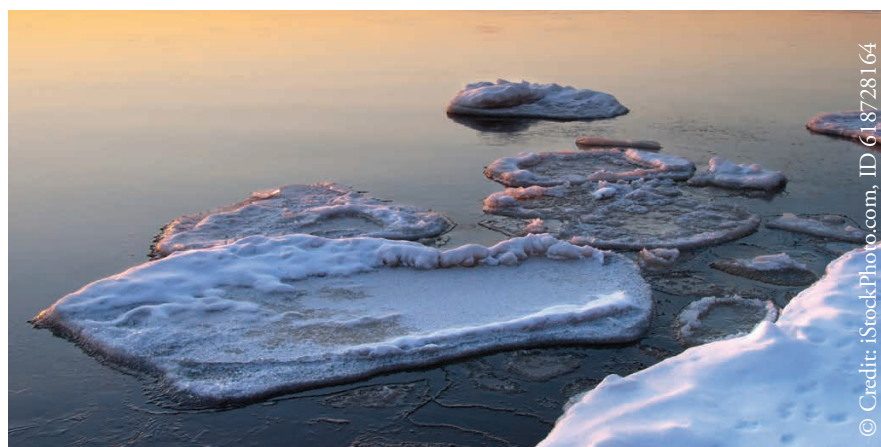




PLAIN LANGUAGE SUMMARY

SEXUALLY TRANSMITTED AND BLOOD-BORNE INFECTIONS IN INDIGENOUS POPULATIONS: *Understanding the social determinants*

Indigenous¹ people experience disproportionately high rates of sexually transmitted and blood-borne infections (STBBIs). Statistics can provide a snapshot of STBBI rates and trends among Indigenous populations but not the root causes of STBBI transmission. Without a full understanding of the causes of Indigenous health inequities generally, developing effective solutions to improve STBBI health outcomes among Indigenous populations will be difficult. This plain language summary provides an overview of the broader structural and systemic factors that influence the prevention, transmission, and treatment of STBBIs among Indigenous populations in Canada.



This summary is derived from the background paper, *Sexually transmitted and blood-borne infections in Indigenous populations*, which provides a literature review of STBBIs among Indigenous populations in Canada and ways of reducing STBBI transmission in Indigenous communities. The background report and this summary are two of several knowledge translation products developed by the National

Collaborating Centre for Indigenous Health (NCCIH), in collaboration with the National Collaborating Centre for Infectious Diseases (NCCID), on STBBIs and the accessibility, availability, and delivery of STBBI services among First Nations people, Inuit, and Métis people in Canada. More information and access to these knowledge products can be found on the NCCIH and NCCID websites.

¹ In this fact sheet, the term “Indigenous” is used as an umbrella term referring to First Nations (status and non-status) people, Inuit, and Métis people, collectively. Wherever possible, the terms “First Nations”, “Inuit”, and/or “Métis” are used to reference and distinguish specific Indigenous populations.



Colonialism as a determinant of STBBI transmission, prevention, and treatment

STBBI prevention requires a focus on an individual's perception of risk, their health behaviours, and the social, cultural, and interpersonal contexts in which they engage in practices that either protect them from, or render them vulnerable to, infection. For Indigenous Peoples, this context is heavily influenced by colonialism and ongoing harms that affect not only the traditional ways in which knowledge about sexual health and healthy relationships are passed on to younger generations, but also conditions that influence Indigenous peoples' risk taking and health seeking behaviours. These conditions include socio-economic marginalization, inequitable access to and inappropriate health services,

and various forms of violence and abuses of power, all of which have resulted in high rates of intergenerational trauma, mental health issues and addictions, as well as multiple stigmas. Moreover, these conditions intersect with each other to drive higher rates of STBBIs among Indigenous populations.

The intersection of multiple forms of violence and abuse

Colonialism and intergenerational trauma contribute to the disproportionately high rates of STBBIs among Indigenous populations in multifaceted ways. As a result of colonialism, for instance, Indigenous women and girls experience disproportionately high rates of gendered violence and sexual abuse compared to their non-Indigenous counterparts. Colonialism has also contributed to disproportionately high rates of childhood abuse, which can have life-long impacts that increase

the risk of exposure to STBBIs, including alcohol and substance abuse, homelessness, self-harm, mental health issues, multiple sexual partners, and sex work.

