE PREVENTION OF SEXUALLY TRANSMITTED AND BLOOD BORNE INFECTIONS (STBBIs)?

Providing information that is inclusive and relevant to diverse needs is critical to supporting individuals in their ability to make decisions and adopt behaviours that protect their health throughout the lifecourse. A large body of literature suggests that culturally-based programs and interventions are more effective in supporting the health and well-being of ethnocultural minorities than generalized interventions.[28] Inclusive practice is important in understanding the conditions that create disparities in health outcomes. It brings cultural considerations into program and policy planning to support the health and well-being of ethnocultural minorities. Inclusive practice emphasizes the need to engage the local community and to integrate their priority concerns into programing. It focuses on self-determination, social justice, and builds capacity among ethnocultural communities to support the health of individuals.

In this way, inclusive practice results in tailored programs and prevention efforts. Unlike targeted programs, which use the same messaging or media to target specific ethnocultural groups (e.g. using the same message in different languages), tailored efforts develop the message and material with the local ethnocultural community to reflect the cultural realities of individuals, and to build upon cultural beliefs, perspectives and practices. Research shows that tailored approaches increase message relevance and are more likely to lead to changes in health-related attitudes, beliefs and behaviour, compared to non-tailored or group-targeted interventions.[29] Tailored illness prevention and health promotion programs are a promising practice for supporting the health and well-being of ethnocultural minorities.

By engaging individuals and communities, health professionals are better able to identify and support individual health needs and reduce STBBIs among ethnocultural minorities. Inclusive practice in the prevention of STBBIs has the potential to foster resilience against adverse experiences and negative environments that contribute to vulnerabilities to infection.

WHAT ARE THE SOCIAL, STRUCTURAL, OR ECONOMIC DETERMINANTS OF VULNERABILITY TO SEXUALLY TRANSMITTED AND BLOOD BORNE INFECTIONS (STBBIs) AMONG ETHNOCULTURAL MINORITIES?

There are multiple factors that influence health outcomes and create disparities in health and illness among a population. These include racism and discrimination, socioeconomic status, sex and gender, substance use, and mental health and

mental illness.[30] In developing inclusive practice, it is important to recognize and address the factors which create vulnerabilities to poor health and foster resilience among ethnocultural minorities.

RACISM AND DISCRIMINATION

In 2003, 20% of people in Canada reported they had experienced discrimination or unfair treatment "sometimes" or "often" within the past five years.[31] This proportion was higher among specific racial groups including those who identify as Black (32%) or South Asian (21%). One study suggests that as many as 17% of elementary and high school students from racialized groups experience bullying and victimization related to their race or ethnicity.[32]

Racial discrimination may take multiple forms, including: verbal abuse (i.e. racial slurs); taunting and teasing; bullying and physical violence; unequal treatment; and unequal access to resources.[33] Racism is not limited to the dominant racial group in society nor is it directed towards ethnocultural minorities alone. Instead, anyone can have racist attitudes or act in racist ways.[34]

Multiple forms of discrimination can be experienced simultaneously by individuals as a result of the multiple characteristics that make up their identity, including race, ethnicity, gender identity, age, ability or sexual orientation. For example, ethnocultural minorities who are also sexual minorities (e.g. gay, lesbian, bisexual) or gender minorities (e.g. transgender) can experience multiple layers of discrimination in the form of homophobia, transphobia, heterosexism, and racism.[35]

Experiences of discrimination can have a significant impact on identity, sexuality and mental health, including self-esteem, life satisfaction and the ability to cope effectively with stressors.[36] Discrimination can also affect access to resources such as education, employment and health services, the ability to set health policies or priorities and the opportunity to develop health promotion messaging.[37] A history of colonization or oppression of certain ethnocultural groups can lead not only to systemic racism and discrimination but also to feelings of powerlessness and reduced willingness or trust to work with health service providers.[38]

In light of the multiple layers of discrimination that may be experienced by ethnocultural minorities, it is important to build capacity and to foster resilience by engaging the community, posing questions, and providing opportunities for their needs to be heard and to shape information and services available to them.

SOCIOECONOMIC STATUS

Socioeconomic status refers to an individual's or a family's social position in relation to others. It is typically based on income, education and occupation. Ethnocultural minorities are disproportionally represented in the lower socioeconomic categories in Canada. According to the 2006 census, the overall poverty rate for visible minorities in Canada was 19.3% compared to 15.3% for the general population.[39]

There are multiple social, structural and economic factors that contribute to lower socioeconomic status among ethnocultural minorities. These include language barriers, racial discrimination, unemployment and disparities in opportunities for higher income employment including barriers that impede the recognition of foreign credentials or work experience.[40]

Research suggests that socioeconomic status has a significant impact on health outcomes and accounts for many of the ethnic differences in health.[41] Individuals from low-income families generally report having a greater number of chronic medical conditions, receiving less medical treatment, and having poorer access to health

services than those with higher incomes.[42] Those who experience the highest burden of STBBIs often come from low income families.[43]

Disparities in access to health services and information among those in lower income categories impact their ability to protect themselves from STBBIs (e.g. condoms) and to be treated for STBBIs.[44] Moreover, immigrant women and women with low socioeconomic status experience a higher prevalence of physical and/or sexual intimate partner violence.[45] Women who experience intimate partner violence may not have the ability to negotiate condom use in relationships, putting them at increased risk of STBBIs.

SEX AND GENDER

Sex (biological characteristics that distinguish males and females) and gender (socially defined characteristics and roles ascribed to men and women) both impact behaviours, opportunities, risks and health outcomes related to STBBIs. For example, due to different physiological characteristics associated with male and female sexes (genital anatomy), women are biologically more vulnerable to STBBIs. Biological characteristics can also impact the different ways in which males and females respond to bacterial or viral infections. For example, women are more likely than men to not experience symptoms with bacterial STBBIs, such as chlamydia or gonorrhea.

