PARTICIPANT WORKBOOK

2017

MOVING BEYOND THE BASICS

An advanced workshop about sexual health, substance use, STBBIs and stigma

Calgary Sexual Health Centre

CANADIAN PUBLIC HEALTH ASSOCIATION

ASSOCIATION CANADIENNE DE SANTÉ PUBLIQUE

In April 2014, the Canadian Public Health Association (CPHA) launched the project *Impacting attitudes and values: Engaging health professionals to decrease stigma and discrimination and improve sexually transmitted and blood-borne infection (STBBI) prevention*. Funded by the Public Health Agency of Canada, this project aims to enhance the prevention of STBBIs and reduce the associated stigma and discrimination by developing capacity building resources for health and social service providers.

As part of this project and in collaboration with the Calgary Sexual Health Centre (CSHC), CPHA developed a suite of professional development workshops that were pilot tested in several Canadian cities with a diverse group of frontline service providers.

The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada.

CANADIAN PUBLIC HEALTH ASSOCIATION
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Calgary Sexual Health Centre

MOVING BEYOND THE BASICS

AN ADVANCED WORKSHOP ABOUT SEXUAL HEALTH, SUBSTANCE USE, STBBIS AND STIGMA

AT THE END OF THIS WORKSHOP, YOU WILL:

- increase your knowledge of the various forms of stigma and the factors that contribute to STBBI-related stigma;
- increase your ability to reflect on societal values and beliefs related to STBBIs, sexuality and substance use;
- enhance your skills in discussing STBBIs, sexuality and harm reduction. This includes increased skills in providing services using a trauma- and violence-informed care approach, in a manner that is non-stigmatizing, empowering, and authentic; and
- increase your awareness of how to develop a personal action plan for the delivery of safer and more inclusive STBBI-related services.

WORKSHOP AGENDA

- **Module 1:** Introduction
- **Module 2:** Exploring stigma and the factors that contribute to stigma
- **Module 3:** Strategies to reduce stigma and discuss sexual health, substance use and STBBIs
- **Module 4:** Closing

What would you like to get out of this workshop?

KEY TERMS

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed.
Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.[1]

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.[1]

Sexual health requires a positive and respectful approach to sexuality and sexual relationships.

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:

- the highest attainable standard of sexual health, including access to sexual and reproductive health care services
- seek, receive and impart information related to sexuality
- sexuality education
- respect for bodily integrity
- choose their partner
- decide to be sexually active or not
- consensual sexual relations
- consensual marriage
- decide whether or not, and when, to have children
- pursue a satisfying, safe and pleasurable sexual life[2]

The responsible exercise of human rights requires that all persons respect the rights of others.

1 *Defining sexual health*, World Health Organization, 2006. Accessed on March 18, 2015 from http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/.

2 *Defining sexual health*, World Health Organization, n.d. Accessed on March 18, 2015 from http://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/. Note that this definition does not represent an official WHO position.

KEY TERMS

Sex-positivity

Adopting a sex-positive approach means respecting the diversity of human sexuality and talking with your clients openly and without judgement about their sexuality. A sex-positive approach respects the sexual rights of all persons, yet also acknowledges that not all persons have learned about or experienced sexuality in a positive and affirming way.

Harm reduction

Harm reduction encompasses policies, strategies and services which aim to assist people who use substances to live safer and healthier lives. Harm reduction recognizes that people use substances for many reasons; reduction of substance use and/or abstinence is not required in order to receive respect, compassion or services.[3] Adoption of harm reduction strategies, policies and services can have many benefits for people who use substances, including improved prevention of STBBIs, decreased overdoses, increased capacity for self-care and increased stability.[4] Example harm reduction strategies to discuss with clients include: use of barrier methods during sexual activity, use of sterile needles, not using substances when alone, etc.

