2025

PRAXUS HEALTH

AWARENESS & ADVOCACY

Hepatitis B

Newcomer and Immigrant Health



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Acknowledgements

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Praxus Health is a not-for-profit that collaborates with a diverse range of partners to drive meaningful change and improve the health of communities. By connecting diverse sectors, from public to private, we solve complex health problems and empower communities to take control of their health.

At Praxus Health, we act as a catalyst for system change, committed to making a tangible impact. Our collaborative approach unites stakeholders across industries to address the needs of underserved populations, including Indigenous, rural, and remote communities, immigrants, and immunocompromised communities. Our multimodal approach enables us to meaningfully engage, develop, implement, evaluate, and disseminate all the work we do.

CCIS is the largest immigrant and refugee serving agency in the Prairies, serving over 15,000 Newcomers annually. In addition to direct services, CCIS is often called upon to partner with mainstream systems, organizations, and institutions to support their work with Alberta's increasingly diverse population. This includes meaningful engagement with organizations across a number of sectors including academia, public health, criminal justice, education, family violence, and child welfare.
www.ccisab.com

Habitus Collective is a research and evaluation consultancy with a focus on supporting non-profit and public organizations to understand complex social issues, demonstrate impact, and identify strategic and programmatic opportunities to enhance equity. Habitus works with organizations and populations that represent diversity across the intersections of gender, sexuality, age, mental wellness & addiction, culture, racial-ethnic identities, socioeconomics, and immigration status.
www.habituscollective.ca

Introduction

Despite being a preventable and treatable liver infection, hepatitis B (HBV) remains a significant public health concern in Canada, especially among immigrants and newcomers, who are overrepresented in HBV cases nation-wide (up to 70%).[1] In addition to the unique barriers to diagnosis and care that immigrants and newcomers face, research highlights a gap in newcomer and immigrant knowledge about the importance of HBV testing and vaccination.[2]

Additionally, a high proportion of individuals newly arrived in Canada may be susceptible to vaccine preventable diseases because of a lack of effective immunization programs in their country of origin. For example, a study in Canada revealed that only 25% of immigrants at risk for HBV had undergone screening.[3] Ongoing barriers, such as health system navigation challenges, language and cultural barriers, and limited access to timely care, continue to undermine prevention and early diagnosis.

Over the past decade, national and provincial initiatives have identified the same systemic challenges and opportunities for improving hepatitis B care for newcomers and immigrants. Action Hepatitis Canada's latest *Immigrant Health Report* reflects this pattern once again, highlighting continued gaps in equitable access to HBV testing, vaccination, and treatment, while reaffirming the impact of a culturally responsive, well-informed health care system.[4]

Taken together, these repeated findings emphasize a clear message: meaningful progress will require addressing long-standing barriers and investing in approaches that meet immigrant and newcomer communities where they are.



of Canada's Hepatitis B cases occur among immigrants and newcomers [1]



of immigrants in Canada who are at risk for HBV have undergone screening [3]

Key Terms & Definitions

The following key terms and definitions are helpful references for language and acronyms that you will find throughout this document and through your engagement with newcomer-serving agencies. This includes definitions of key population groups and organization types.

Immigrant: The term immigrant is used to broadly capture anyone born outside Canada as a non-Canadian citizen, regardless of the length of time in Canada or their legal status. Of note, a minority of Canadian citizens are born outside Canada and therefore statistics reporting on immigrants versus 'not born in Canada' may differ slightly.

Newcomer or Recent Immigrants: Statistics Canada considers a 'recent immigrant' any individual (non-citizen) born outside Canada within their first 5 years from arrival to Canada. Newcomer can sometimes be used to describe folks within 3 or even 10 years from arrival to Canada, or non-immigrant newcomers to a destination; therefore it is best to confirm the definition being used.

Second-generation Immigrant: Any Canadian-born individual who has one or more parents born outside Canada.

Secondary Migration: Secondary migration refers to migration within Canada.
(Re)Settlement: The process of re-settling in Canada from another country, from the time of arrival until full participation and integration in the local community is achieved, regardless of the timeline attached to that process. So, while someone may not be new to Canada, they may still be new to the provincial or municipal context.