Culturally-defined gender norms can also impact disparities in vulnerability to or resilience against STBBIs experienced by males and females. Gender norms can govern what behaviours are acceptable, who are considered acceptable partners, and how sexual interactions are structured. These gender norms vary by culture. For example, in some cultures females may have more restrictions on dating or sexual relationships due to cultural definitions of femininity or to gendered roles of females within the family (e.g. primary household or care-giving responsibilities).[46] Cultural definitions of femininity and masculinity can also impact decision-making within sexual relationships. For example, in some cultures these gender norms can leave women with little or no decision-making ability with respect to condom use, when to have sex, or with whom to have sex. Interventions and programs that build skills for sexual decision-making and promote healthy relationships built on respect and equality are important for the prevention of STBBIs.

Culturally-defined gender roles can also play a significant role in how prevention programs and information are accessed and experienced. For example, gender roles can impact health-seeking behaviours. In general, women are in more frequent contact with the health system, although this may not be true of women from all cultures.[47] In some cultures, gender roles encourage women to prioritize other roles, such as caregiver of the family, above caring for their own health. This can be a barrier to accessing health services for women from some ethnocultural communities.

Male and female genders are not the only gender identities individuals may have. Within many cultures, there are gender identities that exist on a continuum between male and female. In some cultures, these identities are respected and are a source of resiliency. In other cultures, gender minorities (e.g., transgender) are at increased risk for STBBIs due to stigma, discrimination, and lack of access to health services. Interventions and programs that incorporate concerns of gender minorities can build understanding, respect for diversity and reduce vulnerabilities to STBBIs experienced by these individuals.[48]

The impact of both sex and gender on vulnerability to or resilience against infection needs to be considered in planning and implementing STBBI prevention. Doing so involves more than addressing differences in health outcomes for males and females. It requires an understanding of the factors that lead to these differences and an identification of how gender impacts how health outcomes

are experienced and defined, how issues are communicated and how information is accessed and used by males and females in diverse cultural contexts.

SUBSTANCE USE

Substance use, including use of alcohol, tobacco and drugs, has a direct impact on sexual behaviour vulnerability to STBBIs.[49] In some cases, substance use may directly impact vulnerability to infection. For example, injection drug use is one of the primary transmission routes for hepatitis C virus (HCV) in Canada.[50] In other cases, substance use can lower inhibitions and impact individuals' ability to make health-supporting decisions. In this way, substance use can result in unplanned sexual activity or increase the likelihood of inconsistent or improper condom use.[51] Studies show that, particularly among youth, risk behaviours such as tobacco use, binge drinking, multiple sexual partners, and inconsistent condom use tend to cluster together. [52]

Substance use is shaped by cultural contexts.[53] Culture can affect the age at which people begin using substances, frequency of use, the settings in which people consume substances, or the perceptions of people who use certain substances. For example, in some cultures, alcohol use is perceived positively and is a central part of family gatherings or special events. In other cultures, alcohol consumption may be perceived negatively and prohibited entirely.[54] Views about smoking reflect similar cultural differences, ranging from social acceptance and encouragement to disapproval. While many studies focus on the stressors experienced by ethnocultural minorities that may lead to increased substance use, other studies suggest cultural background may be a protective factor for substance use. Research shows that ethnocultural minority immigrant youth tend to drink less than Canadian-born youth.[55] This may be due in part to different cultural norms surrounding the use of alcohol.

Stressful life events that are experienced more often by ethnocultural minorities, such as immigration, separation or loss from family, financial hardship, unemployment, post-traumatic stress, and discrimination, may further increase the risk of substance use as a coping mechanism.[56] Research suggests that perceived racial or ethnic discrimination is related to drug use which places individuals at increased risk of infection or other negative health outcomes.[57] Patterns of substance use among ethnocultural minorities also vary by age, gender, length of stay in Canada and country of origin.[58] Unequal access to prevention and treatment services prolongs this stigma and can lead to longer term health issues related to substance use.[59]

MENTAL HEALTH AND MENTAL ILLNESS

Many factors can impact mental health and vulnerability to mental illness among ethnocultural minorities. Despite facing challenges, including the stress of stigma and discrimination and stress before (e.g., pre-migration trauma) and after migration, ethnocultural minorities in many cases show a strong ability to overcome difficult situations.[60] For many groups, culture is a source of strength and resilience.[61] Resilience and positive mental health are linked to cultural factors such as personal values and beliefs, as well as support from family, friends and the community. Positive mental health, including self-esteem, self-efficacy, sense of worth, satisfaction with life, and a resilient mindset, is integral to overall health and well-being and can protect individuals from mental illness.[62]

While social support networks and belonging to an ethnocultural group are sources of resilience for ethnocultural minorities, social stresses and life events such as unemployment, discrimination and migration are risk factors for developing poor mental health and mental illness.[63] For example, racial discrimination experienced by ethnocultural minorities can lead to low self-esteem, depression, and suicidal thoughts and suicide attempts.[64]

Ethnocultural minorities may also be vulnerable to suicide and suicide attempts due to feelings of isolation, history of abuse, oppression, poverty, substance use and experiences of stigma or racism.[65]

Immigrants and newcomers can also experience high rates of poor mental health due to the physical, emotional, social and economic stressors involved in migrating to a new country. Stressors can include learning a new language, underemployment, low socio-economic status, separation from family, and isolation from one's cultural background.[66] In one study, over one quarter (26%) of new immigrants and almost one third of refugees (30%) cited learning a new language as the greatest difficulty experienced during their first four years of settlement in Canada.[67]

