Core Competencies For STBBI Prevention

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Acknowledgements

The project Developing Core Competencies for STBBI Prevention would not have been possible without the support and involvement of the many individuals and organizations who participated in community consultations, focus groups, and key informant interviews. The Canadian Public Health Association (CPHA) would like to especially acknowledge the individuals from various communities who participated in local focus groups and shared their stories, insight, and wisdom with us.

Thank you to the lead community partners who coordinated the community consultations and focus groups and enabled us to engage each community in a meaningful way. The community leads included

- Vancouver: AIDS Vancouver
- Saskatoon: Saskatchewan HIV/AIDS Research Endeavour (SHARE)
- Ottawa: AIDS Committee of Ottawa
- Renfrew County: West Champlain Healthy Community Corporation
- Montreal: COCQ-SIDA
- Halifax: AIDS Coalition of Nova Scotia and Nova Scotia Advisory Commission on AIDS
- Yellowknife: Aurora College

CPHA would also like to extend a thank you to the National Reference Group that provided their time, expertise, and guidance throughout the project. Members of the NRG included

- Dr. Gina Ogilvie, Medical Director, Clinical Prevention Services, British Columbia Centre for Disease Control
- Mr. Wayne Robert, Executive Director, Health Initiative for Men
- Mr. Ken Clement, Chief Executive Director, Canadian Aboriginal AIDS Network
- Dr. Johnmark Opondo, Chief Medical Officer, Saskatchewan Ministry of Health, HIV Provincial Leadership Team
- Dr. Joel Kettner (replacing Dr. Allan Ronald) and Ms. Anneliese Poetz, National Collaborating Centre for Infectious Disease
- Dr. Marc Stebben, Médecin conseil, Direction des risques biologiques et de la santé au travail, Institut national de santé publique du Québec
- Ms. Kim Thomas, Director of Programs, Canadian AIDS Society
- Ms. Wangari Tharao, Programs and Research Manager, Women's Health in Women's Hands
- Mr. Mooky Cherian, Prisoners' HIV/AIDS Support Action Network
- Ms. Pam Oickle, Supervisor, Harm Reduction Clinical Services Branch: Healthy Sexuality and Risk Reduction Unit, Ottawa Public Health
- Ms. Maria MacIntosh, Executive Director, AIDS Coalition of Nova Scotia

Members of the CPHA project staff included

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This project was made possible through a financial contribution from the Public Health Agency of Canada (PHAC). The views expressed throughout the document do not necessarily represent the views of PHAC

