Community Awareness Model for Hepatitis C

A Training Guide for Community Care, Health, and Social Service Providers

Produced by

Canadian Ethnocultural Council
in collaboration with
Canadian Liver Foundation

Funding for this guide has been provided by the Public Health Agency of Canada

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Disclaimer: The views expressed in this training guide are those of the authors and do not reflect those of the Canadian Ethnocultural Council, the Canadian Liver Foundation, or the Public Health Agency of Canada.

The information provided in this training guide is for reference only. For specific medical or medicinal concerns, please seek advice from a medical practitioner.

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Acknowledgements

The Canadian Ethnocultural Council (CEC) would like to thank the Canadian Liver Foundation (CLF) for many years of working together on the project "Engaging Ethnocultural Communities on Hepatitis C".

This training guide was developed in collaboration with the Canadian Liver Foundation. We would like to thank the following individuals and organizations for contributing in various ways to the success of this project:

- **Billie Potkonjak**, National Director of Health Promotion and Patient Services, CLF, for reviewing and editing the contents of the training guide, as well as for providing resource materials for the development of the guide.

- Annette Martin, Regional Manager Eastern Ontario, CLF, for sharing CLF publications, PowerPoint presentations, and handouts on liver and liver diseases including hepatitis C.

- The members of the Project Expert Advisory Committee for reviewing the training guide and providing valuable input.

- The trainers from the various ethnocultural communities who participated in the training workshops.

- The ethnocultural community organizations in Ottawa, Toronto, Montreal, Winnipeg, Calgary, and Vancouver that hosted the training workshops.

- The numerous volunteers who provided support and resources throughout the project.

- Ellen Shenk for editing the training guide.

- The Executive and Membership of the Canadian Ethnocultural Council for their support.

- The Public Health Agency of Canada for their financial assistance.

A very special thanks to **Kazimiera Adamowski,** Hepatitis C Program Consultant, Public Health Agency of Canada, for her support and guidance throughout the project period and for providing up-to-date information on hepatitis C published by the PHAC.

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Section 1.0

Introducing the Training Guide

Section 1.1 Why was the training guide developed?

The hepatitis C virus (HCV), first identified in 1989, is a blood-borne virus that infects and can seriously damage the liver. HCV is transmitted through a blood-to-blood contact with an HCV-infected person. Hepatitis C is a major public health issue in Canada. Worldwide, it is estimated that approximately 170 million people are infected with HCV. In Canada, an estimated 242,500 people are infected with HCV and, in 2007 alone, nearly 8000 individuals were newly infected with HCV. Between 1960 and 1990 an estimated 90,000 to 160,000 Canadians contracted hepatitis C through infected blood or blood products.

Today, hepatitis C infection is largely associated with the sharing of contaminated drug preparation and injection equipment. In some parts of the world, other risk factors have been implicated, including inadequately sterilized medical equipment and certain cultural practices.

According to the 2006 Census of Canada, there are about 6.2 million immigrants in Canada who have come from many countries around the world. Some immigrants come from countries that have reported high levels of hepatitis C infection. Approximately 20% of hepatitis C infection cases in Canada occur in the immigrant community, where access to health care may be less than optimal. By extrapolating data on infection rates in their country of origin, it is surmised that the immigrants from those countries will have similar rates of infection in Canada. There is a lack of information regarding hepatitis C in ethnocultural communities in Canada.

In 2005, the Canadian Liver Foundation (CLF) and the Canadian Ethnocultural Council (CEC), with funding from the Public Health Agency of Canada (PHAC), initiated a national project entitled "*Engaging Ethnocultural Communities on Hepatitis C.*" Immigrant populations from the People's Republic of China, Egypt, the Philippines, and Vietnam were identified for the project. Their selection was based on the following criteria: (1) the percentage of immigrants to Canada from these countries; (2) the prevalence of hepatitis C infection in their country of origin (3% or higher in the general population of their respective country of origin); and (3) the means of hepatitis C transmission (that has occurred or has been reported to occur) through cultural practices such as rubbing the skin with coins until there is bleeding or the use of improperly sterilized hypodermic needles in administering vaccines and other medications.

The final report, *"Engaging Ethnocultural Communities on Hepatitis C - Part IV,"* produced in 2009, clearly demonstrated that expertise is needed to work with and effectively engage members of ethnocultural communities to learn about and gain an understanding of hepatitis C. The report identified a need to develop a hepatitis C health information package and provide specialized training to health care providers from the four selected communities. A copy of the full report is available from the Canadian Liver Foundation (1-800-563-5483).

This guide, produced by the CEC in partnership with the CLF, is a resource for community care, health, and social service providers to help promote a greater awareness about hepatitis C in the ethnocultural communities. The intent is to provide a model that can be adapted to meet the needs of other ethnocultural communities. The hope is that health care providers will continually build on and adapt the content of this guide to meet the needs of Canada's diverse population.

Section 1.2 Who can use the training guide?

This training guide is intended mainly for use by:

- community development and outreach workers;
- social workers;
- nurses and nurse educators;
- multicultural health promoters;
- other health care professionals who work in community settings, hospitals, and health and social service agencies.

It is a useful tool for helping and educating individuals, especially persons from the four identified communities as well as others who may be at risk of contracting hepatitis C. The guide will be of interest to those who:

- prepare and conduct training workshops about hepatitis C;
- work with the Chinese, Egyptian, Filipino, and Vietnamese communities;
- are involved with ethnocultural communities and their organizations;
- develop initiatives to raise awareness about hepatitis C prevention in high-risk ethnocultural populations;
- develop policies relating to health and ethnocultural communities.

Section 1.3 Objectives of the training guide

Goal

To provide community care, health, and social service providers with a culturally appropriate training model on hepatitis C for four selected ethnocultural communities (Chinese, Egyptian, Filipino, and Vietnamese) in Canada.

Objectives

- To provide guidelines and tools to be used in a workshop context and from which to choose for further training, learning, and community action.
- To increase awareness about hepatitis C among health care providers who work with ethnocultural communities.
- To provide helpful information about the cultural characteristics of the four selected ethnocultural communities.
- To establish linkages between national and regional networks and centres capable of providing information and training.
- To create linkages/networks of people working with the selected communities on topics such as hepatitis C.

Section 1.4 Design of the training guide

The training guide is designed as a training and resource tool. It provides information on hepatitis C as well as additional information on conducting workshops in a community setting. It also contains:

- brochures and handouts about hepatitis C published by the CLF and the PHAC;
- hepatitis C brochures in Arabic, Chinese, Tagalog, and Vietnamese;
- CD on hepatitis C developed by CEC in collaboration with CLF containing (1) Hepatitis C screencast (a videoscreen capture with audio narration) and (2) Hepatitis C PowerPoint presentation.

The training guide is divided into 11 sections:

- Section 1 - explains why the guide was developed and details its objectives and limitations.
- Section 2 - provides an overview of hepatitis C and its prevalence in Canada.
- Section 3 - focuses on the risk factors for hepatitis C and barriers faced by members of ethnocultural communities in gaining information about hepatitis C.
- Sections 4, 5, 6, and 7 - deal with prevention, testing, treatment, and management of hepatitis C.
- Section 8 - provides community profiles of the four selected ethnocultural communities.
- Section 9 - deals with workshop logistics and gives tips for trainers on how to organize and conduct a training workshop.
- Section 10 - provides web sites for additional information.
- Section 11 - provides a glossary of terms.

Section 1.5 Limitations of the training guide

This guide describes one model designed to increase awareness and educate healthcare providers in the community on hepatitis C. Other community-based models or approaches may exist in other Canadian cities.

This training guide was developed specifically to provide training about hepatitis C to health care providers to help them meet the immediate needs of the four selected communities who worked with the CLF and CEC during the past five years.

The guide has been developed from a cross-cultural perspective but does not delve into all aspects of cultural specifics. It is acknowledged that no single resource can adequately address all the needs of ethnocultural communities.

Resources that were available to us have been incorporated in the training package. However, we acknowledge that there may be many other useful publications and tools that we have not included here.

Knowledge about hepatitis C in ethnocultural communities is growing slowly but steadily. Health care providers should continuously adapt and build on this training guide and other resources designed to increase awareness about hepatitis C among high-risk ethnocultural communities in Canada and to provide effective strategies for the prevention of hepatitis C.

Section 2.0

Hepatitis C: A Public Health Challenge

2.1 Hepatitis – what is it?[1]

- Hepatitis means inflammation of the liver; it is most often caused by a virus in which case it is referred to as viral hepatitis.
- There are at least seven different viruses that can cause hepatitis. The most common ones in Canada are hepatitis A, B, and C. Hepatitis B and C become chronic, causing long-term illness.
- More than 500 million people around the world are currently infected with hepatitis B or C.
- One in three people have been exposed to one or both of these viruses.

2.2 Hepatitis C – what is it?[2]

- Hepatitis C is a liver disease caused by the hepatitis C virus (HCV).
- HCV is a blood-borne virus.
- The virus is spread by direct exposure to the blood (and body fluids containing blood) of those infected with HCV.
- HCV is a major cause of acute hepatitis and chronic liver disease, including cirrhosis and liver cancer.
- HCV is the leading cause of liver transplants worldwide.
- Out of every 100 people infected with HCV, approximately 75-85 may develop chronic infection, approximately 10-20 may develop cirrhosis over a period of 20-30 years, and approximately one to five may die from the consequences of long-term infections including liver cancer.
- About 85% of the people infected with HCV carry the virus for the rest of their lives.

Hepatitis C is a liver disease caused by the hepatitis C virus (HCV).