Integration: Integration in the Canadian context is defined as the full and equitable participation in all aspects of civic life - and opportunities to take pride in and express one's cultural and linguistic identity.

Immigration Pathways / Legal Status

Permanent Resident (PR): A permanent resident has permanent status in Canada, which they gained by immigrating to Canada from other countries as opposed to being born in the country. Sponsored immigrants, government assisted refugees, privately sponsored refugees and protected persons all qualify for permanent residence.

- **Economic:** A person who has been selected for their ability to contribute to Canada's economy through their ability to meet labour market needs, to own and manage or to build a business, to make a substantial investment, to create their own employment or to meet specific provincial or territorial labour market needs. Most economic immigrants arrive when they are of working age.

- **Family Class**: A person who is sponsored by a Canadian citizen or permanent resident and were granted permanent resident status based on their relationship either as the spouse, partner, parent, grandparent, child or other relative of this sponsor. The terms 'family class' or 'family reunification' are sometimes used to refer to this category. There are a greater proportion of seniors who are family class as opposed to other categories.

- **Government Assisted Refugee (GAR):** Refugees resettled by the federal government and supported through the government's Resettlement Assistance Program (RAP), typically for 12 months after their arrival in Canada. They gain permanent residency upon arrival to Canada.

- **Privately Sponsored Refugee (PSR):** Refugees who are sponsored by an individual or group who commit to receiving them and providing them with lodging, care, and support, typically up to 12 months. They gain permanent residency upon arrival to Canada.

- **Protected Person:** Someone who is determined to be a Convention refugee or someone in need of protection. They either receive a positive decision on their refugee claim, their appeal, their pre-removal risk assessment or their humanitarian and compassionate application. They do not receive permanent residence immediately after gaining protected person or convention refugee status, but are eligible to apply.

Temporary Resident: A temporary resident can legally enter Canada on a temporary basis as a visitor, worker, student or due to holding a temporary resident permit. This includes international students, international visitors, refugee claimants, CAUET Visa Holders (Ukrainian), Temporary Foreign Workers (TFW), and migrant workers.

- **Refugee Claimant (aka Asylum seeker):** Individuals who come to Canada seeking asylum that make a refugee claim to the Immigration and Refugee Board of Canada, who decide whether or not the claim will result in a person being accepted as refugee to Canada. Refugee claimants are typically accepted when they are not able to return to their place of origin because of a well-founded fear or prosecution. The current wait time for a refugee claimant decision is approximately two years. Until receiving approval, Claimants are not permanent residents and therefore have limited access to social and public services.

- **Temporary Foreign Worker (TFW)**: A person who is a temporary resident and in Canada on a work permit, usually by way of the Temporary Foreign Worker Program or the International Mobility Program. If a TFW's work permit expires, they lose their status. Temporary workers are also referred to as migrant workers. The length of stay is variable based on the type of permit and nature of employee/employer relationship: for example, some permits are tied to an employer and others are 'open', just as some are seasonal and others are longer term. Short-stay migrant workers, such as seasonal workers, may return to the country annually for many years and so, while temporary, may have accumulated long-term days of residence in Canada.

- **International Student:** A person who is a temporary resident and in Canada on a study visa. International students must have a valid status in order to enroll in studies.

- **Canada-Ukraine Authorization for Emergency Travel (CUAET):** Someone who is a temporary resident in Canada for up to three years and is a Ukrainian national or a family member of a Ukrainian national. Under this status, a person may apply for an open work permit, free visitor visa, and study in Canada. Many Ukrainians arrived under the CUAET program (March 2022 - July 2025) however this program is no longer active as a pathway to Canada.

No Status/Lapsed Status: A person can have no status in Canada if: a) Their temporary status has expired and has not been renewed/extended (e.g. visitor visa, student visa, permanent resident status, etc.); b) They have entered Canada without making a refugee claim or applying to have status in Canada.

Key Service Providers and Program

Service Provider Agency (SPO): IRCC-funded non-profit organization with a primary mandate to provide services and programs to help newcomers through the settlement process. May also be referred to as an Immigrant Serving Agency (ISA).