Trauma- and violence-informed care (TVIC)

Trauma-informed care (TIC) focuses on creating environments where clients do not experience further traumatization or re-traumatization and where they can make decisions about their treatment needs at a pace that feels safe to them.[5] TVIC expands on the concept of TIC to acknowledge the broader social and structural conditions that impact health, including, but not limited to, institutional policies and practices.[6] Talking about sexuality and substance use can be difficult; using a TVIC approach can help to ensure that the broader structural and social conditions are acknowledged and that organizational policies and practices as well as provider practices do not contribute to re-traumatization. Example TVIC strategies include acknowledging the effects of historical and structural conditions, seeking service user input about safe and inclusive strategies, encouraging service user empowerment in relation to treatment options and adoption of harm reduction strategies, and implementing policies and processes that allow for flexibility and encourage shared decision-making. [5, 6]

Social determinants of health approach

Various structural and social conditions, such as income, housing, social inclusion, employment and education, can impact your clients' health and ability to adopt and maintain STBBI prevention strategies.[7] When discussing sexual health and substance use, it is important to ask your clients about the structural and social conditions that may be impacting their health and to be aware of local resources and referrals, as needed.

3 Adapted from Streetworks Edmonton, 2015.

4 *Understanding harm reduction: Substance use*, HealthLinkBC, 2015. Accessed March 15, 2015 from: https://www.healthlinkbc.ca/healthlinkbc-files/substance-use-harm-reduction.

5 *Trauma-informed practice guideline*, BC Provincial Mental Health and Substance Use Planning Council, 2013.

6 *VEGA briefing note on trauma- and violence-informed care*, VEGA Project and PreVAiL Research Network, 2016.

7 *Factors that impact vulnerability to STBBIs*, Canadian Public Health Association, 2014.

ACTIVITY: THE LANGUAGE OF SEX

List all of the slang terms for sexual activity:

ACTIVITY: NAME THAT SUBSTANCE

STIGMA - BRAINSTORM ACTIVITY

What is stigma?

Where do we see stigma?

What is the impact of stigma on our clients?

STIGMA DEFINED

Perceived stigma: awareness of negative societal attitudes, fear of discrimination and feelings of shame.[8]

Internalized stigma: an individual's acceptance of negative beliefs, views and feelings towards themselves and the stigmatized group they belong to.[8]

Enacted stigma: encompasses acts of discrimination, such as exclusion or acts of physical or emotional abuse (towards an individual's real or perceived identity or membership to a stigmatized group).[8, 9]

Layered or compounded stigma: refers to a person holding more than one stigmatized identity (e.g., HIV positive serostatus, sexual orientation, race, ethnicity).[8]

Institutional or structural stigma: stigmatisation of a group of people through the implementation of policy and procedures.[10]

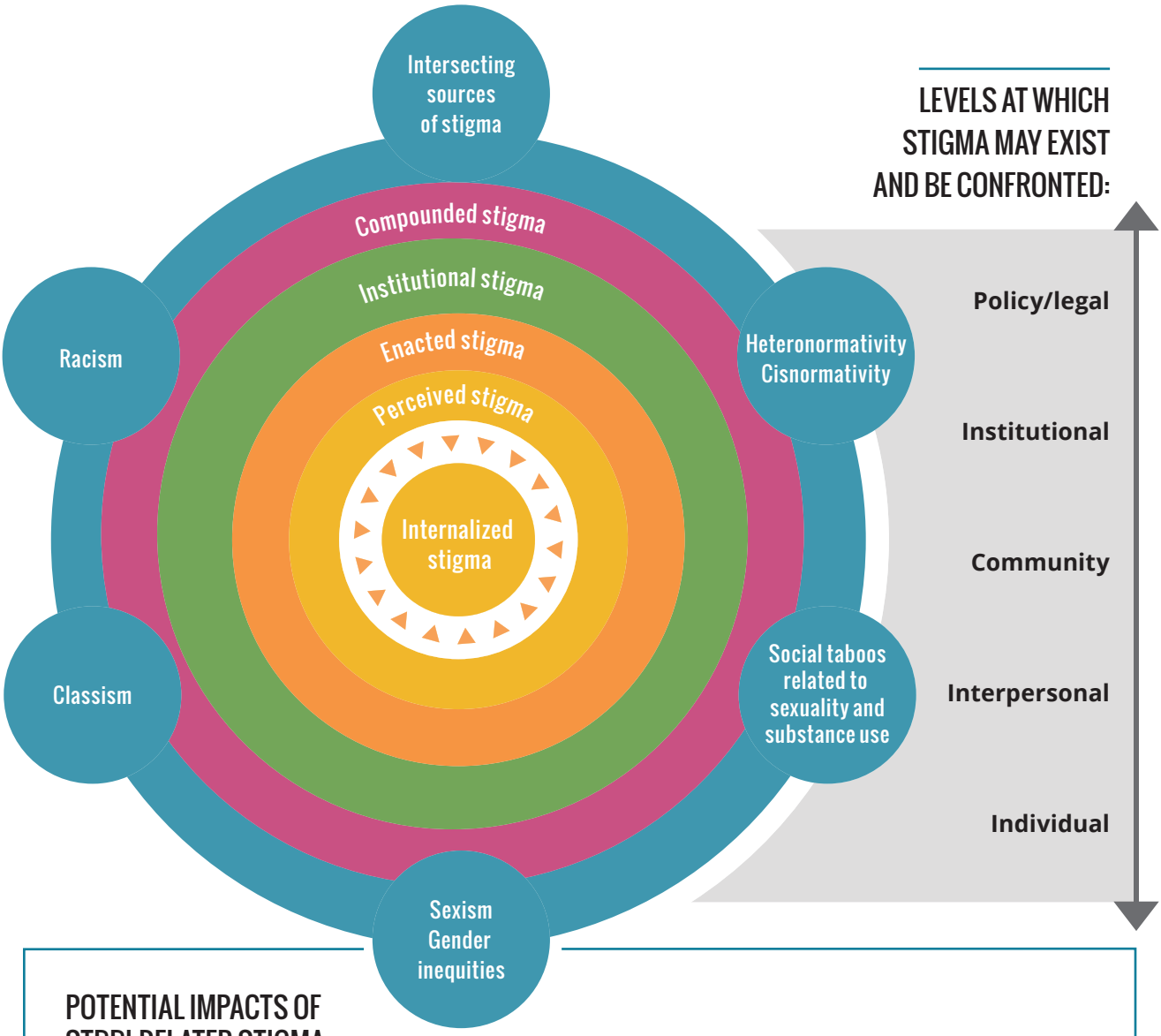
Notes:

8 Loutfy MR, Logie CH, Zhang Y, et al. Gender and ethnicity differences in HIV-related stigma experienced by people living with HIV in Ontario, Canada. *PLoS ONE* 2012; 7(12):e48168.

9 Stangl A, Brady L, Fritz K. *Measuring HIV stigma and discrimination*. Strive, 2012. Available at: http://strive.lshtm.ac.uk/sites/strive.lshtm.ac.uk/files/STRIVE_stigma%20brief-A3.pdf (Accessed January 7, 2015).

10 Corrigan PW, Markowitz FE, Watson AC. Structural levels of mental illness stigma and discrimination. *Schizophrenia Bulletin* 2004; 30(3): 481-491.

STIGMA DEFINED



POTENTIAL IMPACTS OF STBBI-RELATED STIGMA:

- adoption of unhealthy behaviours
- fear of disclosure
- limited uptake of available STBBI-related services
- inappropriate planning and implementation of STBBI prevention and support programs

Adapted from:
Churcher S. Stigma related to HIV and AIDS as a barrier to accessing health care in Thailand: A review of recent literature. *WHO South-East Asia J Public Health* 2013;2:12-22.

Loutfy MR, Logie CH, Zhang Y et al. Gender and ethnicity differences in HIV-related stigma experienced by people living with HIV in Ontario, Canada. *PLoS ONE* 2012;7(12):e48168.

Stangl A, Brady L, Fritz K. *Measuring HIV stigma and discrimination*. Strive, 2012. Available at: http://strive.lshtm.ac.uk/sites/strive.lshtm.ac.uk/files/STRIVE_stigma%20brief-A3.pdf.

ACTIVITY: STIGMA CASE SCENARIO

Read the case scenario that has been provided to you. Take some time to identify the different types of stigma and to brainstorm some potential solutions to address the stigma found in this scenario.

Notes:

BARRIERS TO DISCUSSIONS ABOUT SEXUAL HEALTH AND SUBSTANCE USE

Service providers may refrain from discussing sexual health and substance use for a variety of reasons, including:

- the perception that clients do not want to discuss their sexual health or substance use;
- fear of offending or embarrassing clients;
- their own embarrassment or discomfort in discussing sexual health and/or substance use with clients;
- not feeling prepared due to lack of training, knowledge, or specialization;
- the perception that sexuality or substance use is not relevant to the client's care needs; and
- concerns regarding a lack of time.