[1] *World Hepatitis Atlas,* World Hepatitis Alliance 2008. http://www.aminumber12.org/theWHA.aspx
[2] Hepatitis C – Get the Facts. PHAC. http://www.phac-aspc.gc.ca/hepc/index_e.html

2.3 How is hepatitis C different from hepatitis A and B?

- Hepatitis A is an infection of the liver caused by the hepatitis A virus (HAV).
- HAV is spread by fecal-oral route through contaminated food, such as raw or insufficiently cooked seafood and shellfish, and contaminated water (including ice cubes).
- It can be passed by a person, infected with the virus, who does not wash his/her hands properly after a bowel movement and then touches food eaten by others.
- Hepatitis B is a liver disease caused by the hepatitis B virus (HBV).
- HBV is one of the most common forms of viral hepatitis.
- The virus is spread by blood or other body fluids as well as by sexual contact.

2.4 Hepatitis C - a major public health problem

Hepatitis C is a major public health problem in Canada and throughout the world because of the high rate of infections in some countries throughout the world. Although, the incidence of the disease has been reduced through various public health measures in several countries, very little is being done in many countries where the prevalence of hepatitis C is high and data on transmission routes are scarce. Canada continues to draw immigrants from countries where the prevalence of hepatitis C is high.

It is estimated that approximately 250,000 persons in Canada are infected with HCV, and between 3,200 and 5,000 new infections occur in Canada each year[2].

HCV infection is rapidly reaching the point of crisis across Canada and poses a serious threat to population health. Because of the lack of symptoms, many people are completely unaware that they have been infected.

HCV infection is rapidly reaching the point of crisis across Canada and poses a serious threat to population health.

[2] *Hepatitis C – Get the Facts*. PHAC. http://www.phac-aspc.gc.ca/hepc/index_e.html

2.5 Hepatitis C - a health concern

- Initial, or acute, infection with HCV usually produces no symptoms; less than a quarter of those infected show symptoms such as jaundice (yellowing of the skin and/or eyes) or fatigue.
- Some individuals may recover from their infection, but approximately 75-85% of those infected will progress to the chronic (or carrier) state[2].
- Chronic hepatitis can be silent and HCV-infected individuals can remain without any symptoms for decades.
- Chronic hepatitis can lead to liver damage, liver cancer, and the need for a liver transplant.
- Approximately 20% (one in five) of those infected with HCV are not aware that they are infected[2].

Approximately 20% (one in five) of those infected with HCV are not aware that they are infected

2 *Hepatitis C – Get the Facts*. PHAC. http:www.phac-aspc.gc.ca/hepc/index_e.html

2.6 Prevalence of hepatitis C in Canada

The reported cases and rates of hepatitis C by province and territory and by sex is given in Table 1.

Table 1. Reported cases and rates[1] of hepatitis C[2] by province/territory and by sex, 2005 to 2007[3]

Source : Hepatitis C and STI Surveillance and Epidemiology Section, Community Acquired Infections Division, Centre for Communicable Diseases and Infection Control, Public Health Agency of Canada, 2008.

Year		Sex	Hepatitis C												
			NL	PE	NS	NB	QC	ON	MB	SK	AB	BC	YT	NT	NU	Total
2005	Cases	Male	53	22	186	202	1639	2904	263	353	1011	1891	22	15	2	8563
		Female	31	22	31	73	733	1577	153	301	517	989	15	6	5	4453
		Unspecified[4]	0	0	3	0	23	13	0	0	0	2	0	0	0	41
		Total	84	44	220	275	2395	4494	416	654	1528	2882	37	21	7	13057
	Rates	Male	20.9	32.6	40.7	54.9	43.7	46.9	44.9	71.7	60.1	90.9	135.2	66.5	12.7	53.6
		Female	11.9	31.2	6.4	19.2	19.1	24.9	25.8	60.1	31.5	46.7	96.0	28.8	34.2	27.4
		Total	16.3	31.9	23.5	36.8	31.6	35.9	35.3	65.8	46.0	68.7	116.0	48.4	23.1	40.5
2006	Cases	Male	65	26	185	168	1469	2510	212	341	910	1933	24	11	3	7857
		Female	35	12	66	84	697	1425	117	293	465	1001	14	8	0	4217
		Unspecified[4]	0	0	1	0	34	12	0	0	0	3	0	0	0	50
		Total	100	38	252	252	2200	3947	329	632	1375	2937	38	19	3	12122
	Rates	Male	25.9	38.5	40.5	45.9	38.9	40.1	36.0	69.4	52.4	92.0	145.3	48.9	18.9	48.7
		Female	13.5	17.1	13.7	22.1	18.1	22.2	19.7	58.5	27.6	46.7	88.8	38.6	0.0	25.7
		Total	19.6	27.6	26.9	33.8	28.8	31.2	27.8	63.7	40.2	69.2	117.7	44.0	9.7	37.2
2007	Cases	Male	58	32	162	140	1213	2698	240	353	872	1862	22	10	1	7663
		Female	32	17	62	65	614	1756	107	255	417	1037	15	6	1	4384
		Unspecified[4]	0	0	0	0	28	25	1	1	1	2	0	0	0	58
		Total	90	49	224	205	1855	4479	348	609	1290	2901	37	16	2	12105
	Rates	Male	23.3	47.4	35.6	38.3	31.9	42.7	40.4	71.3	48.8	87.2	132.3	44.2	6.2	46.9
		Female	12.4	24.1	12.9	17.1	15.8	27.1	17.8	50.5	24.2	47.7	94.0	28.7	6.6	26.4
		Total	17.8	35.5	23.9	27.5	24.1	35.0	29.2	60.9	36.7	67.3	113.6	36.8	6.4	36.8

[1] Rate per 100,000 population. Population estimates provided by Statistics Canada. (Source: Statistics Canada, Demography Division, Demographic Estimates Section, July Population Estimates, 2005 final intercensal estimates, 2006 final postcensal estimates, 2007 updated postcensal estimates.)
[2]Does not distinguish between acute and chronic hepatitis C infection
[3]2006 and 2007 data are preliminary and changes are anticipated. Data were verified with provinces and territories as of December, 2008.
[4]Unspecified sex includes transgender cases.

Note : A small variability may exist between data reported by the provinces/territories and the Public Health Agency of Canada. Provincial/territorial data are definitive, should a discrepancy exist. Date Modified: 2009-06-09

2.7 Reported cases of hepatitis C in Canada

Table 2 and Figures 1 and 2 provide the reported cases of Hepatitis C[1] from January 1 to June 30, 2007, and January 1 to June 30, 2008, giving corresponding rates for January 1 to December 31, 2007, and projected rates for 2008[2].
(Data are provided by the Surveillance and Epidemiology Section, Community Acquired Infections Division, Centre for Communicable Diseases and Infection Control, Public Health Agency of Canada)

Table 2. Reported cases of hepatitis C in Canada

Province / Territory	Hepatitis C			
	Cases: January 1 to June 30		Rates: January 1 to December 31	
	2007	2008	2007 Actual Annual Rate[3]	2008 Projected Annual Rate[4]
National	6109	6153	37.1	37.3
NL	44	51	17.4	20.1
PE	26	30	37.5	43.3
NS	102	150	21.8	32.1
NB	106	93	28.3	24.8
QC	963	940	25.0	24.4
ON	2215	2330	34.6	36.4
MB	177	192	29.8	32.4
SK	294	358	59.0	71.8
AB	687	615	39.6	35.4
BC	1462	1376	66.8	62.8
YT	24	12	154.9	77.4
NT	7	6	32.8	28.1
NU	3	0	19.3	0.0

[1] Does not distinguish between acute and chronic hepatitis C infections
[2] Data are preliminary and expected to change: 2008 data are expected to change more than 2007 data.
[3] Rate (per 100,000) based on all reported cases for 2007. Population estimates provided by Statistics Canada. (Source: Statistics Canada, Demography Division, Demographic Estimates Section, July Population Estimates, 2007 updated postcensal estimates).
[4] Rate (per 100,000) based on all reported/extrapolated cases for 2008. Population estimates provided by Statistics Canada. (Source: Statistics Canada, Demography Division, Demographic Estimates Section, July Population Estimates, 2007 preliminary postcensal estimates). No adjustment has been made for seasonal variability.
Note: A small variability may exist between data reported by the provinces/territories and the Public Health Agency of Canada. Provincial/territorial data are definitive, should a discrepancy exist.

Figure 1.