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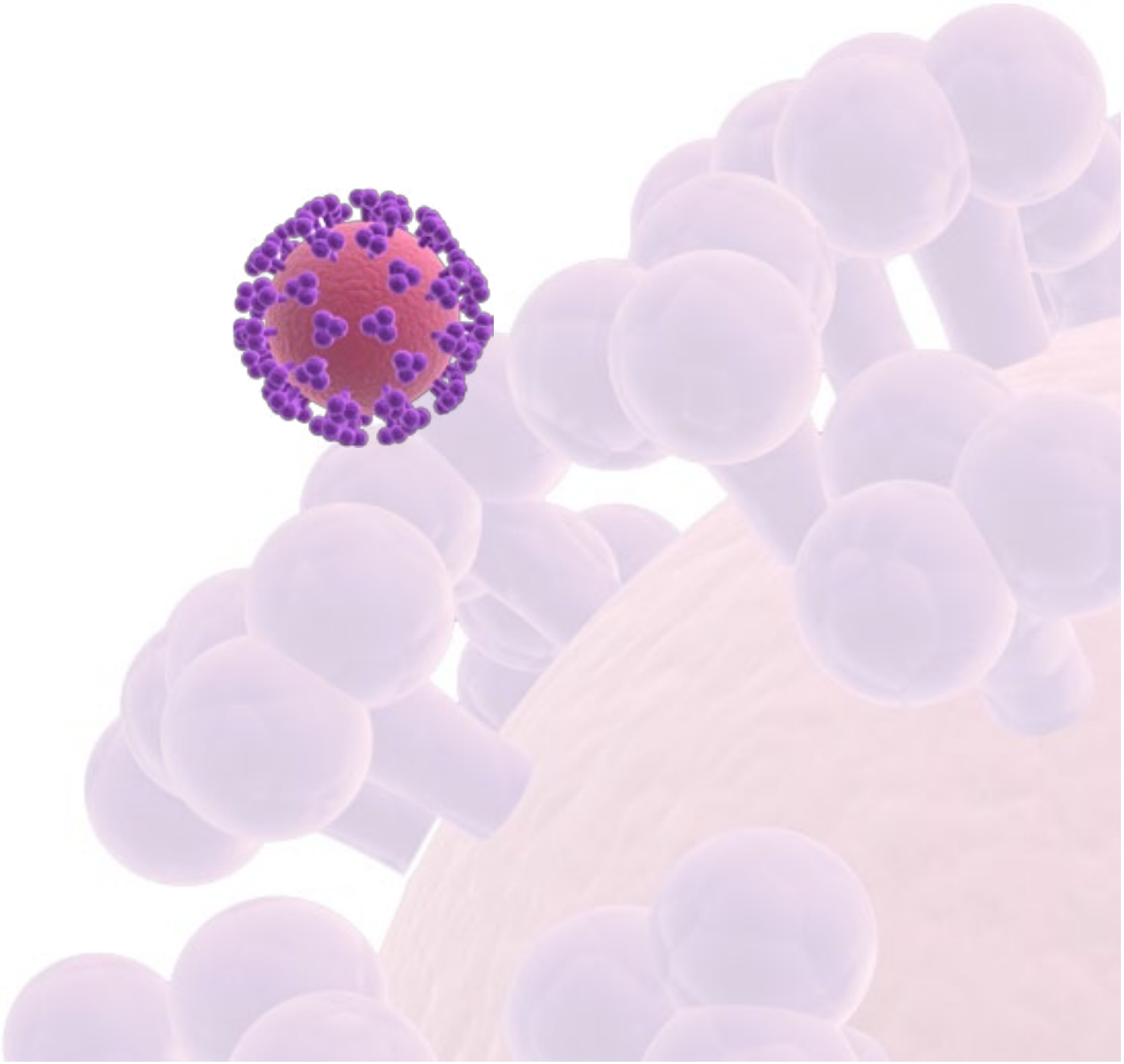


List of terms and short forms

Not all of these terms are used in this document, but they are all useful in understanding the context of STBBI prevention and sexual health.

Aboriginal peoples: First Nations, Inuit, and Métis people in Canada (for the purpose of this document).

ACB: African, Caribbean, and Black communities; there is a high rate of HIV within groups of people in Canada who have originated from ACB countries.

AIDS: Acquired immune deficiency syndrome; caused by HIV infection and diagnosed according to certain clinical criteria, such as AIDS-defining illnesses and specific blood tests.

ASO: AIDS service organization.

Barrier-less sex: Sexual activity that does not include any type of physical protective barrier; examples of barrier methods include condoms and dental dams.

BBI: Blood-borne infection; transmitted by direct blood contact from one individual to another through injured skin or a mucous membrane; also transmitted through drug use and sexual contact; examples include hepatitis A, B, and C.

Bisexual: An individual who is sexually attracted to both men and women.

CBO: Community-based organization.

Co-infection: More than one infection at a time; HIV and HCV are examples of co-infections.

CPHA: Canadian Public Health Association.

DoH: Determinants of health; health is determined by complex interactions among social and economic conditions, the physical environment, and individual behaviour; in Canada, 12 broad determinants of health have been identified; some examples are gender, income, employment, working conditions, housing, and education; these determinants do not exist in isolation from each other; it is the combined influence of the determinants that results in health status. See also SDH (social determinants of health).

FIV: Factors that impact vulnerability; factors that impact a person's risk of STBBIs and vulnerability to STBBIs.

Front-line service providers: Any individual who is the first point of contact with the patient or client of a public health unit, community-based organization, or AIDS service organization.

Gender identity: A person's self-image or belief about being female or male; does not always correspond to biological sex.

HCV: Hepatitis C virus.

Health equity: The absence of health disparities between groups even though they are differently advantaged according to the social determinants of health; reducing the barriers that result in health disparities leads to health equity.

HEIA tool: A health equity impact assessment tool.

Hepatitis: A viral inflammation of the liver; there are several different forms of the virus, including types A, B, C, D, E, and G; hepatitis C is often associated with intravenous drug use and is a chronic liver disease.

HIV: Human immunodeficiency virus; results in a combination of illnesses that in advanced stages can lead to AIDS.