There is a strong relationship between poor mental health, mental illness and vulnerability to STBBIs.[68] Depression and low self-esteem have been shown to play an important role in the development and maintenance of sexual risk behaviours, including inconsistent condom use.[69] Research shows that adults with severe mental illness, including schizophrenia, bipolar disorder and major depression, have higher rates of sexual risk behaviour associated with STBBI transmission. This includes inconsistent condom use, multiple sex partners, and involvement in sex work.[70] Other studies with youth have found that individuals with depressive symptoms are at risk for not using a condom, having been diagnosed with one or more STBBIs, or engaging in other risk behaviours to facilitate social acceptance (e.g. consuming alcohol).[71] Individuals with low self-esteem, depression, and feelings of low self-worth are more likely to report intentions to engage in unprotected sex compared to individuals with high self-esteem.[72] Fear of stigma and discrimination about mental health may discourage individuals from seeking treatment or mental health support services, prolonging their vulnerability to STBBIs.[73]

Poor mental health and mental illness are also significant concerns for ethnocultural minorities living with chronic STBBIs such as hepatitis B, hepatitis C, and HIV. People living with chronic conditions such as these are twice as likely to experience mental illness such as depression and anxiety, compared to the general population.[74] On the one hand, mental illnesses such as depression have been cited as side effects of the antiretroviral medications used to treat these chronic STBBIs.[75] On the other hand, stigma associated with being infected with a STBBI may result in mental illness due to discrimination, social isolation and the removal of those living with infection from important social support networks.

Depression and other mental illnesses can impact how people living with chronic diseases manage and care for their health. These can impact, for example, adherence to medications, exercise, nutrition, and communication with family, friends and health service providers.[76] Stigma and discrimination can also act as major barriers to disclosing chronic infection to family, friends, health professionals or sexual partners, due to fear, guilt or anxiety. It is important that people affected by or vulnerable to chronic STBBIs have mental health supports in place to reduce barriers to treatment and ongoing care. Establishing collaborative networks of patient care among family physicians, psychologists, psychiatrists and other support workers can leverage existing programs and services to better support these individuals in a more integrated way.

The link between mental health, mental illness and STBBIs is an important aspect to consider in STBBI prevention. By understanding the relationship between various elements of health, health professionals can help individuals achieve overall health and well-being and build resilience to stressors.

WHAT ARE KEY CONSIDERATIONS FOR SEXUALLY TRANSMITTED AND BLOOD BORNE INFECTION (STBBI) PREVENTION IN DIVERSE ETHNOCULTURAL ENVIRONMENTS?

There are many aspects of culture that impact health outcomes including vulnerability to and resilience against STBBIs. These cultural elements include language and communication styles, immigration status, religion, health beliefs, and perceptions of sexuality. It is important to take stock of these in planning STBBI prevention programs with ethnocultural minorities.

LANGUAGE AND COMMUNICATION STYLES

For ethnocultural minorities, language may be a major barrier to accessing health information and prevention services.[77] In 2008, more than one quarter of immigrants to Canada indicated they spoke neither English nor French.[78] In many cases, the languages spoken in some cultures may not have exact word-equivalents to English terms. For example, English terms related to anatomy or specific sexual behaviours may not have direct word equivalents in certain languages. It is important not to assume that individuals prefer information or services in a specific language based on their ethnicity or cultural identity, but rather to provide information and services to ethnocultural communities in multiple languages. In some cases, talking about these issues in a second language may provide more opportunities for individuals to explore sensitive issues that may not be possible or appropriate to discuss in their first language.

Communication styles may also impact access to information or services among ethnocultural minorities. Communication styles vary by culture and can include variations in body language, eye contact, expression, and tone of voice. For example, in some cultures, direct eye contact can be seen as a sign of disrespect or sexual invitation, especially if it takes place between a male and female.[79] The way in which sexual health information is communicated and delivered may influence the uptake of information and services among ethnocultural minorities.

It is important that prevention programs be delivered in a way that respects communication styles, customs and practices, and that considers a variety of learning formats and settings to provide individuals with choice and flexibility. Alternative formats may include group classes, interactive websites, booklets, storytelling, or peer-based learning. Ensuring that ethnocultural minorities are involved in the planning process and are given opportunities to identify the languages and communication styles to effectively convey and exchange information will help reduce potential barriers to information and service access.

IMMIGRATION

Research suggests that, in general, newcomers to Canada are healthier than both the Canadian born population and longer-term immigrants who have lived in Canada for more than 10 years.[80] While individuals who migrate to Canada may be in better health, there are also social, structural, and economic factors that impact health outcomes and the ways in which newcomers access health information and services once they arrive in Canada.

Immigration can be a positive experience and new beginning for many individuals. However, the experience of migrating can also be very difficult for some as they may have to adjust to a new language, culture, social status and income. Moreover, migration may also pose challenges to newcomers who find themselves caught between the norms and expectations of their own culture and the cultures of the country they have come to. Some may feel a loss of control and reduced

self-esteem, while others can experience a change in identity, including greater power and autonomy over their bodies or their sexuality.[81] These experiences of immigration may affect access to social or emotional support, access to networks of information, and the ability to make meaningful connections with others.[82] Newcomers may feel isolated, or may be unaware of where or how to access sexual health services or what services are available in their community.[83] Adapting to life in a new country may also take priority over the health of some newcomers to Canada.