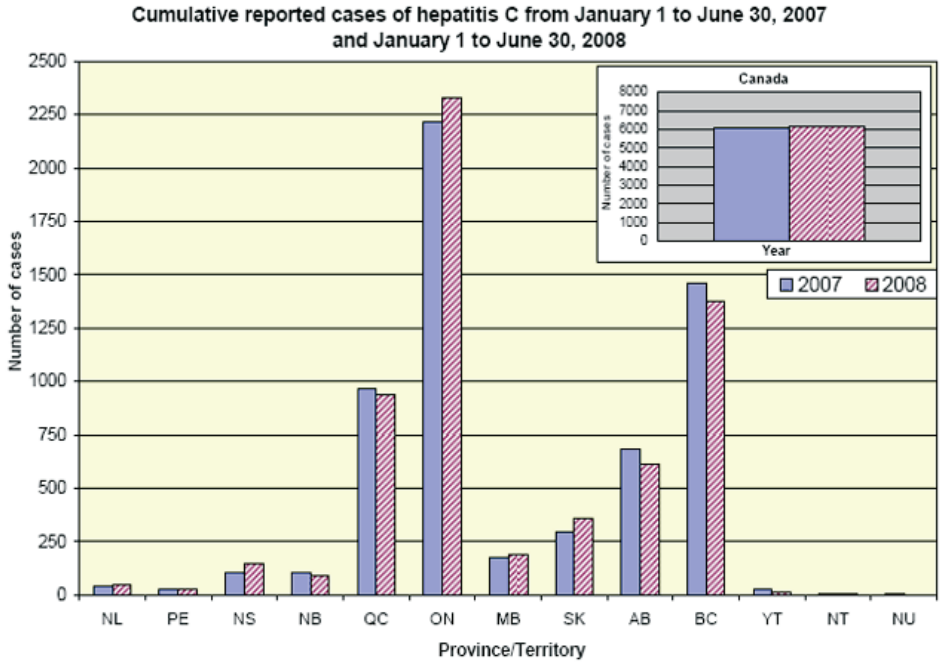
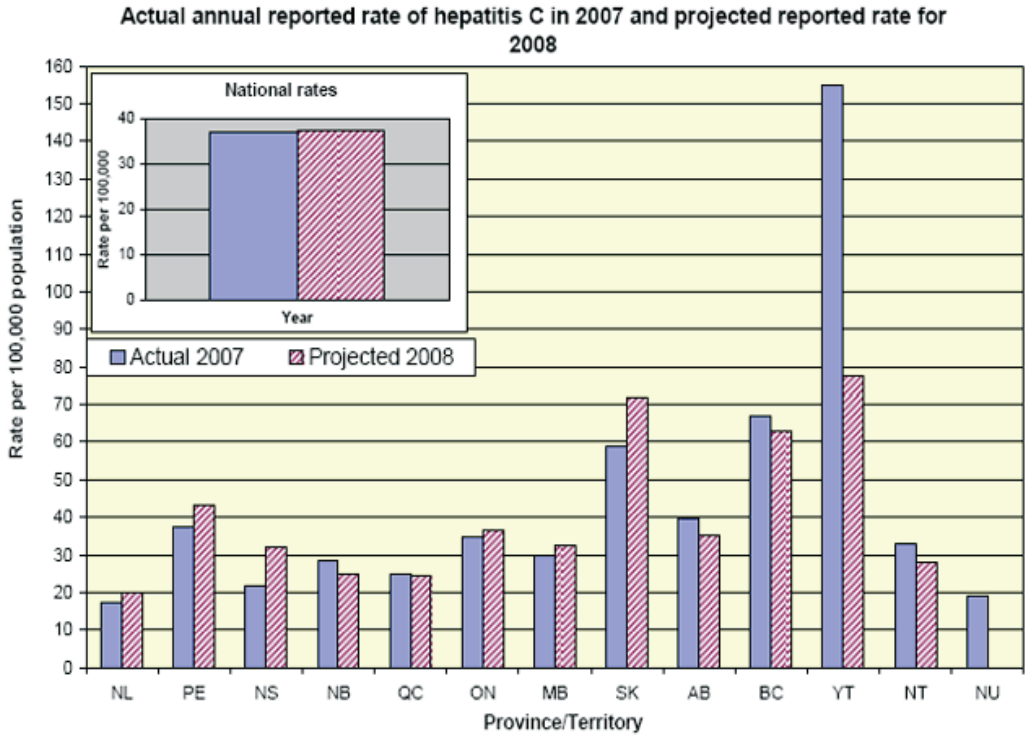


Figure 2.



Date Modified: 2009-03-19

Source: Surveillance and Epidemiology Section, Community Acquired Infections Division, Centre for Communicable Diseases and Infection Control, Public Health Agency of Canada, 2009.

2.8 Public awareness of hepatitis C in Canada

General public awareness about hepatitis C remains low. Despite ongoing calls for extensive awareness campaigns, little has been done for the general public, for those who have low literacy, and for those from diverse cultural and linguistic backgrounds.

Individuals who may be infected or at risk of hepatitis C infection do not know the severity of this disease. They may be unknowingly transmitting the virus to others or not taking the necessary precautions to safeguard their own health.

Capacity building among health care providers is also an issue. There is a great need for training of the front line health care workers about hepatitis C.

A major barrier is the stigma around hepatitis C and its association with drug use and alcohol abuse. This stigma is linked to immigrants from HCV-endemic countries. The HCV-positive individuals experience shame, isolation, hopelessness, and fear of being ostracized from their communities. They are, therefore, reluctant to access care, to get treatment, or to learn enough about HCV so they can take precautionary measures to prevent further spread of the disease.

Women appear to have greater anxieties related to the transmission of HCV and their ability to carry out their social roles. They are particularly concerned about issues related to social stigma, sexual transmission, pregnancy, and childcare.

From 1999 to the present, numerous projects have been funded by Health Canada that contribute to increasing awareness about hepatitis C such as, initiating and sustaining peer support groups; assisting people to make decisions regarding treatment, housing, and employment; and supporting hepatitis C-related programs and services. Most of this work has been focused on the needs of the mainstream population.

Hepatitis C programs targeted to the general public are not readily accessed by refugees and recent immigrants to Canada because of linguistic and cultural barriers. The British Columbia Multicultural Health Service Society (BCMHSS) has made some effort to increase awareness and understanding about hepatitis C within the Vietnamese and Latin American communities in

Vancouver and the lower mainland. They have developed a training manual for peer educators and have developed and distributed multilingual resources dealing with hepatitis C prevention, care, treatment, and support.

The aboriginal communities have used theatre, dance, and music as vehicles to educate and create awareness about hepatitis C among aboriginal and non-aboriginal youth.

In developing communication strategies for ethnocultural communities, special consideration needs to be given to cultural norms, ethnicity, gender, and language and literacy barriers. Strategies should accommodate the stigma around hepatitis C and its association with drug and alcohol use. However, as reported in *Responding to the Epidemic: Recommendations for a Canadian Hepatitis Strategy (2005)*[3], most of the Canadian communities do not have access to HCV-related services, and community-based organizations that are uniquely positioned to offer the appropriate services are unable to do so because of lack of funding.

When an infection such as hepatitis C is identified, the challenge arises to determine the best ways to conduct effective public awareness and education campaigns that are based on population health. These campaigns must not only reach an established population with a particular set of risk factors, but also speak to emerging communities whose members have become infected in other ways.

The Canadian Association for the Study of the Liver (CASL) 2004 consensus document on the Management of Viral Hepatitis recommends that immigrants from countries with high prevalence rates of hepatitis C be included in an initial assessment for hepatitis C. The report states that testing for the hepatitis C virus is a part of a larger set of activities that must take place. There are several reasons for this. First, testing activities will help those infected deal with the effects of the hepatitis C infection and initiate treatment to prevent liver failure and the need for liver transplants. Second, these activities will also help control the spread of infection. The document stresses the importance of culturally appropriate information and education resources that address the specific needs of all populations with HCV.

[3] *Responding to the Epidemic: Recommendations for a Canadian Hepatitis C Strategy*.2005.http://www.hepc.cpha.ca

The Public Health Agency of Canada initially started dealing with the needs of this large segment of the Canadian population by producing brochures and posters for some of the larger immigrant groups to use. Following this initial effort, it became clear that the task is far more complex than had been anticipated. Special expertise in dealing with ethnocultural communities is needed to formulate a plan to effectively engage their members in promoting a better understanding of hepatitis C, its transmission, and the means of controlling its spread.

By taking prompt and appropriate action, current interventions in Canada could benefit a largely hidden population. Continued inaction will lead to a crisis that will manifest itself in new hepatitis infections that could have been prevented, in lost years of life for those unaware that they are infected, and in increased economic costs both to individuals and to Canadian society at large.

General public awareness about hepatitis C remains low. Despite ongoing calls for extensive awareness campaigns, little has been done for the general public, for those who have low literacy, and for those from diverse cultural and linguistic backgrounds.

Section 3.0

Risk Factors for Hepatitis C

3.1 Most common risk factors for hepatitis C

Hepatitis C infection in the developed world is largely associated with sharing drug equipment among people who use drugs. A person can become infected after a single event of sharing contaminated drug use equipment. In developing countries, other risk factors have been implicated; these factors include inadequately sterilized medical equipment, blood transfusions, and various cultural practices.

In Canada, the risk of infection through blood transfusion has been substantially reduced (<1 in 500,000) by the introduction in 1990 of universal testing of blood donations for HCV[4]. However, despite some notable improvements, blood safety is not optimal in many developing countries. Current screening tests for hepatitis C are expensive, which explains why not all countries routinely screen for HCV.

Growing up in countries with inadequate resources is a risk factor due to lower health care standards. This may explain why Asians are at a greater risk for hepatitis C. In Vietnam, for instance, nurses reuse a needle for several patients. Certain cultural practices such as coin rubbing until there is bleeding (a form of faith healing), acupuncture, and tattooing (with reused and inadequately sterilized needles) may also contribute to the spread of blood-borne diseases. In Egypt, however, a nationwide effort to control an infectious liver disease led to an enormous spread of HCV between 1950 and 1982. Sterilization of reusable needles and syringes was not adequate or was some times omitted due to shortage of equipment and time constraints. Because of this, immigrants from these countries may share some of the same risk factors as people born in Canada, but they may have also been exposed to the virus in different ways than native-born Canadians.

[4] *Hepatitis C: Medical Information Update*. Can.J. Publ. Hlth, 91,1,S4-S9.CLF 2000.

The most common risk factors for HCV infection include:

- Injection drug use (past or present) and intranasal drug use (snorting) when sharing contaminated drug-using equipment such as needles, straws, pipes, spoon, cookers, rolled bills, etc.
- Tattooing, body piercing, or acupuncture using unsterile equipment or techniques.
- Exposure in the workplace from a needle-stick injury or sharp equipment that has infected blood on it.
- Exposure, both inside and outside Canada, when infection control precautions are not observed and/or during medical or dental procedures that involve the use of improperly sterilized equipment.
- Sharing personal care articles such as razors, scissors, nail clippers, or a tooth brush with an infected person.
- Unprotected sexual activity that includes contact with blood or an exchange of blood with an infected person.
- Being born to a mother who has HCV[2].

3.2 Ethnicity and hepatitis C

It is evident from the research that studies about hepatitis C in the ethnic population are limited. In Canada, even the prevalence of hepatitis C in ethnic communities is not known.

Particular ethnic groups may have specific concerns about treatment, such as specific beliefs about blood-borne viruses and the nature of treatment and illness.

3.3 Ethnocultural communities that are at risk for hepatitis C

The limited data on hepatitis C regarding the four identified ethnocultural communities come from their home countries. Data suggest that immigrant communities in Canada may have similar rates of infections as in their respective country of origin.