CLIENTS' PERSPECTIVES

While it is common for service providers to worry that clients do not want to be asked about their sexual health or substance use, research shows that these concerns are unwarranted. Clients in a variety of settings, and across age groups expect health care providers to ask questions about their sexual health.[11] While less is known about clients' expectations around talking about substance use, the positive outcomes associated with screening for substance use are well documented, so long as discussions are respectful and non-judgmental.[12]

11 Sargant NN, Smallwood N, Finlay F. Sexual history taking: A dying skill? *Journal of palliative medicine* 2014; 17(7): 829-831.

12 *Engaging clients who use substances*, Registered Nurses Association of Ontario, 2015.

DISCUSSING SEXUAL HEALTH AND SUBSTANCE USE: CREATING A SAFE AND RESPECTFUL ENVIRONMENT

A number of strategies for creating safer and more respectful environments were identified through consultations with service providers and clients from across the country, and through a review of the literature.

- To respect client confidentiality and minimize interruptions, the discussion occurs in a private room.
- Clients are referred to by their chosen name and are asked about the pronoun they use.
- The client is explained their right to confidentiality as well as potential limits to confidentiality (e.g., how client information might be shared with other service providers).
- The service provider facilitates open communication by asking questions in a professional, open-minded and empathetic manner while also being aware of body language and non-verbal cues.
- The service provider asks questions that are open-ended to encourage discussion and does not ask unnecessary or intrusive questions.
- The language used is clear and accessible. Some terms (e.g. STI, STBBI, sexually active, sex) are defined to ensure a common understanding.
- The language used is inclusive (e.g., partner instead of husband or wife).
- The client is explained why certain questions are asked and is reassured that a discussion about sexual health and substance use is routine and occurs with every client. Clients are reminded that they do not have to answer any or all of the questions, and are encouraged to ask questions of clarification.
- The service provider refrains from making assumptions about a client's sexual behaviours, substance use, sexual orientation, gender identity, etc. based on the client's age, sex, race, relationship status, education, socioeconomic status, appearance etc.

A NOTE ABOUT CONFIDENTIALITY

As a service provider, you need to create a safe space for clients to share intimate details and personal experiences without fear of losing control over their personal information or being subject to stigma and discrimination as a result of revealing personal information.

Clients have a right to know how you will use their personal information and with whom it will be shared. There may be circumstances where the law authorizes or requires you to disclose confidential information. Clients should be told about such limitations so that they can maintain control of how their personal information will be handled by others.

Clients should also be told about practices they might not know about; for instance, that provider-client records can be seized under a search warrant for a criminal investigation, or that the provider is obligated to report a child "in need of protection" under provincial or territorial legislation.

Agencies should also consider what 'protecting privacy' means, beyond formal systems to maintain files. For example, confidentiality may require that service providers not communicate, even casually, with clients they meet outside the office, to avoid unintentionally revealing that the client has a certain condition, or has accessed a certain program (e.g., HIV support group).

Notes:

For more information, refer to *Reducing stigma and discrimination through the protection of privacy and confidentiality*, Canadian Public Health Association and Canadian HIV/AIDS Legal Network, 2017.

DISCUSSING SEXUAL HEALTH, SUBSTANCE USE AND STBBIS: A GUIDE FOR SERVICE PROVIDERS

Discussing sexual health, substance use and STBBIs: A guide for service providers aims to reduce stigma by offering strategies that facilitate safer and more respectful discussions about sexual health, substance use and STBBIs between service providers and clients. The guide also offers ways to improve prevention, diagnosis and treatment of STBBIs.

The discussion guide is not a standard for STBBI diagnosis or sexual health and substance use history-taking. Rather, it provides sample dialogue and other suggestions for a broad range of issues that may arise when discussing sexuality, substance use and STBBIs with your clients. It also gives tips to ensure that conversations are safe, respectful and trauma- and violence-informed.

The considerations and sample dialogue in the discussion guide are organized according to the "five Ps" which represent general issues that may arise when discussing sexual health, substance use and STBBIs with clients.

1. PRACTICES

Asking about your client's sexual and substance use practices will help you identify their health and well-being needs. This can lead into talking about testing and harm reduction strategies to reduce STBBI transmission.

2. PARTNERS

Gather some information about the client's partners to add to your discussion of strategies to reduce STBBI transmission.

3. PROTECTION FROM STBBIS

Find out what, if any, strategies your client uses to limit STBBI transmission. You'll be better able to assess the challenges they face and offer the right support and referrals.