For newcomers to Canada, there can also be delays in accessing health services, depending on the province or territory. For example, some provinces have a three month waiting period before new residents can access provincial health coverage. However, some coverage for essential and emergency care may be available for resettled refugees, refugee claimants and certain other newcomers to Canada who are not yet eligible for health insurance.[84] Many uninsured newcomers suffer poor health results because they do not have identifying documents to meet enrolment requirements or lack access to preventative or medically necessary care.[85]

For many refugees, meeting basic settlement needs such as food and housing, or caring for family members can also take precedence over health needs. Furthermore, some refugees may have little experience in accessing sexual health services, such as Papanicolaou (Pap) tests or screening for STBBIs, in their country of origin.[86]

Papanicolaou test (Pap test or Pap smear): A routine screening procedure designed to find early indications of cervical cancer. Canadian guidelines recommend routine screening every three years for women aged 25 to 69 years.

The process of interaction and exchange among and between different cultural groups can further influence health behaviours and health outcomes. In some cases, it may lead to negative health outcomes through the adoption of more unhealthy behaviours, such as alcohol or tobacco use, or casual sexual relationships.[87] For example, studies have shown higher proportions of self-reported STBBI diagnoses, greater numbers of lifetime sexual partners, alcohol use prior to and during sexual intercourse and inconsistent condom use among certain ethnocultural groups.[88] In contrast, studies among immigrants in Canada have shown that greater interculturation is associated with resilience including increased help-seeking, access to care and use of preventative health services.[89] In particular, improved language proficiency and insurance coverage, as well as knowledge, beliefs and familiarity about health and the health care system appear to facilitate access to health services.[90]

Immigration impacts the health of newcomers, refugees and longer-term immigrants in different ways. Interventions and programs that incorporate the concerns and experiences of immigrants and newcomers; link newcomers into health services and supports; consider how the unique experiences of immigration impact access to information, care and support; and tailor programs to meet the needs of immigrants and newcomers are critical to the prevention of STBBIs among ethnocultural minorities.

RELIGION

Religion or spirituality is often an important element of cultural identity. It can play a significant role in shaping one's values, beliefs and practices about sexuality. These values may also impact risks, opportunities, behaviours and how health programs and services are accessed and experienced by different cultural groups. They can affect the ways in which individuals interact with and respond to sexual health information. For example, among

some religious groups, sexual activity is reserved for the purpose of reproduction and condom use is seen as an unnatural form of contraception because it interferes with the creation of life. Therefore, members of the community may be reluctant to use condoms in their own sexual relationships and may only access sexual health information in the context of preparation for marriage.

For example, based on religious values, some cultural communities may support an abstinence-only approach to sexual health education that does not include discussions of contraception or protection against STBBIs. These communities may be faced with challenges of silence and stigma about accessing or sharing sexual health information or prevention programs resulting in unmet needs of community members.

Given how central religion or spirituality is in certain cultural communities and its impact on access to health information, faith-based organizations and religious institutions can be important partners in providing information that is inclusive and responsive to the needs of ethnocultural minorities. Faith-based organizations may be ideally suited for health promotion and illness prevention activities as they are places where certain cultural groups spend a significant amount of time and where health behaviours are encouraged and supported.[91] Their trusted status in the local community and their established networks make faith-based organizations and religious institutions well-placed partners in providing culturally-based STBBI prevention information and programs to ethnocultural minorities.[92]

HEALTH BELIEFS

People from diverse ethnocultural backgrounds may have different beliefs about health and illness, including the sources or causes of illness, whether or how they can be treated, and who should be involved in treatment and treatment decisions.

These beliefs shape people's perceptions of what behaviours lead to certain health outcomes, as well as their help-seeking behaviour.[93] For example, culturally-based health beliefs impact how people perceive their own risk of STBBIs, the precautions they take to avoid them and the services or treatments they seek if they experience symptoms.[94]

In some cultures, condom use is viewed as taboo and may be seen as a sign of promiscuity, infidelity or having a STBBI.[95] It is important to work within the context of individuals' culturally-based health beliefs about the sources of illness and forms of treatment when providing sexual health education in diverse ethnocultural communities. Respected cultural leaders, including traditional healers or elders, can advise, support and facilitate cooperative learning environments and an open exchange of ideas. Involving members of the cultural community who are respected and understand these health beliefs is one strategy for developing inclusive practice in the prevention of STBBIs that meets the needs of diverse populations.

PERCEPTIONS OF SEXUALITY

Perceptions of sexuality vary both across and within cultures. Categories of sexual identity or behaviour, such as homosexuality or heterosexuality, for example, may have very different meanings across cultures. Culturally-based perceptions of sexuality impact norms and patterns of dating, sexual relationships, communication about sexuality, and sexual behaviour people engage in. Furthermore, media and popular culture play key roles in the

construction of gender, identity and sexuality for different ethnocultural groups, which can impact their self-identification and sexual behaviour.[96]

Assumptions about the perceptions of sexualities among certain cultural groups may impact the type and quality of programming provided within a cultural community. For example, assumptions about perceptions of sexuality may lead to omission of certain topics from sexual health information, embarrassment or discomfort in seeking information or programs and further stigmatization of ethnocultural groups.[97]

Inclusive practice in STBBI prevention recognizes diverse values, attitudes and beliefs among and between different cultural groups. Engaging members of the ethnocultural community in the development of prevention programs can assist in tailoring programs to meet the needs of the community and to respect the diverse ways members convey and exchange information. Health professionals and educators can work with individuals within the cultural community to define the issues, learn about diverse needs, and build the capacity of the ethnocultural community to support the sexual health of people within their community.

WHAT CAN I DO TO ENSURE INCLUSIVE PRACTICE IN THE PREVENTION OF SEXUALLY TRANSMITTED AND BLOOD BORNE INFECTIONS (STBBIs) AMONG ETHNOCULTURAL MINORITIES?