The literature review highlighted two key themes that are central to understanding the high rates of STBBIs in Indigenous communities – abuses of power and the normalization of sexual abuse. Abuses of power, experienced at multiple levels, including inter-personal relationships, intergenerational, communal, societal, and systems levels, and the normalization of sexual abuse in Indigenous communities collectively work to disempower Indigenous women and girls. This disempowerment poses a barrier to reporting sexual abuse and accessing sexual health supports and inhibits agency over safe sex practices (for example, when to have sex and whether or not contraception will be used).



Research has shown that exposure to historical and intergenerational trauma has increased Indigenous people's risk of mental health issues and substance use disorders. Mental health issues and addictions can elevate the risk of STBBIs through unhealthy coping strategies (e.g., substance abuse) and sexual risk-taking pathways. Injection drug use is considered one of the most common determinants of hepatitis C virus and HIV infections among Indigenous populations. Substance abuse is associated with reduced condom use and is considered a major barrier to accessing and engaging with STBBI care and prevention services because it hinders health-seeking behaviours and adherence to STBBI treatment.



Socio-economic marginalization

Socio-economic marginalization can lead to poorer health outcomes, generally, and increase susceptibility to STBBIs, specifically. Lower socio-economic status can create competing life challenges that may compel individuals to prioritize their immediate physical needs over sexual health concerns.

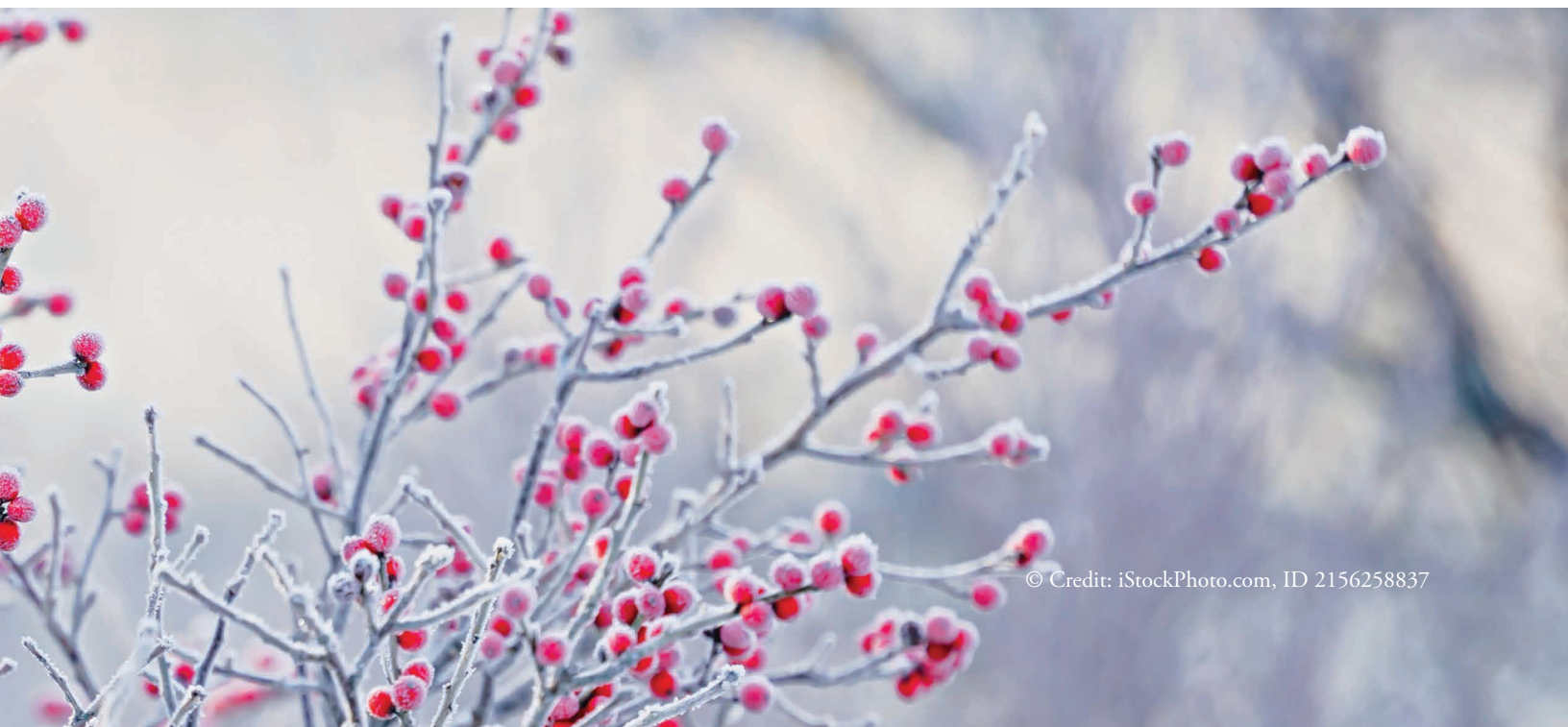
Poverty increases biological susceptibility to HIV through food insecurity and malnutrition. Poverty also affects access to health care (e.g. ability to pay for transportation to medical appointments, health insurance, medications, or certain treatments) and the ability to afford condoms.