[2] *Hepatitis C – Get the Facts.* PHAC, 2009: http://www.phac-aspc.gc.ca/hepc/index_e.html

In certain countries from which Canada drew its immigrants before 1970, large numbers of people were infected with hepatitis C as a consequence of medical procedures that used improperly sterilized syringes and needles. Coupled with this factor are complex cultural, social, and economic factors.

Immigrant populations from Egypt, the Philippines, the People's Republic of China, and Vietnam have been selected for this project not only because of their higher rate of hepatitis C prevalence (3% or more of the population in their country of origin), their size, and their immigration patterns but also because the causes of infection in each community are somewhat different, making each community unique.

Egypt: In Egypt, the primary means of hepatitis C transmission was the use of improperly sterilized medical equipment, especially equipment used in schistosomiasis (a parasitic disease) control program undertaken by the government from the 1950s until 1982. This time span coincides with periods of immigration from Egypt to Canada.

The Philippines: In 2001, more than 230,000 Filipinos called Canada home. The Filipino population was chosen because the hepatitis C infection rate in the Philippines is 3.6% and because a better understanding of this community will yield insights into the engagement of a community that had centuries of exposure to "western" cultures (Spanish and American) before arriving in North America. The pattern of integration into Canadian society differs from that of other Asian populations. As well, many Filipinos in Canada are employed in the health sector and have mobilized and participated in advocacy campaigns around issues relating to domestic workers for years.

People's Republic of China: The Chinese community has a history of immigration to Canada that dates back to the middle of the 19th Century. It is a growing community that has immediate settlement needs and numerous community associations that can facilitate an educational program. The most recent influx of immigrants has come from Mainland China, Taiwan, and Hong Kong. As well, there are immigrants who form part of the ethnic Chinese communities in countries like the Philippines, Vietnam, Cambodia, and other parts of Southeast Asia. All arrive with different levels of education and different needs. For this project, the focus is on immigrants from Mainland China, where the hepatitis C prevalence rate is 3.2%.

Vietnam: The Vietnamese community entered Canada as both immigrants and refugees. In the late 1970s, many refugees were sponsored by church and community groups located in urban and rural areas across Canada. Family reunification followed. For this group, with an infection rate of 6.1%, an urban/rural breakdown would yield insights that can be applied to a hepatitis C education program. It is a complex community with Buddhist and Christian roots and an ethnic Chinese culture. Means of transmission might include traditional medical practices, such as rubbing the skin with coins until there is bleeding. All of these factors play important roles in the community's response to hepatitis C infection.

3.4 Language as a barrier to accessing health care

Effective communication is crucial to the delivery of culturally competent health care. Culturally and linguistically diverse groups and individuals with limited English proficiency typically experience less adequate access to health care and poorer health status and outcomes. An inability to communicate with the health care provider creates a barrier to accessing health care. It also undermines trust in the quality of medical care received and decreases the likelihood of appropriate follow-up. In addition, lack of a common language between the client and the provider can result in diagnostic errors and inappropriate treatment.

The challenge now facing health care organizations is how to ensure quality care and services to the diverse patient population. This can be overcome to a great extent by providing interpretation and translation services, cross-cultural publications, and education and training for the health care providers.

A large number of resources have been developed and distributed in Canada, but there appear to be some challenges in accessing hepatitis C information that is appropriate in terms of literacy level and cultural sensitivity.

3.5 Culture as a barrier to accessing health care

The cultural barriers, while more subtle, may have profound effects on the interaction between the patient and the health care provider. Communication may not take place even when the language barriers are removed. The patient might withhold information which in turn might affect proper

diagnosis or might concurrently seek alternative treatments, thereby complicating or impeding the treatment prescribed by the health care provider. The level of integration has been shown to account for differences in the use of health services within ethnic groups after controlling for age, gender, health status, and insurance coverage. Health care providers should be aware of these differences in order to provide ethnic population with accessible and appropriate services.

Many cultural taboos exist with regard to hepatitis C. In some ethnocultural communities, even talking about the disease is a taboo. They are also reluctant to talk about the disease for fear of being stigmatized and labeled.

There is an urgent need in Canada to develop a community strategy to increase awareness and educate individuals about the hepatitis C risk, transmission, prevention, treatment, and management. Many studies have stressed the importance of providing culturally appropriate information and education resources that address the specific needs of all populations infected with HCV. Although the Canada Health Act recognizes the need for "inclusiveness and equity" in healthcare, there are no standards to accomplish this. Some health care providers have developed creative and successful programs to meet the emerging needs of the underserved, culturally diverse population in Canada. They have created multilingual brochures, established interpreter service, provided cultural competency training to staff, and used other culturally appropriate interventions.

Addressing hepatitis C would be a fiscally responsible endeavour, as HCV costs the Canadian health care system approximately $500 million annually, and the cost is expected to double in five years [6].

In certain countries from which Canada drew its immigrants before 1970, large numbers of people were infected with hepatitis C as a consequence of medical procedures that used improperly sterilized syringes and needles. Coupled with this factor are complex cultural, social, and economic factors.

[6] Canadian Institutes of Health Research: http://www.cihr-irsc.gc.ca/e/193.html

Section 4.0

Prevention of Hepatitis C

4.1 Can hepatitis C infection be prevented?

The only effective prevention is to avoid contact with infected blood. Current blood collection practices in Canada should make the risk minimal.

4.2 How can hepatitis C infection be prevented?

General rules for prevention include taking the following precautions:

- Do not share needles/syringes, spoons, drug solutions, water, cookers, pipes, straws for snorting drugs, and other drug-related equipment.

- Always insist that only fresh ink, and single use, disposable needles are used for tattooing, body piercing, acupuncture, etc. All equipment as well as the ink should be sterile.

- Wear latex gloves if contact with another person's blood is likely.

- Practise safer sex. In a monogamous, long-term relationship, sexual transmission of hepatitis C is rare. In non-monogamous relationships and with new sexual partners, condoms should be used during sex for protection from HCV and sexually transmitted diseases. The risk of sexual transmission of HCV is low, but not absent. This is particularly true for those with more than one sexual partner, if there are concurrent sexually transmitted infections with open sores present, or if contact occurs during menstruation[2].

4.3 Can someone with hepatitis C infect family and friends?

Individuals, who have been diagnosed with HCV, may worry about passing on the virus to friends and family. This may be true in situations where the individual has had the infection for a long time and did not know it. It is important to remember that HCV is spread only through contact with infected blood and body fluids containing blood. Hepatitis C is not spread by casual contact, such as shaking hands, talking, sharing food and utensils, sneezing, or hugging.

[2] *Hepatitis C – Get the Facts.* PHAC, 2009: http://www.phac-aspc.gc.ca/hepc/index_e.html

4.4 How can someone with hepatitis C decrease the risk of infecting family and friends?

To decrease the risk of HCV infection to family and friends, individuals should follow these guidelines[7]:

- Do not share razors, toothbrushes, nail clippers, scissors, or anything else that could have blood on it;
- Cover any open wounds or sores with a bandage;
- Get rid of articles contaminated with blood (e.g., tampons, sanitary napkins, tissues, bandages, and needles) by placing them in a protective container;
- Persons who inject, snort, or smoke drugs, should not share needles, straws, or other equipment (containers, cookers, filters, or water) with anyone else;
- Mothers should not breastfeed if their nipples are cracked or bleeding;
- Persons who are not in a long-term, monogamous relationship should always use condoms.

  (Using condoms will protect partners from hepatitis C and will also reduce the risk of getting hepatitis B, HIV, and other sexually transmitted infections (STIs). The risk of sexual transmission of HCV is very low, but it may happen if a woman is having her period, a person has sores from an STI, or the sex is rough enough to produce cuts or sores.)

It is important to remember that HCV is spread only through contact with infected blood and body fluids containing blood. Hepatitis C is not spread by casual contact, such as shaking hands, talking, sharing food and utensils, sneezing, or hugging.

[7] *Healthy Living with Hepatitis C*. CLF: http://www.liver.ca

Section 5.0

Testing for Hepatitis C

5.1 What are the symptoms of hepatitis C?

Most people with hepatitis C have no symptoms and may even feel quite healthy. Others may develop fatigue, jaundice (yellowing of the skin and eyes), abdominal and joint pain, nausea, and loss of appetite.

5.2 Who should be tested for the hepatitis C virus?

- Anyone who is worried about having done something that could have put them at risk – even once or a long time ago – should go to a clinic or their health care provider to be tested for HCV.

- Anyone with signs or symptoms of having hepatitis C (e.g., nausea, fatigue, reduced appetite, jaundice, dark urine, abdominal pain) should consider being tested for HCV.

- Anyone who was born or has resided in countries where hepatitis C is more common (e.g., Egypt, southern Italy, India, Pakistan, China, The Philippines, Vietnam) and has been exposed to blood products, medical procedures, or vaccinations should consider being tested for HCV[7].

5.3 What is the test for hepatitis C?

Anyone who thinks that they may be at risk for hepatitis C should consult a health care provider. The health care provider will be able to request a blood test to determine if the hepatitis C virus is present.

5.4 Why are there several blood tests for hepatitis C?

Since most people infected with HCV have no symptoms, a blood test is the easiest way for health care providers to look for HCV and other diseases. The results of the following tests[7] will help to decide on the options for treatment.

1. The *Anti-HCV test* looks for antibodies to HCV. A positive test only means that there has been an infection with the virus at some point in time.

[7] *Healthy Living with Hepatitis C*. CLF: http://www.liver.ca

It does not show whether this is a new infection, how long the person has been infected, or if the infection is still present. A positive test will necessitate further testing to answer those questions.

2. The *HCV RNA tests* can tell if the individual still has the virus and how much of the virus is in the blood. They are used to qualify (positive or negative result) and quantify (how much of the virus or viral load) the hepatitis C virus in the blood.

3. The *HCV genotyping test* can tell the type (or genotype) of HCV. There are six common genotypes of HCV, numbered from 1 to 6, and an individual can be infected with more than one genotype at the same time. In Canada, genotype 1 is the most common but also the most difficult to treat. Genotypes 2 and 3, which are the most easily treated, account for almost all other HCV infections in Canada.