The following are considerations and examples of promising practices for community organizations, health professionals, and educators to support them in efforts to provide STBBI prevention programming that meets the needs of various ethnocultural communities and aims to reduce health disparities experienced by ethnocultural minorities.

- Reflect on your own values and beliefs about sexuality and different ethnocultural groups. What are your personal values, experiences, interests, beliefs and commitments? What assumptions are you bringing to your work with this ethnocultural community? Taking an inventory of your values, attitudes, assumptions, beliefs and social position can highlight biases and help you to recognize how your own position and values might influence how you provide prevention programs.
- Engage members of the ethnocultural communities in program planning, development and implementation. Engaging members of the ethnocultural community can help to identify priority health concerns of the community and can ensure that programs are tailored to meet their needs. For example, recruit members of the ethnocultural community to:
  - identify priority concerns of the community;
  - assist in the development of program materials; or
  - advise on program delivery formats.
- Engage members of the ethnocultural community in the delivery of programs. Community members can serve as information resources or liaisons between the ethnocultural community and community organizations. Learning from members of their own ethnocultural community, who share similar values and experiences can:
  - foster a sense of belonging;
  - support members of the community in developing resilient mindsets; or
  - increase the likelihood that information is incorporated into personal health practices.

- Use local data on differences in sexual health outcomes (e.g. vulnerability to sexually transmitted and blood borne infections, sexual violence) to:
  - identify particularly affected ethnocultural groups;
  - identify social, cultural, or economic determinants of vulnerability; or
  - develop, implement and monitor the effectiveness of your program or intervention.
- Develop and implement programs and interventions that target conditions that disproportionately affect ethnocultural minorities in your area.
- Create collaborative networks with cultural groups, faith-based organizations and other community organizations to work together to address health disparities among ethnocultural communities. Hold regular forums with these community partners to exchange ideas and identify areas for collaboration, working toward common goals. For example, collaborate with other local program providers to host a Health Fair as a way to get information out to ethnocultural communities and to raise awareness in the community of programs and services available.
- Set up continuous learning opportunities for staff to learn about:
  - health disparities;
  - the ways in which social, cultural, and economic conditions impact sexual behaviours, access to programs or services, and vulnerability to STBBIs; or
  - strategies for reducing disparities in health among ethnocultural communities.
- Consider using visual representations in posters and other information materials that reflect the ethnocultural communities served and the desired outcome or behaviour. Some ethnocultural groups do not have word equivalents for English terms related to sexuality, or that do not lend themselves to written expression easily. Using visual representation in place of text is another way to convey information to various ethnocultural communities.
- Inquire about language preferences other than English or French and identify communication preferences, norms and expectations of individuals in the community. Identifying language and communication preferences of individuals in the communities you serve can help to establish open and non-discriminatory dialogue or match individuals with resources, programs or providers in their language of choice. For example, inquiring about language and communication preferences can assist in:
  - development of materials in languages and communication styles that meet the needs of the community;
  - hiring of interpreter services; or
  - recruitment of program staff whose linguistic abilities reflect the language profile of the ethnocultural community.
- Provide services in a variety of settings. Time and transportation difficulties are often cited as barriers to accessing health information or programs among ethnocultural minorities. Multiple points of access within the community will greatly enhance the ability of ethnocultural minorities to access information and programs. For example, consider establishing mobile services to bring program elements such as testing for STBBIs to individuals. Or, establish "Sexual Health Information Desks" in local community centres, shopping malls or other settings where ethnocultural minorities visit. Train members of the ethnocultural community to staff the information desk, answer questions, and refer people to local resources. In addition, sexual health information could be built into English as a Second Language (ESL) classes or

faith-based learning environments to ensure that newcomers and longer-term immigrants have access to information.

- Provide information to ethnocultural communities in a variety of formats that are consistent with their cultural values, beliefs and practices. For example, engage members of the ethnocultural community to plan and host storytelling or sharing circle events. These events could involve members of the community telling stories that highlight themes and concerns that are priorities for that community. These events are a promising practice for engaging members of the community, involving them in program development, and including them in program implementation. They are also means to learn more about the needs, values and practices of the ethnocultural community and to build trusting relationships with them.
- Create tools to increase awareness among the ethnocultural community of programs and services available to them in the area. Ethnocultural minorities, particularly newcomers, are less likely to access services in part because they are unaware of what is available to them. For example, collaborate with other community organizations to establish a resource database for ethnocultural minorities in your area. The database could be shared with the community in a variety of formats including mobile phone apps, public websites, or print form in a variety of settings.
- Incorporate regular evaluations into all interventions, programs and activities. Share results of these evaluations with:
  - other community organizations;
  - local health authorities;
  - provincial or territorial ministries of health and education; or
  - other policy makers.

  For example, present findings from the evaluation of your activities at local health conferences, symposia or summits. Sharing evidence on programs and interventions that show promise in improving health outcomes and reducing health disparities will help others develop programs, policies or interventions in their own jurisdictions.
- Read your provincial or territorial sexual health education curricula to identify where and how the sexual health education learning needs of ethnocultural minority youth are being addressed. Discuss any gaps with school administrators, raise issues with school board trustees, or contact your curriculum representative, depending on the protocol in your jurisdiction.