- **Language Instruction for Newcomers (LINC):** A person who has been selected for their ability to contribute to Canada's economy through their ability to meet labour market needs, to own and manage or to build a business, to make a substantial investment, to create their own employment or to meet specific provincial or territorial labour market needs. Most economic immigrants arrive when they are of working age.

Umbrella Agencies (in the settlement sector): IRCC-funded organizations, associations, or collaborations that represent and support the work of immigrant-serving agencies in their respective provinces. These exist across the country.

Local or Zonal Immigration Partnerships (ZIP, LIP): Immigration partnerships are IRCC funded collaboratives that connect SPO's with mainstream organizations/institutions to foster more welcoming and equitable communities. These exist across the country.

Interim Federal Health Program (IFHP): The IFHP provides basic, supplemental, and prescription drug coverage for a limited time after arrival in Canada for those who aren't eligible for provincial or territorial health insurance. Resettled refugees, protected persons, refugee claimants, victims of human trafficking, as well as people detained by the Canada Border Services Agency (CBSA) are eligible cases, no application is needed; immigration status determines eligibility and coverage is activated or cancelled automatically.

1. The Settlement Journey: Key Touchpoints

To orient the reader to the experiences of the target population, this section provides a general overview of the re-settlement process for newcomers to Canada. The purpose is to provide context into the newcomer experience with a focus on key touchpoints and the role of federally-funded settlement services.

Re-settlement

(Re) Settlement is defined as "a process or a continuum of activities that a new immigrant or refugee goes through upon arrival to a new county".[5] Each individual process is impacted by factors such as: country and culture of origin, immigration status, reason for immigrating, age at time of arrival, level of education, level of English, employment experience, family size, and presence of a pre-existing social network. While each settlement journey is unique, it can be conceptually divided into three stages:

- **Adjustment:** The early period after arrival, when an individual is "acclimatizing and getting used to the new culture, language, people, and environment".[6] At this stage, access to information, orientation to Canadian norms, referrals to support, language learning, employment, and the meeting of basic needs are of importance.

- **Adaptation:** A period of "learning and managing the situation without a great deal of help". At this stage, an individual shows greater familiarity with and knowledge of local norms, may demonstrate changes to behavior and lifestyle according to those norms, and is less reliant on formal support.

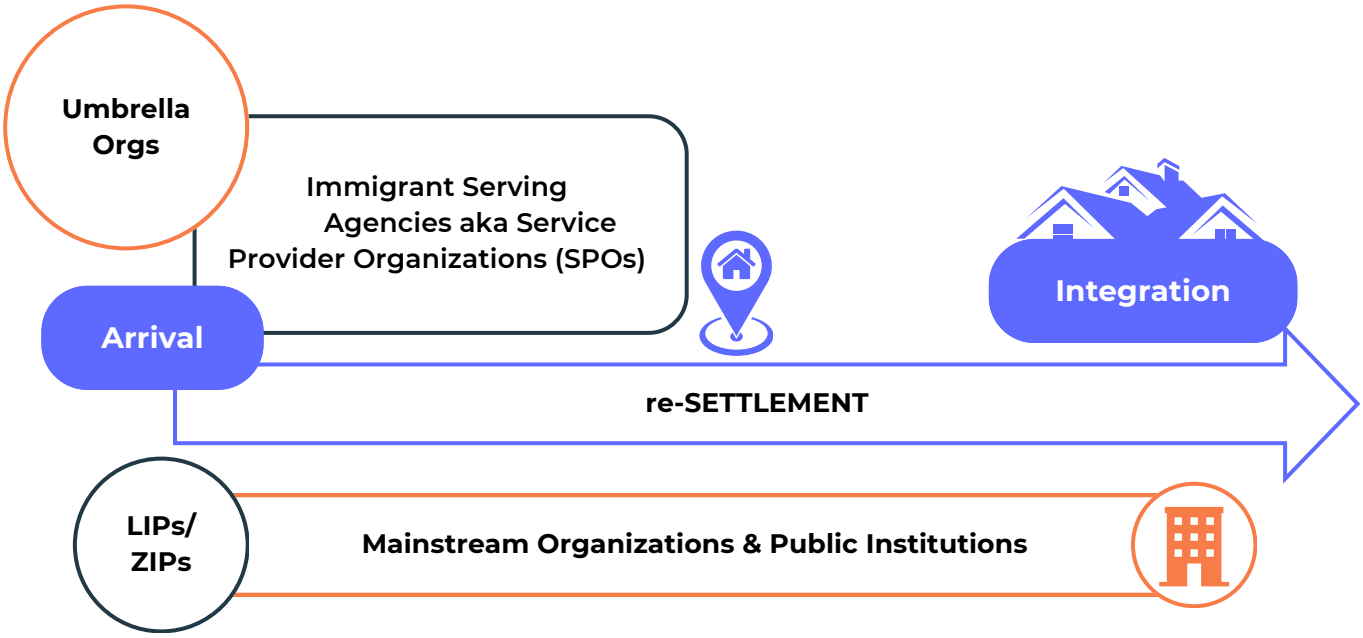
- **Integration:** "Actively participating, getting involved, and contributing as a citizen of a new country".[7] At this stage, an individual has an equitable opportunity to contribute to local society and culture while at the same time maintaining ties to traditional practices.