4. *Liver function and liver enzymes tests* tell how well the liver is functioning.

5. *Liver biopsy* is a procedure that is normally done in a hospital to understand the amount of damage done to the liver by the virus as well as by fat and alcohol.

5.5 Can individuals get hepatitis C more than once?

No one can have lifelong protection from hepatitis C[7]. Although the body's immune system makes antibodies to HCV, these antibodies do not offer protection. The virus changes so quickly that it can escape the body's defences.

5.6 Is there a vaccine to prevent hepatitis C infection?

No hepatitis C vaccine exists at this time. A person who has been successfully treated for HCV can still be infected again. However, what a person does, or does not do, can affect the level of risk for getting hepatitis C again[7].

[7] *Healthy Living with Hepatitis C*. CLF: http://www.liver.ca

Section 6.0

Treatment for Hepatitis C

6.1 What is the treatment for hepatitis C?

Effective treatment for hepatitis C is available. Many people who have hepatitis C may not require treatment. For some individuals with hepatitis C drug treatment may be appropriate. About one half of those with the most common HCV genotypes reach a point where the HCV can no longer be found in the blood. At present, the treatment consists of a combination of two medications: pegylated interferon and ribavirin.

Some individuals may have concerns about initiating treatment, due to ethnic and cultural beliefs, the nature of treatment and its effectiveness. In addition, the "relationship with the doctor" is an important consideration for many ethnocultural individuals. The individual with hepatitis C needs to consult with a doctor to make sure that the treatment is right for him/her.

If an individual or the health care provider feels that treatment might be right, it is important to consider and discuss the following questions[7]:

- What is the current treatment for hepatitis C?
- How effective is treatment?
- What are the side effects of treatment?
- Who is a candidate for treatment?
- How does someone get treatment?

To prevent further damage to the liver, the health care professional may advise vaccination against hepatitis A and hepatitis B. Many provinces and territories provide these vaccines at no cost.

6.2 Are there alternative therapies for hepatitis C?

No alternative therapy (homeopathy, herbal medicine, vitamins, minerals, probiotics, etc.) has been proven safe and effective for treating hepatitis C. Individuals who wish to learn more about the risks and benefits of alternative therapies should look for a therapist who belongs to a professional organization and has a good understanding of hepatitis C. However, most alternative therapists are not regulated by provincial and territorial laws[7].

[7] *Healthy Living with Hepatitis C*. CLF: http://www.liver.ca

Section 7.0

Management of Hepatitis C

7.1 What does the liver do?

The liver is the largest internal organ in the body. It is a strong organ and can continue working even when two thirds of it have been damaged by scarring (cirrhosis). The liver is a complex organ that performs many important functions.

It helps to:

- digest food
- store vitamins and minerals
- manufacture blood and body proteins
- produce, store, and export fat
- regulate the balance of many hormones
- regulate the supply of body fuel
- destroy poisonous substances that enter the body [8].

7.2 How is hepatitis C managed?

To stay healthy, reduce stress on the liver, and remain feeling well, it is important that individuals follow these instructions[8]:

- Avoid or limit alcohol – anyone who drinks should try to stop
- Avoid or limit tobacco – anyone who smokes should try to stop
- Eat healthy food – individuals should follow the guidelines in *Eating Well with Canada's Food Guide*[9]
- Avoid illnesses – e.g., viruses like hepatitis A and B can damage the liver. Get tested and get vaccinated against hepatitis A and hepatitis B.
- Avoid "street" drugs including marijuana
- Practise safer sex
- Be active
- Get an adequate amount of sleep.

[8] *Your Liver: Owner's Manual*. CLF: http://www.liver.ca

[9] *Eating Well with Canada's Food Guide.*Health Canada: www.hc-gc.ca/fn-an/food-guide-aliment/index_e/html

Individuals with advanced liver disease will need to avoid certain medicines – including aspirin, sleeping pills, and non-steroidal anti-inflammatory medication. Drugs should never be mixed, especially with alcohol. This includes mixing prescription drugs, over-the-counter drugs, "street" drugs, and alternative medicines. Before taking any medicine, individuals should talk to a health care provider to be sure that it is safe for them to take[7].

[7] *Healthy Living with Hepatitis C*. CLF: http://www.liver.ca

Section 8.0

Supporting Community Data

8.1 Ethnocultural community profiles

Community profiles were created for the People's Republic of China, Egypt, the Philippines, and Vietnam in Part I of the project "Engaging Ethnocultural Communities on Hepatitis C" produced by the CLF and CEC in 2006.

Statistical information on the communities came from the 2001 Census of Canada[10] and 2002 Statistics Canada's Ethnic Diversity Survey (EDS)[11]. However, feedback from the communities indicates that the actual numbers for immigrants are higher than those reported in the 2001 Census of Canada. Quantitative data was used to determine the economic and educational levels of individuals in these communities. As well, information about attitudes and values held by individuals from the People's Republic of China, the Philippines, and Vietnam that the EDS provides facilitated the development of culturally appropriate strategies for increasing awareness about hepatitis C within these communities.

8.2 People's Republic of China

According to the 2001 Census of Canada, immigrants from the People's Republic of China number 788,180. The EDS, carried out in 2002, indicates that about 52% of these individuals arrived after 1991.

About 30% of the group members have a university degree or better, as did their fathers. About 19% of their mothers have a university education. Another 11% have a trade or technical degree. Their spouses have similar educational levels. This is somewhat higher than the entire Canadian population where 21.5% posses a university degree or better and 17.8% have a technical degree. From this immigrant group, 72% did their schooling outside Canada.

Working at a job is the main activity for 47% of this group with 12% doing household work and another 12% attending school. Employment income was reported by 52%, 14% received government transfer payments, and 18% had no income. Household income for 48% was reported to be less than $40,000 per year. At the upper end of the income levels, about 22% reported having household incomes of $80,000 or more.

[10] *Topic-Based Tabulations*, Census of Canada, 2001.Staistics Canada: http://www.statcan.gc.ca
[11] Ethnic Diversity Survey, 2002. Statistics Canada: http://www.statcan.gc.ca

Languages spoken by immigrants from the People's Republic of China stand at 66% for a non-official language and for English; 12.3% spoke only a non-official language, and 18.1% spoke more than one non-official language. At work, 38% spoke only English. About 34% spoke both English and a non-official language at work and a further 17% spoke only a non-official language. At home, 55% spoke a non-official language, 32% spoke English and a non-official language, and about 4% spoke English.

No religious affiliation was indicated by about 65% with about 14% stating Buddhism as their religious affiliation.

About 84% of the population declared a very strong sense of belonging to a family and about 54% have a strong sense of belonging to an ethnic group. A strong satisfaction with life is reported by 69%.

Approximately 53% report having family living in Canada and about 52% report seeing their family once a week. About 77% still have family living in their country of birth. A further 18% of the China-born population has contact with family members in other countries at least once a week.

Having friends who are of the same ancestry is reported by 29% with 49% indicating that most of their friends come from the same ancestry.

Carrying out customs and traditions is important to 44%, but ethnic identification is important to 77%. About 45% were familiar with ethnic or cultural associations.

About 10% admitted to feeling discomfort due to their ethnicity or culture. However, 50% indicated that they trusted people in their neighbourhood with about 53% saying that, in general, people can be trusted.

Cities in Canada with 500+ immigrants from the People's Republic of China in 2001[10]

Cities with 500+ immigrants from the People's Republic of China	Number
Toronto	136,135
Vancouver	101,770
Montreal	21,700
Calgary	14,760
Ottawa-Hull	13,285
Edmonton	11,150
Winnipeg	3,470
Victoria	3,175
Hamilton	2,905
Windsor	2,825
Kitchener	2,305
London	1,685
Saskatoon	1,430
St. Catharines-Niagara	890
Guelph	835
Halifax	825
Regina	755
Oshawa	665
Kingston	660

[10] *Census of Canada*, 2001. Statistics Canada: http://www.statcan.gc.ca

8.3 Egypt

Data on the Egyptian community was derived from the 2001 Census of Canada because not enough people of Egyptian origin were interviewed in the EDS to provide a statistically valid sample. The following statistics are for the population 15 years and over. The total population interviewed was 31,160.

English was used by 71% at work followed by 19% who spoke French and 7% who used both English and French.

About 69% of the population 15 years of age and over was in the labour force; of these, 63% were employed and 6% were unemployed. Of those in the labour force, 33% held management occupations and 21% held sales and service occupations. Of paid workers, 86% were employees and 14% were self-employed.

The average employment income was $55,234 with 64% of respondents earning less than $40,000 and 15% earning $60,000 and over.

About 55% held a university degree and 4% held a trades certificate or diploma.

Cities in Canada with 500+ immigrants from Egypt in 2001[10]

Cities with 500+ Immigrants from Egypt	Number
Montreal	14,180
Toronto	12,445
Ottawa-Hull	2,080
Vancouver	1,235
Calgary	850
Hamilton	640
Kitchener	550

[10] *Census of Canada*, 2001. Statistics Canada: http://www.statcan.gc.ca

8.4 The Philippines

According to the 2001 Census of Canada, immigrants from the Philippines, number 327,550. The EDS carried out in 2002 indicates that about 43% of these arrived since 1991.

About 32% have a university degree or better, as did 31% of their fathers. About 25% of their mothers have university education. Another 23% have a trade or technical degree. Their spouses have similar educational levels. This is somewhat higher than the entire Canadian population where 21.5% posses a university degree or better and 17.8% report having a technical degree. Within this immigrant group, 50% were schooled outside Canada.

Working at a job is the main activity for 72% with 6% doing household work and another 9% going to school. Employment income was reported by 77%. A further 15% reported receiving government transfer payments or had no income.

Household income for 32% was reported to be less than $40,000 per year. At the upper end of the income levels, about 28% reported having household incomes of $80,000 or more.