  Encourage the use of the *Canadian Guidelines for Sexual Health Education* at the local, provincial and territorial levels, as a framework for developing inclusive, broadly-based sexual health promotion and STBBI prevention curriculum.
- Consider the use of social media to learn about the health concerns of the local ethnocultural community and to exchange health information with its members. For example, dedicate a discussion board on your website to a specific community or establish a Facebook page. Invite members of the community to comment and post on the discussion board.
- Collaborate with faith-based groups or spiritual leaders to provide sexual health information or services in places of worship. Faith leaders or congregation members can serve as lay leaders or peer educators to deliver health information on STBBI prevention. For example, partner with faith-based organizations to host a Youth Summit or health fair to bring youth together to share information and to explore values related to

sexuality. Places of worship can be key places where individuals connect to programs and discuss issues of sexuality in a way that is consistent with their values and beliefs. It can also help reduce the stigma, myths and taboos around STBBIs within faith communities.

- Establish peer support groups that provide an opportunity for people to connect with their own ethnocultural group to:
  - share experiences;
  - affirm beliefs; and
  - get health information.

  Peer support groups also provide a platform to address stigmatization and sensitive issues.[98]

HOW CAN I HELP TO BUILD RESILIENCE AMONG ETHNOCULTURAL MINORITIES?

Resilience requires a set of skills or a way of thinking that enables individuals to cope with stress and adversity. Building resilience has positive benefits that go beyond health to impact all aspects of an individual's life.

Research identifies seven resilience factors among culturally diverse populations:[99]

- access to material resources (i.e. food, clothing, shelter, education);
- access to supportive relationships (i.e. peers, family, community);
- a strong personal identity (i.e. sense of purpose, beliefs and values);
- a strong sense of personal power and control (i.e. ability to effect change in one's environment);
- adherence to cultural traditions (i.e. adherence to one's local and/or global cultural practices);
- a strong sense of social justice (i.e. finding a meaningful role in community and social equality); and
- a strong sense of cohesion with others (i.e. balancing personal interest with a responsibility to the greater good).

Community organizations, health professionals, and educators can do several key things to build the resilience of ethnocultural minorities.

- Encourage individuals and groups to recognize their individual and collective strengths.
- Facilitate opportunities for the community to identify and work with ethnocultural groups, positive role models (i.e. cultural leaders, public media role models) and networks of support in their communities. This can lead to greater sense of self-worth and self-esteem, as well as a stronger sense of belonging, among and between different ethnocultural groups.
- Help create diversity clubs, events and activities. These groups provide an opportunity for individuals to:
  - explore and take pride in their cultural identity;
  - build self-esteem;
  - create a sense of belonging; and
  - debunk stereotypes about people of different cultural backgrounds.
- Build individual capacity through peer education, mentoring and leadership development. This can reinforce values of cooperation, mutual respect and support, and allow ethnocultural minorities to participate in meaningful roles in helping one another.[100]
- Make culturally-inclusive resources available in the community and in classroom curricula. Exposing all individuals to this material will not only increase understanding and awareness among individuals from diverse cultural, ethnic and religious backgrounds, but will also create a sense of belonging and identification among ethnocultural minorities.

Ethnocultural minorities who have higher levels of self-esteem, a strong personal identity, and strong family and peer support networks, are more likely to make health-supporting decisions and be better placed to prevent negative health outcomes, such as STBBIs. Community organizations, health professionals, and educators have an important role to play in helping to protect and improve the health of ethnocultural minorities by fostering resilience and building both individual and community capacity.

CONCLUDING REMARKS

It is important to recognize that health disparities in sexual health outcomes, such sexually transmitted and blood borne infections (STBBIs) vary with cultural contexts. Given the growing cultural diversity in Canada it is important for prevention programs to be grounded in cultural contexts. It is also important that programs, policies and curriculum are developed to address the various social, structural, and economic determinants that impact ethnocultural minorities' vulnerability to and resilience against poor health outcomes. It is also important to recognize that differences exist among ethnocultural groups and that there is no "one size fits all" solution to reducing health disparities and improving health outcomes. Engaging members of the ethnocultural community in the planning, development and implementation of programs and interventions will ensure that they are tailored to the needs of the community, reflect the demographic and socioeconomic make-up of the community, and respect the cultural values of the community. Inclusive practice in the prevention of STBBIs is a promising approach to reduce the health disparities experienced by ethnocultural minorities and to improve the health of all individuals in Canada across the lifespan.

PROMISING PRACTICES

The following are examples of programs in Canada that have shown promise in addressing determinants of vulnerability to and resilience against sexually transmitted and blood borne infections (STBBIs) among ethnocultural minorities.

Mobile Health Clinic Program
Immigrant Women's Health Centre
(Toronto, ON)
http://immigranthealth.info

The Mobile Health Clinic (MHC) program is a satellite extension of the Immigrant Women's Health Centre. It works in partnership with workplaces, agencies and community groups to provide sexual healthcare services including contraception, STI counseling, testing and treatment, breast exams and pap tests, referrals for other clinical to immigrant, refugee and marginalized women across Toronto.

Families Achieving Inclusive Relationships (FAIR)
Calgary Sexual Health Centre
(Calgary, AB)
www.cbca.ab.ca

The FAIR project offers support and information to help immigrant parents talk to their children about their family values and how they are connected to healthy relationships and healthy bodies. Topics include: how to talk openly about relationships and values, understanding choices young people face when their family values are different from those of their friends and the challenges of raising children in a Canadian culture and how to talk to children about those differences.

Brownkiss
Alliance for South Asian AIDS Prevention (Toronto, ON)
http://brownkiss.ca

Brownkiss is a sexual health and HIV prevention program for South Asian women and newcomers. It is an online community dedicated to creating a safe space for individuals to feel comfortable in, while gaining knowledge about sex and sexuality, HIV/STI prevention and health as a whole.