4. PAST HISTORY OF STBBIS

Finding out about your client's past STBBI history opens the door to talking about the importance of routine STBBI testing and other STBBIs not included in testing (e.g. herpes, warts).

5. PREGNANCY

Discuss pregnancy with those who want to become pregnant now or in the future, with those who do not want to become pregnant, and with those who are pregnant and want to discuss their options. Also discuss pregnancy with any client whose sexual and/or romantic partner(s) is pregnant, may become pregnant, or does not want to become pregnant.

DISCUSSING SEXUAL HEALTH, SUBSTANCE USE AND STBBIS: A GUIDE FOR SERVICE PROVIDERS

WRAPPING UP THE DISCUSSION

- If not already covered, give the client a chance to discuss the structural and social factors that may be influencing their sexual health, substance use and overall health (e.g., access to safe housing and/or employment, social support networks, food security, access to STBBI prevention tools such as condoms or safe injection equipment, transportation, etc.).
- It is unlikely that you will have the time to cover all of the client's concerns in one visit. Make sure they know how to get support outside of clinic hours or appointments (within your service setting and others). If possible, schedule follow-up appointments.
- Offer resources and referrals as needed. If possible, make the referral call during their visit or introduce them directly to the referral service or practitioner. Follow-up with the client after their visit, if possible.

Notes:

CONFIDENTIALITY AND HIV NON-DISCLOSURE

Under criminal law, people living with HIV have a legal duty to disclose their HIV-positive status to a sexual partner when they engage in sex that poses a "realistic possibility of HIV transmission" (as interpreted by the courts).

As a service provider, it is important to discuss potential limits to confidentiality, including the criminalization of HIV non-disclosure. Service providers cannot provide legal advice, but can provide general information and counselling .

Give clients appropriate referrals and materials on criminal law and HIV from reliable sources. Work with them to promote their overall health and well-being, including minimizing the adverse or negative effects of disclosure if they choose to disclose their status.

The role of service providers is not to enforce the criminal law but to provide care and counselling to clients.

There is no obligation under the criminal law to report a crime to the police or provide the police with information about a client unless such a requirement is set out in a search warrant or it involves a child in need for protection.

There is no obligation for service providers to inform clients about their possible option to press charges against a sexual partner who may have exposed them to a risk of HIV (or other STBBIs).

When service providers decide to take action because they are concerned someone may be at risk for harm, they should not go to the police unless it is absolutely necessary given a particular exceptional situation. If service providers and organizations become, or are perceived to be, conduits of information to the police, it could undermine their work by breaking the trust that exists between agencies and clients.

Services providers who have a client that has been charged or that is concerned they may be under investigation related to HIV non-disclosure should direct their client (or their client's defence lawyer) to the Canadian HIV/AIDS Legal Network's resource *Responding to the criminalization of HIV transmission or exposure: Resources for lawyers and advocates*.

They can also inform their clients that defence lawyers can contact the Canadian HIV/AIDS Legal Network, the HIV & AIDS Legal Clinic Ontario (HALCO) (in Ontario) and the Coalition des organismes communautaires québécois de lutte contre le sida (COCQ-SIDA) (in Quebec) to discuss the details of their cases. These three organizations routinely work with defense lawyers in cases related to HIV non-disclosure.

For more information, refer to *Reducing stigma and discrimination through the protection of privacy and confidentiality,* Canadian Public Health Association and Canadian HIV/AIDS Legal Network, 2017.

GLOSSARY

ALLY: A person who is actively supportive of LGBTQ+ people and their rights. Allies may be gay, straight, transgender, queer, two-spirit, etc.

ASEXUAL: A person whose attraction to others does not include sexuality.

BISEXUAL: A person who is physically and emotionally attracted to their own gender and other genders.

BLOOD-BORNE INFECTION: An infection transmitted by direct blood contact from one individual to another through injured skin or a mucous membrane, or transmitted through substance use and sexual contact (e.g., hepatitis B and C, HIV).

CISGENDER: A person whose gender identity is the same as the sex they were assigned at birth.

CISNORMATIVITY: The assumption that all people are cisgender or that those assigned male at birth grow up to be men and those assigned female at birth grow up to be women. It may also refer to the oppression experienced by transgender people in a society that represents cisgender people as dominant, normal and superior.

DISCRIMINATION: Unjust treatment based on an individual belonging or perceived to be belonging to a traditionally marginalized social group (e.g., by race, gender, orientation, etc.).