Languages spoken stand at 90% for a non-official language and English; 5% spoke only English; and 3.9% spoke English, French, and a non-official language. At work, 64% spoke only English. About 35% spoke both English and a non-official language. At home, about 13% spoke a non-official language, 60% spoke English and a non-official language, and about 20% spoke only English.

About 84% stated Roman Catholic as their religious affiliation.

About 91% of the population declared a very strong sense of belonging to family and about 72.4% have a strong sense of belonging to an ethnic group. A strong satisfaction with life was reported by 82%.

Approximately 70% report having family living in Canada and about 48% report seeing them once a week. About 95% report still having family living in their country of birth. A further 17% of the Filipino population has contact with family members in other countries at least once a week.

Having friends who are all of the same ancestry is reported by 16% with 43% indicating that most of their friends are of the same ancestry.

Carrying out customs and traditions is important to 58% but ethnic identification is important to 81%. About 52% were familiar with ethnic or cultural associations.

About 10% admitted to feeling discomfort due to their ethnicity or culture. However, 47% indicated that they trusted people in their neighbourhood with about 35% saying that people in general can be trusted.

Cities in Canada with 500+ immigrants from the Philippines in 2001[10]

Cities with 500+ immigrants from the Philippines	Number
Toronto	103,170
Vancouver	46,215
Winnipeg	20,105
Montreal	13,205
Calgary	12,205
Edmonton	10,220
Ottawa-Hull	3,840
Hamilton	3,530
Windsor	2,100
Victoria	1,365
London	1,120
Saskatoon	990
St.Catharines-Niagara	860
Kitchener	780
Guelph	770
Regina	710
Oshawa	610
Red Deer	580

[10] *Census of Canada*, 2001. Statistics Canada: http://www.statcan.gc.ca

8.5 Vietnam

According to the 2001 Census of Canada, immigrants from Vietnam, number 107,005. The EDS carried out in 2002 indicates that about 20% of these immigrants arrived since 1991.

About 23% have a university degree or better, as did 25% of their fathers. About 10% of their mothers have university education. Another 7% have a trade or technical degree. Their spouses' educational levels stand at 17%. This is somewhat higher than the entire Canadian population where 21.5% posses a university degree or better and 17.8% report having a technical degree. From this immigrant group, 50% did their schooling outside Canada.

Working at a job is the main activity for 56%, with 11% doing household work and another 11% going to school. Employment income was reported by 66%; additionally, 15% received transfer payments and 7% had no income. The household income for 33% of those responding was reported to be less than $40,000 per year. At the upper end of the income levels, about 19% reported having household incomes of $80,000 or more.

About 63% of the respondents spoke a non-official language and English, while 24% spoke English, French, and a non-official language. At work, 47% spoke only English. About 25% spoke both English and a non-official language. At home, about 48% spoke a non-official language, 33% spoke English and a non-official language, and about 7% spoke French and a non-official language.

About 20% stated that their religious affiliation was Roman Catholic, 50% were Buddhist, and 15% had no religious affiliation.

About 72% of the population declared a very strong sense of belonging to family and about 81% have a strong sense of belonging to an ethnic group. A strong satisfaction with life was reported by 74%.

Approximately 82% report having family living in Canada and about 46% report seeing them once a week. About 84% report still having family living in their country of birth. A further 10% of the Vietnamese population reports having contact with family members in other countries at least once a week.

Having friends who are all of the same ancestry is reported by 16%, with 40% indicating that most of their friends are of the same ancestry.

Carrying out customs and traditions is important to 60% but ethnic identification is important to 81%. About 44% were familiar with ethnocultural associations.

About 10% admitted to feeling discomfort due to their ethnicity or culture. However, 47% indicated trusting people in their neighbourhood with approximately 47% saying that people in general can be trusted.

Cities in Canada with 500+ immigrants from Vietnam in 2001[10]

Cities with 500+ immigrants from Vietnam	Number
Toronto	52,600
Vancouver	22,140
Montreal	21,250
Calgary	11,770
Edmonton	9,335
Ottawa-Hull	5,905
Winnipeg	3,295
Hamilton	2,765
Kitchener	2,755
London	1,745
Windsor	1,415
Guelph	1,370
Regina	755
Victoria	690
St.Catharines-Niagara	585
Saskatoon	560
Nanaimo	530

[10] Census of Canada, 2001.Staistics Canada: http://www.statcan.gc.ca

Profile Observations:

- Community profiles for immigrants from the People's Republic of China, Egypt, the Philippines, and Vietnam will provide an overview that will help to guide the outreach work to these communities.

- In the case of the Vietnamese and Egyptian communities, it will prove useful to develop materials in the French language, as a significant proportion of both communities speak French.

- All groups value their ethnic backgrounds and about half of those interviewed were familiar with ethnic organizations in their community. This highlights the need to work through ethnic community organizations.

- The number of religions associated with these groups also points to the need to take into account how religion affects attitudes about health information. More than half of the immigrants from the People's Republic of China, for example, report having no religious affiliation. Therefore, distributing information through places of worship for this group would not be as effective as with the Vietnamese community.

- The high levels of education in each of these groups should prove to be an asset in finding leadership potential for outreach work within these communities.

Taking these similarities and differences into consideration, effectively tailored ways of reaching these immigrant communities will enhance the ability of health agencies to serve these populations.

Section 9.0

Guidelines for Conducting a Training Workshop

9.1 Sample agendas for a training workshop

Sample Agenda (full day)
Workshop timing: 9:00 am to 4:30 pm
Number of participants: 10

9:00 – 9:15	Welcome Ground rules (section 9.2) Introductions (name, community, organization, and city)
9:15 – 9:30	Ice breaker (section 9.6)
9:45 – 10:00	Introducing the training guide (section 1)
10:00 – 10:45	Hepatitis C – A public health challenge (section 2) Risk factors for hepatitis C (section 3)
	Break
11:00 – 12 noon	Prevention of hepatitis C (section 4) Testing for hepatitis C (section 5)
	Lunch
1:00 – 1:30	Treatment for hepatitis C (section 6) Management of hepatitis C (section 7)
1:30 – 2:30	Role playing (section 9.7)
	Break
2:45 – 3: 30	Supporting community data (section 8) Guidelines for conducting training workshop (section 9) Helpful information on hepatitis C (section 10) Glossary of terms (section 11)
3:30 – 4:00	Screencast (CD) CLF and PHAC brochures and CDs (review)
4:00 – 4:30	Evaluation (section 9.8) Wrap up

Sample Agenda (half day)
Workshop timing: 9:00 am to 1:00 pm
Number of participants: 10

9:00 – 9:30 am	Welcome Ground rules (section 9.2) Self -introductions Introducing the training guide (section 1)
9:30 – 10:30 am	Hepatitis C – A public health challenge (section 2) Risk factors for hepatitis C (section 3) Prevention of hepatitis C (section 4)
	Break
10:45 – 12 noon	Testing for hepatitis C (section 5) Treatment for hepatitis C (section 6) Management of hepatitis C (section 7)
12:00 – 12:30 pm	Supporting community data (section 8) Guidelines for conducting training workshop (section 9) Helpful information on hepatitis C (section 10) Glossary of terms (section 11)
12:30 – 1:00 pm	Evaluation (section 9.8) Wrap up
	Lunch

For a half day session, the focus of the training will be on information pertaining to hepatitis C (Sections 2 – 7). Other sections and additional materials (brochures, CDs etc) will be quickly reviewed by the trainer to familiarize participants with the contents of the training guide.

9.2 Ground rules

At the beginning of the training session it is helpful to review some ways to encourage and facilitate the discussion and be respectful of every participant. It is important to post discussion guidelines, or ground rules, where everyone can see them during the training session and to ask group participants whether they agree to follow them. Some guidelines to follow include:

- Only one person speaks at any given time.
- Everyone is encouraged to contribute.
- Everyone's views are respected.
- We want to hear all sides of the issue – both positive and negative.

9.3 Tips for trainers

Every trainer has his/her own style, but a few guidelines are important to remember:

- Be non-judgmental.
- Try to remember and use people's names when you address them.
- Ensure that everyone can see and hear you.
- Maintain good eye contact with your audience.
- Explain the nature of the project.
- Emphasize key words.
- Speak slowly and distinctly.
- Use simple language and explain the meaning of all technical terms.
- Keep the training session moving by staying on track. If someone has specific problems you may want to talk to them during the break.
- Try not to let one person dominate the discussion. Be polite if you have to intervene to get people back on topic. Encourage others to participate.
- Encourage discussion by all participants.
- Dress appropriately, stand with confidence, and use natural gestures to emphasize important points.
- Recognize and show appreciation to participants for their time and contributions.
- Remember to thank participants at the beginning and at the end. Let them know that the information they have shared is a valuable contribution to the success of the project.

Special tips for training trainers in a multicultural setting:

- Be aware of the influence of culture on people's beliefs, values, and behaviour, including your own.
- Be aware of, and sensitive to, the verbal and non-verbal communication rules across cultures.
- Be able to identify cultural viewpoints that may be barriers to effective communication in a training workshop setting.
- Be sure that your style of communication is culturally appropriate.

9.4 Preparation

- Review your material before the session and make your own notes for points to remember in your presentation.
- Be clear in your own mind what you are going to say and do. If you know the content of the training manual, you will be able to communicate clearly.

Pre-Preparation

- **Time**: select a time that is convenient for the identified group.
- **Location**: select a location that participants can reach easily, i.e., near a public transportation route or with nearby parking available (possibly free).
- **Room**: the size of the room should be appropriate for the number of participants. An ideal group size for training is 10-12 participants.
    - Working area: the room should have comfortable chairs and working spaces.
    - Temperature: the temperature of the room should be comfortable.
    - Sound: the room should have good acoustics and not be affected by background noises.
    - Light: the room should be well lit.
    - Electrical outlets: there should be outlets near the trainer's table and an extension cord.
- **Washrooms**: make sure that the washrooms are close to the room to be used for the training workshop.
- **Refreshments**: arrange for refreshments in advance.