The role of social services organizations in supporting newcomer integration

The requirement for specialized support programs and services for newcomers can also be understood along the adaptation-adjustment-integration continuum described in the previous section. Most settlement services are focused on the first 3-5 years from arrival. These services focus on adjustment and adaptation by preparing the individual with information and skills to succeed locally through the provision of, for example, employment services and language programs. The integration phase, in theory, requires less individual support or fewer specialized services and greater attention to supporting the broader community to foster cross-cultural relationships and ensure inclusion and equity.

Figure 1, below, illustrates at what phases of resettlement different types of organizations might be touchpoints for newcomers. Definitions can be found in the glossary.

Figure 1: Re-settlement service continuum



Service Provider Agencies (SPOs): service scope

SPO's are a key access point for many newcomers to Canada. These are usually large, IRCC-funded organizations with a primary mandate to support newcomer resettlement. These organizations focus on the early phases of settlement by helping prepare newcomers with the information, knowledge, and skills they need to succeed in the local community.

However, health services and health-related outcomes are not included in the IRCC Settlement Program logic model, which is the framework for all IRCC-funded settlement services. This means that often, settlement outcomes and public health outcomes, are not necessarily in line (see below).

Health-related support by SPOs would be generally limited to information, navigation, and in some cases partnerships. Health information and health system orientation may be provided through various types of programs including airport reception services, language classes, client case management, in-school settlement services, refugee-specific services, childcare services, and orientation/information sessions. However, direct coordination with medical services is not typically provided by except when serving GARs or other newcomers arriving with urgent or complex medical needs.

IRCC SETTLEMENT OUTCOMES

Language

Newcomers improve official language skills

Employment

Newcomers acquire knowledge, skills, and connections to prepare for and participate in the Canadian labour market

Community

Newcomers participate in and are connected to communities and support systems

Services

Newcomers are able to access services that meet their settlement needs

PUBLIC HEALTH OUTCOMES

Health Living & Prevention

Promote healthy behaviors and implement prevention strategies to reduce disease burden

Health Equity & Well-Being

Reduce health disparities and enhance overall well-being through equitable access to care

Strengthen Public Health Systems

Build capacity and infrastructure to improve health services and system responsiveness

Emergency Preparedness

Ensure effective planning and response to public health emergencies to protect communities

Immigrant-serving agencies (ISAs) or Service Provider Agencies (SPOs) (cont'd)

Not all newcomers are eligible for all types of IRCC-funded settlement programs:

- **Permanent residents** (PR) generally have access to federally-funded services to support language learning, employment readiness, basic information and orientation, and creating community connections.

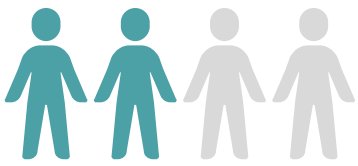
- Across the country there are select SPO's that are Resettlement Assistance Program agreement holders, meaning they are IRCC-funded to support all **government-assisted refugees (GAR)** upon arrival, which often includes temporary accommodations. GARs have access to the same settlement services as all PRs along with some dedicated supports during the first year of arrival (Resettlement Assistance Program) .