MSM: Men who have sex with men, regardless of how they identify themselves; this is an epidemiological classification for STBBI transmission.

Perinatal: The period directly before and after birth.

PHAC: Public Health Agency of Canada.

Priority populations: Populations identified by PHAC as most at risk of STBBIs in Canada, based on risk exposure categories and rates of infection collected by PHAC; eight broad categories have been defined; the categories are not mutually exclusive; the overlap and intersection between groups results in complex identities and complex health issues.

Risk gradient: The more prevalent risk factors for STBBIs are in a person's life, the more a person's risk increases over time and the greater the risk a person faces from the various factors; social gradient is similar: the lower a person's socio-economic status, the lower a person's health outcome is likely to be.

SDH: Social determinants of health; specific to the social and economic conditions that shape the health of individuals, communities, and countries; these determinants also influence the extent to which individuals have the physical, social, and personal resources to achieve their goals, satisfy their needs, and cope with their environments.

Sexual orientation: How people think of themselves in terms of sexual desire for another person.

STBBI: Sexually transmitted and other blood-borne infections; examples include chlamydia (sexually transmitted) and hepatitis C (blood-borne).

STBBI HEIA tool: The tool developed as part of the CPHA project Developing Core Competencies for STBBI Prevention.

STI: Sexually transmitted infections; infections caused by sexual activity or exposure. (Note: The term sexually transmitted disease is no longer used.)

Transgender: A person whose gender identity, outward appearance, expression, or anatomy does not fit into conventional expectations of male or female.

Two-spirited: "Native people who are gay, lesbian, bisexual, and transgender individuals who walk carefully between the worlds and genders," as defined by the organization 2-Spirited People of the 1st Nations; this term is not used in all communities.

Why Develop STBBI-Specific Core Competencies?

Core competencies for the prevention of sexually transmitted and other blood-borne infections, including HIV, reflect the knowledge, skills, attitudes, and behaviours that front-line service providers need in order to strengthen services and improve health outcomes for those at risk of sexually transmitted and other blood-borne infections, including HIV (hereafter referred to as STBBIs).

The Canadian Public Health Association (CPHA) worked with communities across Canada, including a National Reference Group, to identify the knowledge, skills, attitudes, and behaviours that enhance prevention activities. The competencies were then refined and selected according to three criteria:

1. Specific to STBBIs
2. Measurable
3. Building on, but not duplicating, the Core Competencies for Public Health

The Core Competencies for STBBI Prevention are not meant to replace or circumvent organizational policies, guidelines, or procedures. Rather, they provide a framework for strengthening and developing consistent, standardized services, whether delivered by staff, volunteers, or peers. They are not specific to any particular profession or discipline. Organizations can use them to

- guide recruitment and selection,
- identify training needs,
- ensure competencies within a team, and
- form part of an individual performance review process.

Evaluating an individual's core competencies should be part of a process that involves assessing the organization as a whole. It is essential to acknowledge the role that organizational culture, policies, and practices play in shaping a service provider's knowledge, skills, attitudes, and behaviours toward sexual health.

The core competencies reflect the complexity of the Canadian context and the knowledge, skills, attitudes, and behaviours needed to serve diverse populations where the epidemic is concentrated.

In addition to the Core Competencies, a Health Equity Impact Assessment Tool specific to STBBIs and Factors that Impact Vulnerability to STBBIs in priority populations were created.

The Core Competencies

1. Knowledge of STBBI transmission modes, infection and disease progression, and treatment options

a. Demonstrates consistent use of universal precautions.
b. Identifies, shares, and contextualizes best practices in the prevention of STBBI transmission.
c. Understands that the presence of one STBBI may increase the risk of other infections.
d. Demonstrates knowledge of bio-medical risks associated with sexual practices (including insertive, receptive, anal, and vaginal).
e. Recognizes the complex factors involved in assessing a person for risk in sexual and non-sexual decision making, including the need for intimacy and pleasure.

2. Respect for the diverse range of beliefs, practices, and values that influence sexual practices and decision making

a. Recognizes how the determinants of health (DoH) influence STBBI risk for specific populations.
b. Understands how culture shapes an individual's sexual health and decision making.
c. Understands how stigma and discrimination can lead to further exclusion and isolation.
d. Knows and appreciates the factors that impact vulnerability (FIV).
e. Understands how a person's experiences affect decisions about accessing services, getting tested, and having treatment.