- **Materials and Equipment**: organize notepads, pens, pencils, and name tags or place cards.
- **Audio-visual equipment**: arrange for audiovisual equipment.
- **Keep at hand**:
    - Agenda for the training workshop
    - Registration form with the names of registrants and their contact information
    - Copies of Training Guide
    - Handout materials
    - Evaluation forms
    - Signs giving directions to meeting room, washroom etc.
    - Flip charts and markers
    - Masking tape
    - Laptop

Before the session, remind all participants of the time and location of the training workshop; either telephone them or send them an email.

9.5 Facilitation

- On the training session day
    - Bring name tags or place cards for training workshop participants.
    - Arrive early to ensure that the room is ready.
    - Check laptop and electrical points and set up the laptop.
    - Welcome each participant by name as they arrive and introduce yourself.
    - Provide each participant with their name tag or place card.
    - Request that each participant check their name and contact information on the registration form to ensure accuracy.
    - Invite each participant to get some food and drink.

- Getting the workshop going
    - Call the session to order.
    - Introduce yourself, welcome the participants, and thank them for coming.
    - Address any housekeeping issues such as washroom locations, etc.
    - Describe the project very briefly and explain your role.
    - Read the ground rules for the group.

- Explain that participation is voluntary.
- Have participants introduce themselves to the group by stating their name, the community they represent, and the city they live in.
- Provide the agenda and timeframe for the session.
- Ensure that everyone knows the length of the session and when there will be breaks, etc.
- Give guidelines about the format of the training session.
- Hand out evaluation forms for participants to complete and return at the end of the session.
- Distribute handout materials.
- Place any additional materials on a display table.

- Training Session
  - Explain briefly the content of the training guide.
  - Go through the training guide sections in sequence.

- Closing
  - Conclude by thanking every participant for contributing to the success of the training workshop.
  - Request that participants complete and return the evaluation forms.

- After the training session
  - Send thank you letters to participants.
  - Pay any outstanding invoices.
  - Contact participants who requested additional information, providing the information by telephone, mail, or email.

9.6 Ice breakers

Ice breakers can be an effective way of starting a training session. They are often used when people who may not know each other meet for a common purpose. When a warm and friendly learning environment is created, the attendees will participate more freely and learn more.

Ice breakers are structured activities that are designed to help participants relax, further introduce them to each other, and energize them in what is normally a formal atmosphere. They help to establish some commonality among participants. Ice breakers may or may not be related to the subject matter.

Things to consider when choosing an ice breaker activity:

- **Group size**: some ice breakers work best in large groups of 20 or more, while others are better for small groups of 10 or so. If you have too many people for the ice breaker to be effective, divide into smaller groups of the right size and run several ice breakers concurrently.

- **Meeting purpose**: match the mood of the ice breaker to the mood of the meeting. Have several ice breakers ready so you can select one based on the mood of the day.

- **Icebreaker purpose**: ice breakers help to ease introductions or to relax participants. They do not have to be restricted to the start of meetings. Well-timed ice breakers will lift flagging energy levels or encourage creativity.

- **Necessary preparation**: simple ice breakers are effective when explained clearly. More complicated ice breakers may require preparation and special facilitation skills. Choose simple ice breakers over complicated ones, and factor in preparation time.

- **Materials required**: verbal ice breakers require no extra items. Pens and flip charts are usually required for meetings so they should be on hand. If you have bigger, bolder ideas involving ropes, scissors, balls, cards, or other such materials think them through carefully. Make a checklist of all necessary materials so that you have these items.

Be ready to improvise or switch icebreakers if you have forgotten a crucial item or do not have enough to go around.

- **Time available**: group energy levels will be zero if each one-minute introduction takes five minutes. Be realistic about the time you have for the meeting icebreaker and stick to it.

The secret of a successful ice-breaking session is to keep it simple. Design the ice breaker for the session with specific objectives in mind and make sure that it is appropriate and comfortable for everyone involved.

Examples of ice breakers

1. At the beginning of a session you can have people introduce themselves by completing a sentence, such as: "I am in this training workshop because..."

2. You may want to play the toilet paper game. Simply pass a roll of toilet paper around and ask participants to take what they need. Give no further explanation. After the toilet paper has gone around tell the group that each person must give one fact or some information about themselves for each square of toilet paper they have.

3. Another game is to finish a sentence. Write the start of a sentence on the board or flip chart (i.e., “My favorite job was…”; “My hobby is…”; etc.) and have each person in the group complete the sentence. You can keep this up for several rounds by posting another sentence beginning and starting the process again.

4. Have participants mingle in the group and identify the person whose birth month and date is closest to their own. Have them discover two things they have in common.

5. Another ice breaker comes through self introduction. Have participants introduce themselves and tell why they are there. For variations on this ice breaker you can have participants tell where they first heard about the Hepatitis C Training Workshop, how they became interested in hepatitis, what their area of work is, etc.

6. You can also have group members introduce each other. To do this, divide the group into pairs, sometimes with specific instructions to share a certain piece of information. For example, "The one thing I am particularly proud of is..." Each pair talks together for five minutes and then the participants introduce the other person to the group.

7. You can also have an ice breaker related to the topic (hepatitis C). Give each participant a slip of paper with three questions:

- Is hepatitis C an issue with ethnocultural communities? □Yes □No
- Is there a vaccine for hepatitis C? □Yes □No
- If you get hepatitis C once, can you get it again? □Yes □No

Give the participants 5 minutes to answer the questions. Put up the correct answers on a flip chart. Check to see how many got all the answers correct.

Be creative and think up your own ice breakers!

9.7 Role Playing

Role playing is a technique to provide participation and involvement in the learning process. It is particularly important in training community outreach workers. It helps to develop skills in dealing with people without the risks of failure or embarrassment that might arise in real-life situations. Role playing gives the training participants an opportunity to see a community situation from perspectives other than their own and makes them more sensitive to the experiences of others in similar situations. It helps them deal with sensitive and taboo issues, anticipate future situations in a non-threatening context, and practice negotiating.

In role playing, the facilitator invites the participants of the training program to act out the role of an individual in a specific situation.

There are three elements to a role playing session:

(1) Setting up: where the facilitator describes the scenario and assigns roles to participants. The facilitator can include some key dialogue to help the role playing begin and then let the group continue with the act.
(2) Play stage: in which the participants act out their roles and the play is carried out.

(3) Follow up: where the participants and observers discuss why a certain statement was made or an action was carried out. The explanation and resulting discussion help participants get a better understanding of the dynamics of a particular situation in a specific community.

Situation 1. Taking measures to prevent hepatitis C

The suggested timeframe for this activity is 60 minutes.

General instructions:

- Before starting the role play, involve all participants by doing some simple stretches to help them relax. Divide the participants into groups of five or six. Each group picks a recorder and two actors.
- Each group prepares a scenario with the necessary dialogue; this involves brainstorming and rehearsing the skit.
- The time limit for the actual skit is five minutes.
- Each group presents their skit to the other participants in the workshop one at a time.
- The participants discuss the way in which the issues have been dealt with.
- The main points that come out of each skit are noted.

Dialogue Starter

Ms. Grace Nguyen, 60 years old, heard that her friend who is also from Vietnam was diagnosed with hepatitis C. She knows that it is infectious. She approaches her nurse for advice.

Ms. Nguyen: Should I be tested for the hepatitis C virus?

Nurse: It is very important to be tested for the hepatitis C virus. The Public Health Agency of Canada has recommended that anyone who has resided in Vietnam or other countries where hepatitis C is common and has been exposed to blood products or medical procedures should be tested for HCV.

Ms. Nguyen: But I do not have any problems. I feel fine now.

Nurse: In many cases you may not have symptoms for a long time and may not even know that you have been infected. But untreated HCV can lead to many difficult health problems later in life. A blood test is the only way to find out if you have been infected with HCV……. (continue the dialogue)

Situation 2. Accepting illness

Dialogue Starter

When Mr. Yeung Li went for a routine check up he tested positive for the hepatitis C virus. He has to go for treatment and watch what he eats. He has approached his social worker for advice about medicine and food.

Mr. Li: I am taking the treatment that the doctor ordered, but I usually have a drink every night. I have difficulty sleeping unless I do that.

Social Worker: In hepatitis C, the liver is affected and even small amounts of alcohol will put a strain on the liver. We want to keep the liver as healthy as possible. To sleep better, have you tried going for walks or doing some activity that you enjoy? What do you think will work for you?

Mr. Li: I do not know how I got this infection. I am scared to tell my family and friends.

Social Worker: People do not always understand how someone can be infected by hepatitis C and perhaps you can explain the causes to them. The infection may have come in several ways – needles used for vaccination may have been unsterilized or if your barber or dentist was not careful ….

Mr. Li: What specific precautions should I take so that I do not pass it on to my family and friends?

Social Worker: You do not have to be afraid because hepatitis C is a blood to blood infection and you will not pass it on to the others if you are careful. You can decrease the risk of infection to family and friends by not sharing razors, toothbrushes, scissors, or any other items that might possibly have your blood on it. It is also very helpful to cover open wounds with a bandage so blood is not exposed…. (continue the dialogue)

9.8 Sample evaluation form for participants of a training workshop

Canadian Ethnocultural Council
Train-the-Trainer Workshop
Ottawa, ON
September 19, 2009

Evaluation Form

1. Are you:

☐ Male ☐ Female

2. What is your role in your community?

_____

3. Which community do you represent?

☐ Chinese
☐ Egyptian
☐ Filipino
☐ Vietnamese
☐ Other, please specify _____

4. In which city do you live? _____

5. How would you rate the facilities for the Training Workshop? Please place a check in the correct box.

	Excellent	Very good	Good	Fair	Poor
Location					
Room					
Food					

6. In general, how effective was the format (agenda and process) of the Training Workshop?

☐ Very effective ☐ Somewhat effective ☐ Not effective

7. How useful is the information in the Training Guide in helping you feel ready to train others?

☐ Very useful ☐ Useful ☐ Somewhat useful ☐ Not at all useful

8. In general, the trainer of this workshop is:

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

9. The trainer: ***(please check all that apply)***

☐ Was very knowledgeable about issues related to facilitation

☐ Offered good guidelines for effective facilitation

☐ Reviewed the training package thoroughly

10. Overall the Training Workshop was:

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

11. What did you like most about the Training Workshop?

_____

_____

12. What did you like least about the Training Workshop?

_____

_____

13. What additional information would be necessary to improve future Training Workshops*?*

_____

_____

14. What additional information in the Training Guide would better prepare you to implement the model in the target community?