- **Privately sponsored refugees** are typically supported by their sponsors so do not receive the Resettlement Assistance Program (RAP) that is available to GARs but still qualify for other SPO services. and temporary residents do not qualify for many IRCC-funded services, however there are more and more often programs at SPO's to support these groups.

- **Temporary residents** do not have access to the same federal support as PR's, though there are other federal (ESDC) or provincially-funded programs arising to support them.

About half of immigrants will access an SPO

Some may not require it, others may not qualify for services, and others may not know about the services available or choose not to utilize them. this is a key access point to many groups of newcomers but not all.



Mainstream & public institutions

Mainstream services and institutions are important sources of connection for newcomers. For example, many will interact with housing systems, municipal services, employers, and/or education systems early in their arrival. Public Libraries, recreation centres, parks, and public transit may be highly utilized by immigrants. Libraries often have newcomers specific services and/or conversation groups and most major cities have IRCC-funded in-school settlement services that are provided by an SPO.

Local/Zonal Immigration Partnerships (LIPs/ZIPs) and Umbrella Organizations

LIPs and ZIPs are key actors in the resettlement system but are are not involved in direct service delivery. Umbrella organizations are provincial associations made up of a large network of SPO's whereas LIPs/ZIPs typically are made up of SPO and mainstream institutional partners aimed at creating more welcoming communities. Thus, they can be good entry points to the larger system of local SPO's and other organizations whose work intersects with newcomers (such as school boards and health services).

Ethnocultural and Faith Institutions

Ethnocultural communities, community associations, and faith communities can be important connection points for newcomers. Such groups may be important sources of social connection and information, and may offer various forms of formal or informal support to community members. The organizations are connections for newcomers as well non-newcomers who share an ethnocultural or faith identity.



Newcomers build connections and receive support through a broad ecosystem that extends beyond formal settlement services.

2. Considerations for Newcomer Settlement and Access to Healthcare

This section provides a brief overview of the various, intersectional barriers or challenges newcomers may face when accessing health services in Canada. Although not HBV-specific, these challenges are likely to be reflected in the HBV care pathway and provide context to healthcare inequities among immigrants in general.

Newcomer healthcare access and outcomes are affected by several factors, including premigration experiences, the resettlement process, and the accessibility and responsiveness of health care providers and systems.[6] Migration itself is considered a social determinant of health given its potential to affect the physical, mental and emotional health of newcomers and immigrants.

Premigration Experiences

The experiences of newcomers with preventative healthcare are rooted in their home-country systems as well as social and cultural norms (see Appendix A for summary profiles of three endemic countries). In China and the Philippines, more robust public-health programs coexist with lingering gaps in rural access and health system and provider confidence. In Nigeria, preventative care depends heavily on community health workers and informal or traditional providers, where cultural beliefs and faith networks shape decisions about vaccination and treatment. Pre-migration experiences can also influence system familiarity, access to vaccinations (vaccine schedules, interrupted vaccine schedules, vaccine records etc.), and overall prioritization of health services.

Cultural Perspectives

Country of origin, culture, and/or faith can also shape someone's familiarity with the local system, perspectives on prevention and personal agency, engagement with Western and traditional medicine, understandings of the body and healing, perspectives toward vaccination and treatment and trust of the system. All of which can shape if, how, and when immigrants engage with the healthcare system or comply with doctor recommendations or treatment These variations reveal that HBV prevention and treatment is both a medical and a cultural endeavor.

Language Barriers

Language barriers have been consistently identified as a primary challenge faced by newcomers when accessing the Canadian healthcare system,[7] leading to unmet needs, poor disease management, and fewer preventative services used.[8] Language barriers impact healthcare access at several, continuous points of a newcomer's health journey.

Not only does a communication gap impact the ability to make appointments or access information, it also acts as a barrier for newcomers to advocate for themselves in a new system. Often, this leads to feelings of not having control over one's own healthcare and unclear communication between patients and providers disrupts the ability for newcomers to form therapeutic relationships with a provider, wherein safe and respectful care can take place. Official language proficiency is deemed an essential determinant of health.