Housing instability affects Indigenous people's ability to maintain strong social networks,

which is an important factor that influences sexual risk-taking behaviours and access to sexual health information. Conversely, when HIV patients have both housing stability and food security, they are better able to manage their illness with medications and experience improved health outcomes, generally.

Lower levels of education can affect Indigenous people's knowledge and awareness about STBBI risk and prevention, as well as contribute to stigma related to sexual health and STBBIs, which is a known barrier to accessing STBBI-related health services, such as testing.

Finally, socio-economic inequities can lead to mental health issues and substance use. These issues can subsequently affect engagement in safe sex practices, access to STBBI health services, and ability to manage illnesses with medication.





Intersecting stigmas

Multiple forms of stigma intersect to influence STBBI transmission and prevention among Indigenous populations. Colonialism played a significant role in the development of stigma surrounding sexuality and bodies by enforcing normative ideas of shame around sex, as well as imposing Western understandings of gender and sexuality based on a heterosexual man/woman binary. It also disrupted traditional ways of sharing knowledge in relation to sexual health and instilled a taboo on talking about sexual health. As a result, there may be misconceptions about STBBI transmission risk, reduced awareness of prevention

services, and avoidance of or delays in seeking and receiving health services. The attitudes and behaviours of health care providers, the inability of health settings to maintain confidentiality and ensure privacy, and social norms and perceptions of behaviours (e.g. moral judgements on sexual activity or substance use) may amplify these existing stigmas, with subsequent impacts to self-esteem, well-being, and health-seeking behaviour. The barriers of stigma and shame can be particularly significant in small Indigenous communities where health care providers are personally known to individuals accessing health services and the ability to maintain confidentiality and anonymity cannot be assured.

STBBI-related stigma does not exist in isolation from other forms of stigma and discrimination. Indigenous people may experience stigma in relation to their sexual orientation, being sexually active, having a mental health issue, using any substances, living in poverty, and/or being Indigenous. Collectively, these intersecting stigmas can present multiple barriers to accessing safe sex and harm reduction resources and lead to reduced safer sex efficacy. Stigma is thus a key barrier to STBBI prevention and driver of health disparities.



Access to health services

Timely access to health care is critical for controlling STBBIs. In rural, remote, and northern Indigenous communities, STBBI prevention, early diagnosis, and treatment may be especially difficult. These barriers include a lack and high turnover of qualified health providers, reduced hours of health service operations, increased stigma and confidentiality issues, absence of primary care services, and the need to travel outside of the community for services not available locally. All of these factors affect continuity of care.

Access to STBBI testing can vary widely across geographic contexts. Point-of-care testing (POCT) and self-testing kits can help improve the availability of screening and facilitate timely linkages to treatment and care in otherwise underserved areas. POCT enables individuals to collect their own samples and mail them to a lab for analysis; however, POCT may not be available in all rural and remote communities. Self-testing kits offer the benefits of empowering individuals and preventing stigma since testing can be done in private settings, such as home environments. Nevertheless, they also present

drawbacks such as their high-cost for some individuals, long wait times for test results, and increased risk of false negatives.

Although limited, some research evidence suggests that Indigenous users of self-testing kits for sexually transmitted infections and self-screening options for HPV find self-testing to be acceptable and accurate, and generally prefer these methods over care provider options. Self-testing methods may thus be considered as a strategy for improving accessibility of STBBI testing services among Indigenous populations.

In rural and isolated communities, treatment for STBBIs can be complex, particularly for hepatitis C, which requires access to medical services typically delivered by specialists in urban centres. For individuals without their own means of transportation, relying on others to access these services may threaten patients' confidentiality and anonymity. Jurisdictional complexities can also act as a barrier to adequate and consistent STBBI care for Indigenous populations. Navigating the complicated or disjointed referral processes between federal, provincial/territorial, and local

Indigenous service providers can be difficult, and programs and services offered by First Nations communities are generally limited to status First Nations who live on reserve due to limited capacity, limited funding, or other factors.