_____

_____

_____

_____

Thank you for providing your input!

Section 10.0

Helpful Information on Hepatitis C

10.1 Useful web sites

Canadian AIDS Treatment Information Exchange
http://www.catie.ca

Canadian Association for the Study of the Liver
http://www.hepatology.ca

Canadian Association of Hepatology Nurses
http://www.livernurses.org

Canadian Centre on Substance Abuse
http://www.ccsa.ca

Canadian Hemophilia Society
http://www.hemophilia.ca

Canadian Institutes of Health Research
http://www.cihr-irsc.gc.ca/e/4601.html

Canadian Liver Foundation
http://www.liver.ca

Canadian Nurses Association
http://www.cna-aiic.ca/

Canadian Public Health Association
http://www.cpha.ca

Centers for Disease Control and Prevention
http://www.cdc.gov/hepatitis/index.htm

Centre for Addiction and Mental Health
http://www.camh.net

College of Family Physicians of Canada
http://www.cfpc.ca

Correctional Service of Canada
http://www.csc-scc.gc.ca

Government of Ontario
www.hepcontario.ca

Health Canada
http://www.hc-sc.gc.ca
http://www.hc-sc.gc.ca/dhp-mps/prodnatur/index-eng.php

Hep C Connection
http://www.hepc-connection.org

Hepatitis C Class Action Settlement Information
http://www.hepc8690.ca/home-e.shtml
http://www.pre86post90settlement.ca

Hepatitis C Council of British Columbia
http://www.bchepcouncil.ca

Hepatitis C Education and Prevention Society
http://www.hepcbc.ca

HIV/HCV Co-Infection Center of Excellence
http://www.mpaetc.org/coe

National Association of Friendship Centres
http://www.nafc-aboriginal.com/PDF/HepCManual.pdf

National Institutes of Health
http://www.nih.gov

Public Health Agency of Canada
http://www.phac-aspc.gc.ca/hepc/
http://www.phac-aspc.gc.ca/sti-its-surv-epi/hepc/hepc_pt-eng.php
http://www.phac-aspc.gc.ca/sti-its-surv-epi/surveillance-eng.php
http://www.phac-aspc.gc.ca/sti-its-surv-epi/pdf/hcv-epi-eng.pdf
http://www.phac-aspc.gc.ca/sti-its-surv-epi/hepc/index-eng.php
http://www.phac-aspc.gc.ca/sti-its-surv-epi/about-eng.php

Service Canada
http://www.servicecanada.gc.ca

Statistics Canada
http://www.statcan.gc.ca

The John Hopkins Infectious Disease Center for Viral Hepatitis
http://www.hopkinsmedicine.org/medicine/viralhep

The National Foundation of Infectious Diseases
http://www.nfid.org/factsheets/hepc.html

United States Department of Veterans Affairs
http://www.hepatitis.va.gov

World Health Organization
http://www.who.int/topics/hepatitis/en/

10.2 Canadian Liver Foundation offices

City	Address	Telephone	Toll Free	Email
Vancouver	Suite 109 828 West 8th Ave Vancouver, BC V5Z 1E2	(604) 707-6430	800-856-7266	emurgo ci@liver.ca
Calgary	Suite 309, 1010-1 Avenue N.E. Calgary, AB T2E 7W7	(403) 276-3390	888-557-5516	dfernets@liver.ca
Ottawa Eastern Ontario Region	Box 101, Kars, ON K0A 2E0	(613) 489-5208	800-563-5483	amartin@liver.ca
Greater Toronto Region	2235 Sheppard Avenue East Suite 1500 Toronto, ON M2J 5B5	(416) 491-3353	800-563-5483	clf@liver.ca
Montreal	Section de Montréal 1000, rue de la Gauchetière Ouest Bureau 2830 Montréal, QC H3B 4W5	(514) 876-4171		foie@fondationcanadiennedufoie.ca
Winnipeg	P.O. Box 1943 Winnipeg, MB R3C 3R2	(204) 831-6231		kbarnes@liver.ca

For more information on hepatitis C or other liver diseases, please call the Canadian Liver Foundation, National Office, 1-800-563-5483 or (416) 491-3353. Website: www.liver.ca

Section 11.0

Glossary of Terms

11.1 Glossary of terms[7,12]

Abdomen: The middle front part of the body between the ribs and legs; it includes the stomach and liver.

Abstinence approach: An approach to help people completely stop using drugs or alcohol.

Acquired immune deficiency syndrome (AIDS): A disease in which a blood-borne human immunodeficiency virus (HIV) weakens the person's immune system.

Acupuncture: A treatment where small needles are stuck into the skin at specific points, usually to help relieve pain.

Acute infection: An illness/infection that comes on quickly and usually does not last very long.

Amino acids: A building block of proteins used by the body.

Antibodies: Proteins that the body makes to help fight infection.

Anti-depressant drugs: Drugs prescribed to treat depression.

Anti-inflammatory drugs: Drugs that help reduce inflammation or swelling.

Antiviral Drugs: Drugs that work against a virus, such as HCV.

Biopsy: Removal of a small sample of tissue to examine for signs of disease.

Chronic: Something that continues over a long period of time.

Chronic illness/infection: An illness that lasts for at least several months, sometimes for several years or a lifetime.

Cirrhosis: Very bad scarring of the liver that affects the function of the liver.

Co-infection: Being infected with more than one virus at a time.

Contaminated: When something contains, or has touched, bacteria or a virus.

Dehydration (dehydrated): Not having enough fluids in the body.

Diagnosis: Determining the presence of a specific disease or infection; this is usually based on evaluating patient symptoms and results from laboratory tests.

Fatigue: Being extremely tired or weary; exhausted.

Fluid retention: When too much fluid collects in the tissues of the body; it often causes swelling.

Genotype: A way of describing small differences that occur in the genetic makeup of the hepatitis C virus.

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[7] *Healthy Living with Hepatitis C*. CLF: http://www.liver.ca

[12] *Hepatitis C Question and Answer Manual* 2000. CLF:http://www.liver.ca

Harm reduction: Techniques that help people change the way they use alcohol or drugs to cause them less harm.

Health care provider(s): The professionals who help people care for their health. They include doctors, nurses, nurse practitioners, pharmacists, counselors, multicultural health promoters, community developers, outreach workers, and social workers.

Hepatitis: Inflammation or swelling of the liver.

Hepatitis A: A liver disease caused by the hepatitis A virus (HAV). HAV is usually spread by ingesting food, water, or other liquids contaminated with the virus; it is also found in the stool of infected people.

Hepatitis B: A liver disease caused by the hepatitis B virus (HBV). HBV is spread through contact with the blood or other body fluids (such as vaginal fluids or semen) of an infected person.

Hepatitis C: A liver disease caused by the hepatitis C virus (HCV). HCV is spread by blood-to-blood contact with an infected person's blood.

Homeopathy: A system in which diseases are treated with greatly diluted medicines that are believed to cause the symptoms of the disease.

Human immunodeficiency virus (HIV): The virus that causes AIDS. It attacks the immune system, making it harder for the body to fight disease.

Immune system: The complex way the body's parts work together to fight disease. The immune system's job is to look for, and get rid of, bacteria and viruses that do not belong in the body.

Immunization: A way of making a person's immune system able to recognize and prevent infection. A person is usually immunized, or vaccinated, using a needle, but sometimes the vaccine can be swallowed.

Inflammation: The body's response to injury or infection that causes pain, redness, heat, and swelling in the area.

Interferon: One of a number of antiviral proteins that modulate immune response.

Jaundice: A yellow discolouration of the skin and eyes as a result of the build-up of bilirubin in the blood.

Lethargy: When a person does not want, or feel able, to do very much.

Liver enzyme tests: Liver enzymes (AST and ALT) are made in the liver cells and they leak out when cells are damaged. These tests measure the amount of liver enzymes in the blood to help discover potential liver damage.

Liver function tests: These tests determine how well the liver is working. They include INR (blood clotting factor), albumin (protein), and bilirubin.

Marijuana: This psychoactive drug, produced from parts of the Cannabis plant, is also called cannabis, weed, ganja, or hashish.

Menstruation: The monthly discharge of blood from the uterus of non-pregnant women.

Monogamous: This is the practice of having sex with only one partner.

Muscle wasting: This is a shrinking or weakening of the muscles that can make a person feel less strong and even appear skinny.

Mutation: The ability of a virus to change its outer coating and to, therefore, not be recognized and attacked by antibodies.

Nausea: This is when a person feels sick to the stomach or needs to vomit.

Probiotics: Non-food items that contain bacteria or yeast that are believed to help the body, particularly with digesting food.

Sterile: Something that has no bacteria, viruses or any other substance that can cause disease.

Stool: This is the waste the body expels through the bowels, commonly known as a bowel movement.

Sexually transmitted infection (STI): This is a disease that is transmitted person-to-person through sex, including vaginal, anal, and oral sex.

Symptoms: These are the body's signs that a person has an illness.

Transplant: This is when a damaged organ – such as a heart, liver, or lung – is replaced with a healthy organ taken from another person's body.

Traumatic (rough) sex: Sex that results in breaking or tearing the body's tissues and puts a person at risk of infection.

Virus: A form of life, too small to see with an ordinary microscope, that causes disease.