3. Effective use of interventions to modify the risk of STBBIs

a. Creates and maintains appropriate boundaries within the client-service provider relationship.
b. Identifies and applies harm reduction strategies.
c. Applies approaches that meet the STBBI prevention needs of the client, such as motivational interviewing and active listening.
d. Supports clients in making informed decisions while acknowledging they are experts in their own lives.
e. Discusses sexual practices, related risks, and prevention of STBBIs with a level of comfort.

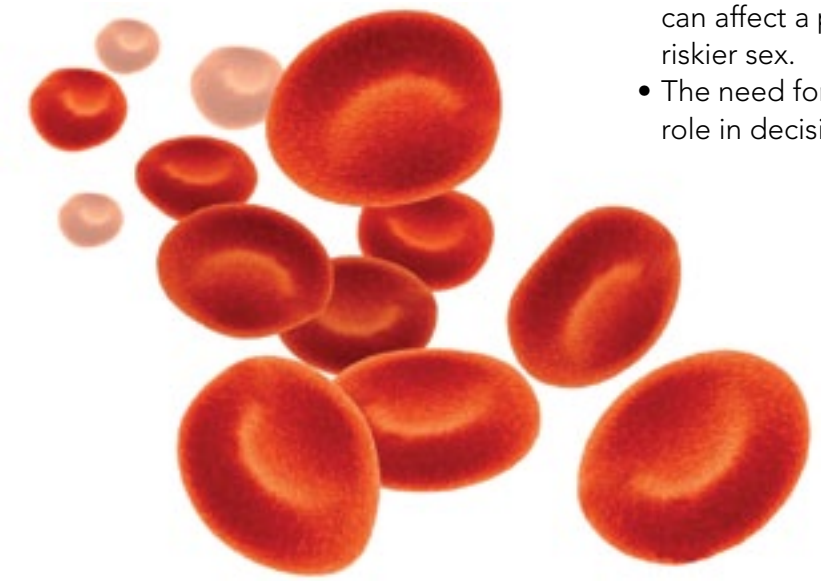
f. Puts situations in context in order to effectively meet the needs of those at increased risk of STBBIs.

4. Advocacy on behalf of those at risk of STBBIs and living with HIV

a. Demonstrates awareness of the impact that organizational policies and practices have on access to STBBI prevention services.
b. Ensures a safe and respectful environment that does not isolate or marginalize clients.
c. Identifies appropriate referral options for clients whose complex health needs may impact their risk of STBBIs.
d. Acknowledges one's own limitations and be able to support clients in the navigation of systems

5. Planning, implementation, adaptation, and evaluation of STBBI programs and policies

a. Applies a health equity lens to inform programs, services, and interventions.
b. Contextualizes disparity and adapt programs to ensure inequities are not increased.
c. Knows the laws and organizational policies surrounding disclosure and confidentiality.
d. Demonstrates an understanding and ability to adapt as necessary to people from diverse backgrounds.
e. Ensures that programs and services are not only culturally relevant but also culturally safe for populations most at risk of infections.
f. Applies organizational procedures, protocols, and standards to the delivery of STBBI services.



Attitudes and Factors that Impact Vulnerability

The attitudes of service providers can have a significant impact on health outcomes for those at risk of STBBIs. Service providers need confidence and a level of comfort to address the complex needs of those at risk in an unbiased, non-judgmental, and inclusive manner. The factors that impact vulnerability (FIV) provide an initial list of factors that can challenge the attitudes and beliefs of those working with people at risk of STBBIs. They need to understand their own role in shaping a client's experience.

An understanding of the FIV is essential for front-line workers if they are going to understand a client's risk of STBBIs. At the same time, workers should not assume that the factors are relevant to each person's experience—they must acknowledge that people are experts in their own lives.

Service providers should consider their personal attitudes toward the people they work with and the choices people make as well as the factors that impact vulnerability. Both attitudes and factors can occur at an individual, community, and system level.

Individual Level

While we often speak of populations, it is individual characteristics, preferences, and practices that shape sexual health and decision making. People need space to tell their stories.

Personal preferences

- The pleasure of sex, including barrier-less sex, and the enjoyment of particular sexual practices can affect a person's decisions to engage in riskier sex.
- The need for intimacy and pleasure can play a role in decision making.