Other Access Barriers

Newcomers also point to lack of transportation, childcare, and supportive care as barriers. It is important to recognize that individuals' predisposed circumstances impact their capacity to access and navigate the healthcare system. Many groups of immigrants also face financial difficulty in their early years in Canada which is a significant intersecting factor in their access to services and treatment.

Provider Readiness

A significant barrier to healthcare access for newcomers in Canada is the lack of cultural competency among healthcare providers. Many healthcare professionals may not fully understand the cultural beliefs, practices, and health-seeking behaviors of diverse newcomer populations. Cultural misunderstandings, biases, and insensitivity can lead to misdiagnosis, inadequate treatment, and distrust among newcomers.

Additionally, newcomers may turn to cultural or traditional medicinal practices due to their familiarity, cultural endorsement, and affordability. However, a significant concern arises when these practices are not documented in their medical records, potentially leading to a lack of insight into their compatibility with mainstream healthcare interventions.

Efforts to enhance cultural competency among healthcare providers through training, cultural awareness programs, community health ambassadors, and diverse representation in healthcare settings are essential to address these barriers and ensure equitable healthcare access for newcomers in Canada.

System Readiness

System-level barriers exacerbate healthcare access challenges for newcomers in Canada. Complex bureaucratic processes, including navigating eligibility criteria, obtaining health insurance, and accessing interpreters pose significant hurdles.

The unavailability of health care services, such as lack of appointments, and long wait times is consistently identified as a major barrier by newcomers.[9] Systemic barriers interact with individual barriers, wherein waiting for appointments, referrals, at medical clinics, etc., are made more challenging. Research points to information and service delivery as disconnected and not sensitive to the experiences of newcomers. For racialized newcomers, these structural barriers often intersect with institutional and systemic racism to foster distrust and disengagement from the healthcare system.

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Key Inequities Along the Hepatitis B Care Pathway

The contextual factors, challenges, and barriers outlined above all influence inequities in access and outcomes for some groups of newcomers and immigrants. Key inequities that should be noted when accessing the hepatitis B care pathway include:

- Lower rates of vaccination[11]
- Lower rates of access to a family doctor for newcomers[12]
- Lower rates of private healthcare coverage for immigrants[13]
- Lower rates of treatment adherence[14]

3. Immigration Status, Health, and Drug Coverage Eligibility

Immigration status plays a central role in shaping access to health services and prescription drug coverage in Canada, often reinforcing existing inequities for immigrants and newcomers. Differences in legal status, documentation requirements, and waiting periods can influence who is able to access timely care, the extent of their coverage, and the financial burden they may face when seeking treatment. These differences can be especially pronounced for those with temporary or precarious status or those who are uninsured.

This section outlines key inequities as they relate to the HBV care pathway as well as a detailed overview of how immigration status affects eligibility for health and drug coverage in Alberta, British Columbia, and Ontario.



Public Health Coverage & Number of Arrivals in 2024 by Immigration Status

This visual illustrates the proportion of newcomer arrivals to Canada from each of the main immigration pathways, based on 2024 arrival data (refer to Glossary for additional information about pathways).

As illustrated, non-permanent residents - namely temporary work permit holders and international students - make up a larger share of arrivals than to permanent residents. Among PR's, economic immigrants are the largest group. This visual also indicates the type of health coverage offered to each group (see Legend &. Refer to Appendix B for additional detail about provincila coverage and immigration status)