Take Care Down There: A Sexual Health Campaign
Sexuality Education Resource Centre (SERC) Manitoba (Brandon, Manitoba)
www.serc.mb.ca

Take Care Down There is a sexual health media campaign developed to improve access to health and social services for immigrants living with or affected by HIV. Sexual health promotion and STI prevention messaging are available in multiple languages including English, Russian, Mandarin, Amharic, and Spanish.

ADDITIONAL RESOURCES

The opinions expressed in these resources are those of the authors and do not necessarily reflect the official views of the Public Health Agency of Canada. In addition, readers may wish to consult other resources developed by the Agency.

Note: Before using these resources with students or clients, it is advisable to preview them as some may contain sensitive content and may not be appropriate for all ages.

ORGANIZATIONS

Affiliation of Multicultural Societies and Services Agencies of BC (AMSSA)
www.amssa.org

205–2929 Commercial Drive
Vancouver, BC V5N 4C8
Tel: 604-718-2780 or 1-888-355-5560
Fax: 604-298-0747
Email: amssa@amssa.org

AMSSA facilitates collaborative leadership, knowledge exchange and stakeholder engagement to support member agencies that serve immigrants and build culturally inclusive communities.

African and Caribbean Council on HIV/AIDS in Ontario (ACCHO)
www.accho.ca

20 Victoria Street, 4th Floor
Toronto, ON M5C 2N8
Tel: 416-977-9955
Fax: 416-977-7664

ACCHO is made up of organizations and individuals committed to HIV prevention, education, advocacy, research, treatment, care and support for African and Caribbean communities in Ontario.

Arc-en-ciel d'Afrique/African Rainbow
www.arcencieldafrique.org

576 Sainte-Catherine Street East, Suite 207
Montréal, QC H2L 2E1
Tel: 514-373-1953
Email: info@arcencieldafrique.org

Arc-en-ciel d'Afrique is a community organization focused on the health and well-being of lesbians, gays, bisexuals and transsexuals from Africa and the Caribbean. Their objective is to educate and raise awareness about prevention, HIV/AIDS, other health issues, homophobia and human rights.

Au-delà de l'arc-en-ciel/Beyond the Rainbow (ADA)
www.lgbt-ada.org/index.htm

2215, Rue de Bordeaux
Montréal, QC H2K 3Y7
Tel: 514-527-4417
Email: info@lgbt-ada.org

ADA was created by the Spanish language Groupe Discussion Masculin (GDM) with the intention to offer a series of services to welcome and assist members of the LGBTQ community. ADA's goal is to help newcomers who have had difficulty in their country of origin due to sexual orientation.

Canadian Ethnocultural Council (CEC)
www.ethnocultural.ca

176 Gloucester St, Suite 205
Ottawa, Ontario Canada K2P 0A6
Tel.: 613-230-3867 x224
Fax: 613-230-8051
Email: cec@web.ca

CEC is a non-profit organization that conducts programs and activities to support an inclusive and multicultural Canada. CEC engages ethnocultural communities across Canada to increase capacity (tools, resources, and collaborative partnerships) in order to raise awareness and understanding of hepatitis C and other related communicable diseases and of their prevention within high-risk ethnic immigrant populations.

Canadian Federation for Sexual Health
www.cfsh.ca

2197 Riverside Drive, Suite 403
Ottawa, ON K1H 7X3
Tel: 613-241-4474
Fax: 613-241-7550
Email: admin@cfsh.ca

The Canadian Federation for Sexual Health (CFSH) is a national voluntary, charitable organization that supports sexual health promotion. CFSH provides education and training on a wide range of issues related to sexual and reproductive health in diverse cultural contexts.

Immigrant Women's Health Centre
http://immigranthealth.info

489 College Street, Suite 200
Toronto, ON M6G 1A5
Tel: 416-323-9986
Fax: 416-323-0447
Email: info@immigranthealth.info

The Immigrant Women's Health Centre is a sexual health clinic serving immigrant, refugee and marginalized women across Toronto.

OPTIONS Sexual Health Association
www.optionssexualhealth.ca

#50, 9912–106 Street
Edmonton, AB T5K 1C5
Tel: 780-423-3737
Fax: 780-425-1782
E-mail: options@optionssexualhealth.ca

The Multicultural Sexual Health Education Program at OPTIONS provides information and support on sexual health related issues to meet the specific needs of the multicultural community. Services include workshops and presentations, training for community leaders as sexual health educators, community-based sexual health needs assessments and education.

Rainbow Health Ontario

www.rainbowhealthontario.ca

Sherbourne Health Centre
333 Sherbourne Street
Toronto, ON M5A 2S5
Tel: 416-324-4100
Fax: 416-324-4262

Rainbow Health Ontario (RHO) is a province-wide program that works to improve the health and well-being of LGBT people through education, research, outreach and public policy advocacy. The RHO website provides searchable databases of trainers, training resources, researchers and research for LGBT people and their health care providers. This includes cultural competency training and resources for newcomers, immigrants and refugees.

RÉZO

www.rezosante.org

2075, rue Plessis, local 207
Montréal, QC H2L 2Y4
Tel: 514-521-7778
Fax: 514-521-7665
Email: info@rezosante.org

RÉZO offers counseling and referral services for gay and bisexual men from ethnic communities. This includes information sessions on sexual health, wellness and sexual orientation.

Sexuality Education Resource Centre (SERC) Manitoba

www.serc.mb.ca/

200–226 Osborne St. N.
Winnipeg, MB R3C 1V4
Tel: 204-982-7800
Fax: 204-982-7819
E-mail: info@serc.mb.ca

SERC is a community-based, non-profit, pro-choice organization. SERC's mission is to promote sexual health through education. Services for immigrant and refugee populations include community education on STIs, sexuality and reproductive health issues, orientation to health services and information, translation and development of health education resources, referrals to other services and cultural competency training for service providers.