Health literacy

- Health literacy and access to information on safe substance use may have an effect on a person's risk for infections.
- Knowing how to navigate health systems affects a person's access to services.
- Health literacy may affect a person's ability to identify and manage risks related to sexual practices, drug use, and other exposures to STBBIs.

Perceptions and beliefs

Culture and faith affect a person's decisions around prevention, medical care, treatment, and intervention.

- A person's perceptions about who is at risk of STBBIs can affect their decision to get tested.
- Fear of rejection and judgement can influence conversations about sexual practices and protection.
- Distrust of systems affects people's decisions to access health services, sexual health services, and testing.

Mental health

- Sense of self-worth and self-esteem may affect choices and influence risk behaviours.
- Poor mental health can influence a person's decision to take part in high-risk activities, such as substance use. Substance use, in turn, impacts decision making abilities and risk-taking behaviours.

Social and economic factors

- A person who feels disadvantaged by age, ethnicity, income, sexual orientation, gender identity, physical appearance, ability, or other personal characteristics may be more willing to tolerate risks in order to fulfill a sexual or non-sexual need.
- Temporary and economic migration may interrupt access to health and harm reduction services, and increase a person's potential for sexual and non-sexual activities that increase risk of infection.

Community Level

Respect for individuals requires an understanding of the social and cultural context in which they live—the norms, practices, and beliefs that impact discussions and decisions around sexual and non-sexual activities. This respect helps service providers to better understand their community and develop interventions that are culturally relevant.

- People living in communities where they feel disadvantaged by their age, ethnicity, income, sexual orientation, gender identity, physical appearance, ability, or other characteristics may be more willing to tolerate risks in order to fulfill a sexual or non- sexual need.
- Attitudes toward sexual and personal practices inform discussions between service providers and service users.
- Taboos and the stigmatization of specific sexual practices may prevent honest discussions around sexuality.
- Service providers' assumptions or perceptions about who is at risk of STBBIs may adversely affect risk triage, leading them to gather incomplete information from clients and/or provide inaccurate information about health care and testing options to clients.
- Evolving cultures and subcultures may affect trends in sexual practices, substance use, and other behaviours that impact risk.
- The ability to see oneself represented in sexual health messaging and education may have an impact on the effectiveness of prevention tools.

System Level

Even though political, economic, and social factors may be beyond an individual's control, service providers need to understand that these factors have an impact on an individual's risk.

- Temporary and economic migration may interrupt access to health, harm reduction services and can also increase a person's potential for sexual and non-sexual activities that increase risk of infection.
- Cultural orientations may influence how people discuss sex in public and in private.
- When health, legal, and education systems show a limited ability to address individual circumstances, they can create a general distrust of systems.
- Some populations (e.g., First Nations, Inuit, and Métis women; refugee women; people with disabilities; sex workers; and LBGTQ people) experience higher rates of violence and trauma. Experiences of violence and trauma have been linked to risk-taking behaviours.
- Laws and organizational policies about disclosure have an impact on discussions between service users and providers.

- Risk assessment protocols and screening processes may affect a person's access to STBBI testing.
- Lateral violence (racism and discrimination directed at peers and internalized feelings of low self-worth) and internalized homophobia may influence a person's risk-taking behaviours and use of community supports.
- Health surveillance data sometimes inaccurately categorizes high-risk populations, misrepresenting the actual risk and compounding existing risks.

How the Core Competencies Were Developed

The *Core Competencies for STBBI Prevention* were developed through a community-based, participatory process. The Canadian Public Health Association held consultations, focus groups, and key informant interviews in seven Canadian locations: Vancouver, Saskatoon, Yellowknife (focus group only), Ottawa, Montreal, Halifax, and Renfrew County. The meetings were semi-structured to allow for both directed questions and open discussion. Participants included people at risk or living with STTBIs, public health professionals, clinicians, allied health professionals, front-line workers, volunteers, experts, and researchers.

Throughout the project, guidance was provided by a National Reference Group that was composed of individuals with vast experience in the field of STBBIs, including representation from national partner organizations and those working with populations most impacted by STBBIs.

Each engagement method used a series of questions to determine the knowledge, skills, attitudes, behaviours, and training that would support and strengthen front-line workers' capacity in STBBI prevention. The information was collected and analysed to form the *Core Competencies for STBBI Prevention*. The National Reference Group, community partners, and experts in competency development continued to take part in this participatory process.