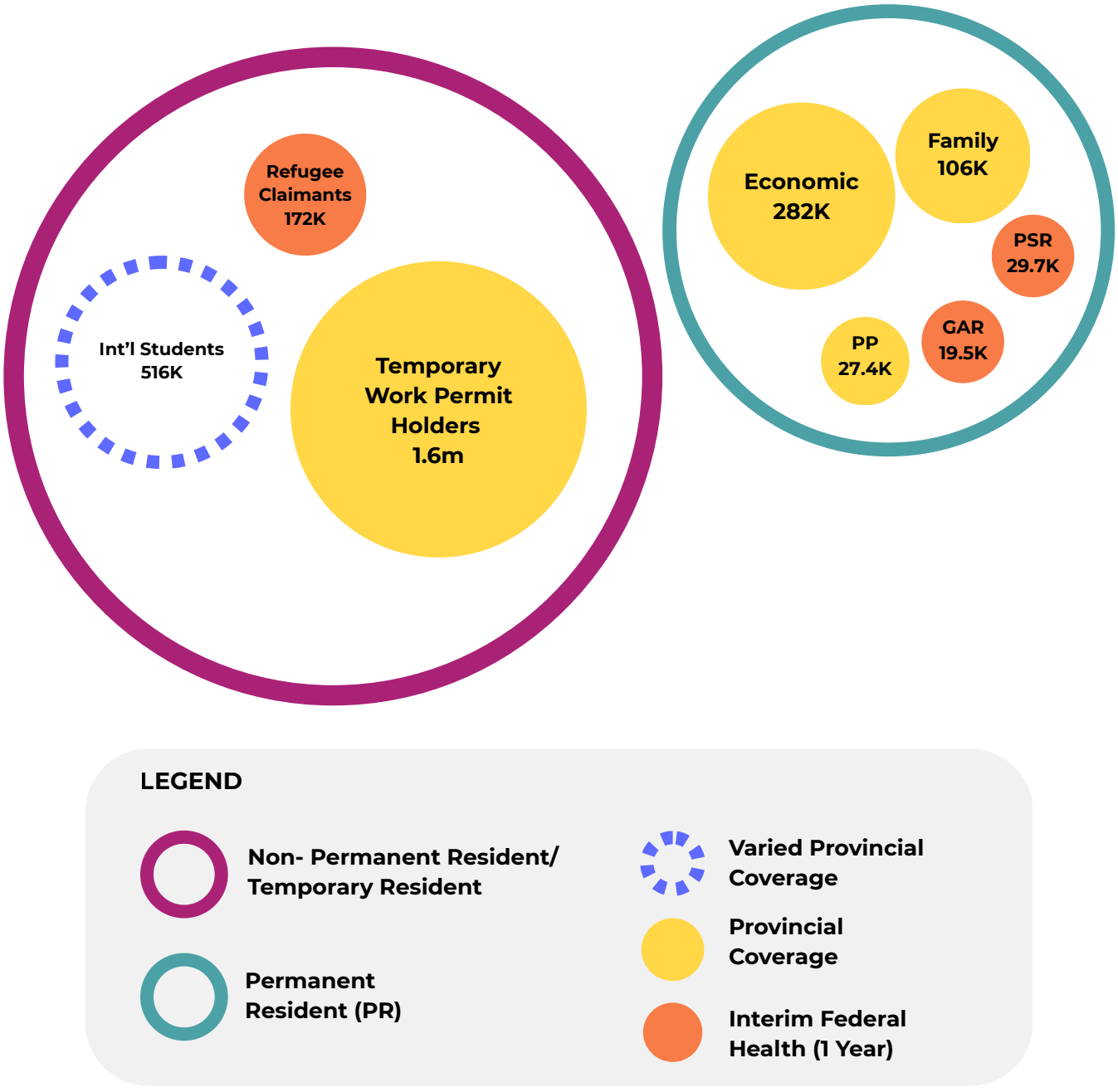


Figure 4: Prescription Drug Coverage across Newcomer Populations

Figure 4. a) Alberta

Alberta

In 2013, Alberta had the **highest rate** of publicly-funded chronic hepatitis B medication use.[15] The province has a range of programs and coverage policies that influence how residents access medications, testing, and treatment:

- Alberta Adult Health Benefit program covers health benefits for Albertans in low-income households who are pregnant or have high ongoing prescription drug needs.[16]
- All public drug insurance plans limit access to antiviral treatment in patients with chronic hepatitis B based on viral characteristics, fibrosis stage and/or specialist approval.[17]
- Alberta Essential Medicine Program provides 12 months of coverage of up to $1,000 for a defined list of prescription medications.[18]
- Some community clinics offer initial testing and help with linkage to care.[19]

Permanent Residents

- Newcomers typically rely on private insurance (through an employer or purchased personally).
- PRs are immediately eligible for the Alberta Health Care Insurance Plan (AHCIP) on the date of their arrival
- Public pharmacare programs do not extend to all PRs. Coverage is generally limited to:
  - Low-income seniors.
  - Individuals on Assured Income for the Severely Handicapped (AISH).