EQUITY/EQUITABLE: Equity means fairness. Equity in health means that peoples' needs guide the distribution of opportunities for well-being. Equity in health is not the same as equality in health status. Inequalities in health status between individuals and populations are inevitable consequences of genetic differences and various social and economic conditions, or a result of personal lifestyle choices. Inequities occur as a consequence of differences in opportunity, which result, for example in unequal access to health services, nutritious food or adequate housing. In such cases, inequalities in health status arise as a consequence of inequities in opportunities in life (Public Health Agency of Canada, 2007).

GAY: A man who is physically and emotionally attracted to other men. Some women attracted to women may also identify as gay.

GAY-STRAIGHT ALLIANCE (GSA): Student-run organizations found in some K-12 schools and universities that create safe and supportive spaces for LGBTQ+ individuals and allies.

GENDER EXPRESSION: The way people communicate their gender identity to others by how they dress, act and/or refer to themselves.

GENDER IDENTITY: A person's internal sense of being a woman or man, or a combination of both, or neither.

GENDER NON-BINARY/GENDERQUEER: Terms for a person whose gender identity is neither woman nor man.

GENDER ROLES: Socially constructed and culturally behavioural norms, such as communication styles, careers and family roles, that are often expected of people based on their assigned sex (Canadian AIDS Society, 2015).

HETERONORMATIVITY: The assumption or belief that every person is heterosexual until proven otherwise, and by default treating individuals as if they would be in a relationship with somebody of the opposite gender.

HOMOPHOBIA/TRANSPHOBIA: An irrational hatred of people who are, or are perceived to be LGBTQ. Often exhibited by prejudice, discrimination, intimidation or acts of violence.

INTERSEX: A general term used to describe people who are born with reproductive or sexual anatomy that does not fit the typical definitions of female or male.

LESBIAN: A woman who is physically and emotionally attracted to women.

LGBTQ: An acronym to describe the following identities: Lesbian, Gay, Bisexual, Transgender and Queer.

NALOXONE: A medication that reverses the effect of overdose from opioids. Peer administered naloxone programs train people in the community to administer naloxone if they witness an overdose.

NEEDLE EXCHANGE PROGRAMS: This is an evidence-based program to prevent the transmission of STBBIs. People can bring in needles and other paraphernalia that they have used for injecting substances and receive sterile injecting equipment. This is typically offered in a setting where various other psychosocial supports or referrals are available.

ORIENTATION: A person's identity in relation to the gender they are attracted to.

OPIOID DEPENDENCY PROGRAM: This is a program for individuals that would like to stop using opiate-based substances. People receive a prescription of methadone or Suboxone® maintenance treatment in an outpatient setting. As part of these programs, people may engage in a wide variety of psychosocial supports to address substance use.

PANSEXUAL: A person who is physically and emotionally attracted to people of any gender.

QUEER: Historically used as a negative term for homosexuality and is still often used as a derogatory term against LGBTQ people. Many LGBTQ people and communities have reclaimed the word and use it in a positive way to refer to themselves and aspects of their identity.

QUESTIONING: A person who is unsure of their sexual orientation or gender identity and experiencing a process of self-discovery.

SAFER INHALATION EQUIPMENT (ALSO KNOWN AS SAFER CRACK PIPE PROGRAMS): Programs where people who inhale substances are provided with new inhalation equipment such as pipes to reduce and prevent the transmission of hepatitis C.

SEX: The category someone is assigned at birth based on their physical body parts and biology.

SEXUALLY TRANSMITTED INFECTION (STI): An infection passed from one person to another through sexual activity, including vaginal, oral or anal sex as well as genital skin-to-skin contact. STIs are grouped into three categories: viral infections (e.g., genital herpes, human immunodeficiency virus (HIV), hepatitis B), bacterial infections (e.g., chlamydia, gonorrhea and syphilis) and parasitic/fungal infections (e.g., trichomoniasis, pubic lice, yeast infection).
NOTE: The term sexually transmitted disease is no longer used.

SOCIAL DETERMINANTS OF HEALTH (SDH): The social and economic factors that influence people's health. These are apparent in the living and working conditions that people experience every day. The SDH influence health in many positive and negative ways. Extreme differences in income and wealth, for example, have negative health consequences for those who are living in poverty and these effects are magnified when these people are congregated in poor regions. In contrast, those who are well-off and living in well-off regions have better overall health.