Distrust in the mainstream healthcare system poses a final, significant barrier, not only to receiving STBBI-related preventive and treatment care, but also in accessing health care, generally. The roots of this distrust are multifaceted and grounded in Indigenous Peoples' historical and contemporary experiences in mainstream health systems, including medical experimentation; segregated and substandard care; uninformed, forced, and coerced sterilizations; the policy and practice of "birth alerts"²; and ongoing acts of systemic racism and discrimination. Distrust in the healthcare system is compounded by a lack of culturally safe and accessible health services for Indigenous patients, particularly in urban centres.



² Administering "birth alerts" is a practice in which hospitals notify provincial child and family services of Indigenous births, prompting state apprehension of infants on the basis of prejudicial assumptions regarding the parents and false pretexts of ensuring the infant's safety and well-being.

Conclusion

The central role that colonialism plays in fostering Indigenous health disparities and creating distrust in the mainstream healthcare system calls for increased action towards reconciliation between Indigenous and non-Indigenous people in relation to health. This includes promoting Indigenous engagement and self-determination in health decision-making; addressing capacity and funding challenges faced by Indigenous health care providers; recognizing the value of Indigenous knowledges and approaches to STBBI prevention and education; and taking actions to ensure Indigenous people have access to culturally safe and appropriate health care that is grounded in a respect for human and Indigenous rights. Taking actions toward reconciliation is an important step to restoring trust among Indigenous people involved in mainstream health services.

This summary, and the literature review from which it was derived, highlight the need to address various social determinants that influence STBBI prevention, transmission, and treatment that are rooted in colonialism. The connection between mental health, substance abuse, and STBBIs, for example, highlights the value of integrated and co-located services as a way of reaching and engaging populations most at risk of

being afflicted with STBBIs. Moreover, links between various forms of violence, abuse, and STBBIs highlight the need to consider gender equity and empowerment in STBBI prevention programming. Limited access to STBBI prevention, testing, and treatment services can be improved through the development of culturally appropriate sexual health information, use of self-testing kits and swabs, and the expansion of POCT, offered in conjunction with rapid and complete treatment, partner notification, and regular testing.

There is also a need to consider the importance of intersecting stigmas when trying to understand the experiences of Indigenous people concerning STBBIs, particularly when considering how certain Indigenous populations may be subjected to multiple harms. Trauma-informed, patient-centred, and culturally safe and appropriate care must become the cornerstone of STBBI health services. Community engagement and decision-making is essential in the development and delivery of these services to improve trust and access to STBBI care.





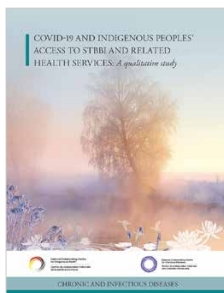
NCCIH-NCCID STBBI RESOURCES

Resources exploring the effects of the COVID-19 pandemic on Indigenous peoples' access to STBBI and related health services

Together, the National Collaborating Centre for Indigenous Health (NCCIH) and National Collaborating Centre for Infectious Diseases (NCCID), with the support of the Public Health Agency of Canada (PHAC), have developed a suite of ten knowledge translation products to enhance understanding of how the COVID-19 pandemic affected the accessibility, availability, and delivery of health services for sexually transmitted and blood-borne infections (STBBI), including harm reduction services, for First Nations peoples, Inuit, and Métis peoples during the pandemic.



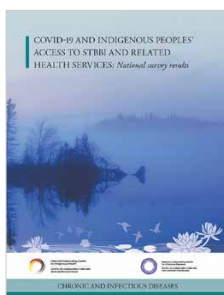
nccih.ca/485/NCCIH_in_the_News.nccih?id=530



COVID-19 AND INDIGENOUS PEOPLES' ACCESS TO STBBI AND RELATED HEALTH SERVICES: A QUALITATIVE STUDY



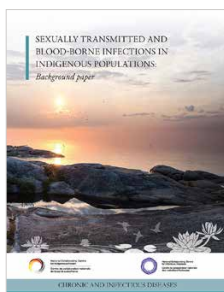
Report summary for the qualitative study and an infographic with recommendations.



COVID-19 AND INDIGENOUS PEOPLES' ACCESS TO STBBI AND RELATED HEALTH SERVICES: NATIONAL SURVEY RESULTS



A report summary and infographic summarizing the national survey.



SEXUALLY TRANSMITTED AND BLOOD-BORN INFECTIONS IN INDIGENOUS POPULATIONS: BACKGROUND PAPER



Three plain language summaries covering rates and trends, health promotion, and social determinants.



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



National Collaborating Centre
for Infectious Diseases
Centre de collaboration nationale
des maladies infectieuses