519 Church Street Community Centre

www.the519.org

519 Church Street
Toronto, ON M4Y 2C9
Tel: 416-392-6874
Fax: 416-392-0519
Email: info@the519.org

The 519 offers a range of services for LGBTQ newcomers and refugees and newcomer families that incorporate community engagement, information and referrals, education, recreation and support activities.

NON-FICTION BOOKS

Canadian Federation for Sexual Health. (2002). *Finding Our Way: A Sexual and Reproductive Health Sourcebook for Aboriginal Communities.* Ottawa, ON: Canadian Federation for Sexual Health.

Finding Our Way is the first comprehensive Canadian resource on sexual and reproductive health within an Aboriginal cultural context. This 335-page Sourcebook includes up-to-date information, teaching resources, program models and personal stories on sexual and reproductive health issues as defined by Aboriginal peoples. It was co-produced by the Aboriginal Nurses Association of Canada and the Canadian Federation for Sexual Health.

Madan-Bahel, A. (2008). *Sexual health and Bollywood films: a culturally based program for South Asian teenage girls.* Youngstown, NY: Cambria Press.

"Sexual Health and Bollywood Films" features a culturally based sexual health prevention program for South Asian female youths. It is a tool for researchers, program developers and service providers to gain knowledge and raise awareness of sexual health issues including the prevention of STIs.

ONLINE RESOURCES

Alberta Health Services

www.teachingsexualhealth.ca

Reproductive Health, Healthy Living
10101 Southport Rd. S.W.
Calgary, Alberta T2W 3N2
Tel: 403-943-6724
Email: tsh@albertahealthservices.ca

This innovative website aims to enhance excellence in education by providing teachers with evidence-based sexual health education background and delivery methods, current lesson plans and activities, and comprehensive resources.

Sexual Health Toolkits

www.catie.ca/en/resources/sexual-health-toolkit-sexuality-and-relationships

www.catie.ca/en/resources/sexual-health-toolkit-sexually-transmitted-infections

These sexual health toolkits were developed by the National Aboriginal Health Organization (NAHO). They provide basic information on sexually transmitted infections, sexuality, and relationships.

PlanetAhead

www.planetahead.ca

PlanetAhead-Condomania
Vancouver Coastal Health
436A–520 West 6th Avenue
Vancouver, BC V5Z 4H5
Tel: 604-714-3771 ext. 2373
Fax: 604-708-5212
Email: planetahead@vch.ca

PlanetAhead-Condomania uses an integrated approach—incorporating school-based workshops, outreach at youth events, and the www.planetahead.ca website—to provide youth with opportunities to explore issues and social contexts that influence their decisions about relationships and sexuality, and to learn safer sex skills.

Sexuality and U

www.sexualityandu.ca

Teaching Sexual Health Education Manual
http://sexualityandu.ca/uploads/files/TeachingSexEdManual.pdf

The Society of Obstetricians
and Gynaecologists of Canada
780 Echo Drive
Ottawa, ON K1S 5R7
Tel: 613-730-4192
Toll Free: 1-800-561-2416
Fax: 613-730-4314
Email: helpdesk@sogc.com

www.sexualityandu.ca is committed to providing credible and up-to-date information and education on sexual health for health care professionals, teachers and parents. The Teaching Sexual Health Education Manual includes strategies on how to address sexual health and STIs in diverse cultural and religious settings.

Wellesley Health Institute
www.wellesleyinstitute.com

Colour Coded Health Care: The Impact of Race and Racism on Canadians' Health
www.wellesleyinstitute.com/wp-content/uploads/2012/02/Colour-Coded-Health-Care-Sheryl-Nestel.pdf

10 Alcorn Avenue, Suite 300
Toronto, ON, Canada M4V 3B1
Tel: 416-972-1010
Email: contact@wellesleyinstitute.com

The Wellesley Institute is a Toronto-based non-profit and non-partisan research and policy institute that focuses on developing research, policy and community mobilization to advance population health. The Institute conducts its work through four core pillars: housing, health care, economics and immigrant health.

ENDNOTES

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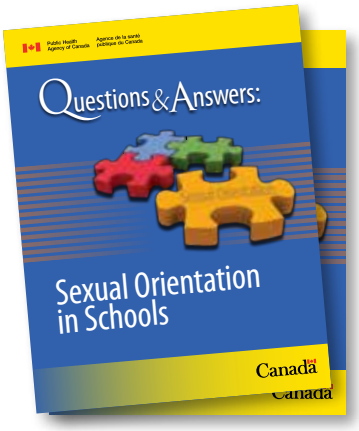

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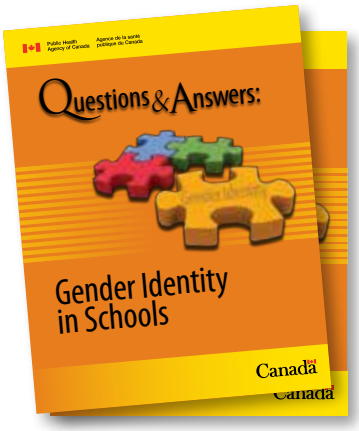

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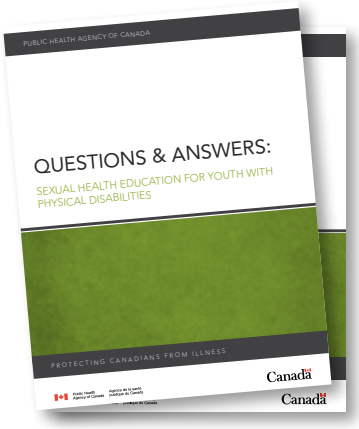

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