STRAIGHT: A person who is attracted to people of the opposite sex or gender to their own.

SUPERVISED INJECTION SITE: Evidence-based health care settings where people who inject substances can use their own personally acquired illicit substances under the supervision of nurses, social workers and other medical staff and where people can access clean syringes, needles and swabs, and safely dispose used needles. People can also receive health care, counseling and referral to social, health and substance use treatment services (adapted from Health Canada, 2008).

TRANS/TRANSGENDER: People whose gender identity, gender expression or behavior does not conform to that typically associated with the sex to which they were assigned at birth.

TWO-SPIRIT: A spiritual identity for some FNMI (First Nations, Metis, Inuit) people. Implies the embodiment of both masculine and feminine spiritual qualities within the same body. Note that this term is not used in all FNMI communities.

UNIVERSAL PRECAUTIONS: The practice of avoiding contact with all bodily fluids through gloves, face masks and a variety of other barriers, whether the health status of said bodily fluid is known or not.

RESOURCES

STBBIS AND STIGMA

Discussing sexual health, substance use and STBBIs: A guide for service providers, Canadian Public Health Association, 2017

Self assessment tool for STBBIs and stigma, Wagner A and Canadian Public Health Association, 2017

Organizational assessment tool for STBBIs and stigma, Canadian Public Health Association, 2017

Reducing stigma and discrimination through the protection of privacy and confidentiality, Canadian Public Health Association and the Canadian HIV/AIDS Legal Network, 2017

SEXUALITY AND STBBIS

Canadian guidelines on sexually transmitted infections, Public Health Agency of Canada, 2006

CATIE, http://www.catie.ca/
Information about HIV/AIDS and Hepatitis C in Canada

Native Youth Sexual Health Network, http://www.nativeyouthsexualhealth.com/
Organization by and for Indigenous youth that works across issues of sexual and reproductive health, rights and justice

Sex & U, http://www.sexandu.ca/
Information and education on topics related to sexual and reproductive health

LGBTQ

Egale, http://egale.ca/
National charity promoting lesbian, gay, bisexual, and trans (LGBT) human rights through research, education and community engagement

Gender Creative Kids, http://www.gendercreativekids.ca
Canadian resource for supporting and affirming gender creative kids within their families, schools and communities

Rainbow Health Ontario, http://www.rainbowhealthontario.ca/
Information and support related to the health and well being of LGBTQ people in Ontario

TRAUMA- AND VIOLENCE-INFORMED CARE

Trauma informed practice guide, BC Provincial Mental Health and Substance Use Planning Council, 2013

Violence, Evidence, Guidance and Action (VEGA) Project, https://projectvega.ca/
A national project developing pan-Canadian public health guidance, protocols, curricula and tools for health and social service providers related to family violence

HARM REDUCTION

Harm reduction training manual: A manual for frontline staff involved with harm reduction strategies and services, BC Harm Reduction Strategies and Services, 2011

The best practice recommendations for Canadian harm reduction programs that provide service to people who use drugs and are at risk for HIV, HCV, and other harms: Part 1, Working Group on Best Practice for Harm Reduction Programs in Canada, 2013

The best practice recommendations for Canadian harm reduction programs that provide service to people who use drugs and are at risk for HIV, HCV, and other harms: Part 2, Working Group on Best Practice for Harm Reduction Programs in Canada, 2015

HIV DISCLOSURE AND THE LAW

Canadian HIV/AIDS Legal Network, http://www.aidslaw.ca
Organization promoting the human rights of people living with and vulnerable to HIV and AIDS, in Canada and internationally

HIV disclosure and the law: A Resource kit for service providers, Canadian HIV/AIDS Legal Network et al., 2012

CANADIAN PUBLIC HEALTH ASSOCIATION

The Canadian Public Health Association (CPHA) is the national, independent, not-for-profit, voluntary association representing public health in Canada. CPHA's members believe in universal and equitable access to the basic conditions which are necessary to achieve health for all Canadians.

CALGARY SEXUAL HEALTH CENTRE

The mission of the Calgary Sexual Health Centre (CSHC) is to normalize sexual health in Alberta by providing evidence-informed, non-judgmental sexual and reproductive health programs and services. The CSHC vision is for all Albertans to experience healthy sexuality across the lifespan.

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