Residents in long-term care facilities

Refugees

- Covered by **IFHP**, which includes HBV testing and treatment.
- IFHP covers prescriptions if provided by an approved provider.

Costs Without Coverage

- Entecavir & TDF: $100–$300 per month.
- Lamivudine (generic): ~$1 per day.

Figure 4. b) British Columbia

British Columbia

In 2013, British Columbia had the third highest rate of publicly-funded chronic hepatitis B medication use.[20] The province has a range of programs and coverage policies that influence how residents access medications, testing, and treatment:

- Fair PharmaCare has 12 plans that help B.C. residents pay for prescription medications, medical devices and supplies, and pharmacy services.
- One person can be covered by several plans. For most plans, you must be enrolled in the Medical Services Plan of B.C. (MSP).

Permanent Residents

- PRs are eligible for Medical Services Plan (MSP) immediately (the 3-month wait was removed in 2022).
- Newcomers can be eligible for Fair PharmaCare, which is income-tested and provides partial or full coverage based on household income and family size. However, it is not automatic. Need to do taxes to be eligible.

Refugees

- Covered by IFHP for drug costs if prescribed by an approved provider.
- Specialized refugee health services support coverage navigation, (rg Bridge Refugee Clinic in Vancouver)

Costs Without Coverage

- Entecavir/TDF: $100–$300 per month (comparable to AB/ON).
- Lamivudine: ~$1/day.
- Fair PharmaCare may cover 70–100% of costs, depending on income and family size.

Figure 4. c) Ontario

Ontario

In 2013, Ontario had the second highest rate of publicly-funded chronic hepatitis B medication use.[21] The province has a range of programs and coverage policies that influence how residents access medications, testing, and treatment:

- Public drug coverage under the Ontario Drug Benefit (ODB) applies only to:
  - Seniors (65+)
  - Ontario Works (OW) or Ontario Disability Support Program (ODSP) recipients
  - Participants in the Trillium Drug Program, which is income-based and offsets high out-of-pocket drug costs.
  - 24 years of age or younger and not covered by a private insurance plan
  - Receiving professional home and community care services

- Currently all Chronic Hep B (CHB) treatments are available through the Exceptional Access Program (EAP). This process takes approx. six weeks and isn't ideal for patients needing treatment quickly.
- The Trillium Drug Program is available for households with high drug expenses relative to income.

Permanent Residents

- Newcomers typically rely on private insurance (through an employer or purchased personally).
- PRs are eligible for Ontario Health Insurance Plan (OHIP) immediately, there is no longer a waiting period.

Refugees

- Covered by IFHP before OHIP eligibility begins.
- Refugees can access HBV antivirals if prescribed by an IFHP-enrolled provider.

Costs Without Coverage

- Entecavir & TDF: $100–$300 per month (similar to AB).
- Lamivudine: ~$1/day.

4. Past and Current Initiatives in the Viral Hepatitis Space

Hepatitis B continues to pose a significant public health challenge in Canada, with low awareness, cultural stigma, and fragmented linkage-to-care undermining progress toward elimination goals. Data from the Canadian Health Measures Survey indicate that only 49% of individuals with a current HBV infection are aware of their status.[22] These findings highlight persistent inequities and the critical need for culturally responsive education, integrated care strategies, and systematic screening for high-risk populations. This section provides an overview of past and current Hepatitis B and C initiatives, models, and research in the newcomer space undertaken across Canada, with a focus on Alberta, British Columbia, and Ontario. Our focus was expanded beyond hepatitis B due to the limited availability of HBV-specific initiatives, with lessons drawn from successfully implemented HCV programs.

National Initiatives

Action Hepatitis Canada



Photo credit: Action Hepatitis Canada

At the national level, Action Hepatitis Canada (AHC) plays a pivotal role in advancing HBV prevention, care, and awareness. Through engagement with government, policy actors, civil society, and community-based organizations, AHC supports initiatives aimed at building public knowledge, expanding healthcare professional capacity, and promoting culturally informed interventions.

In 2024, AHC released a comprehensive report outlining the opportunities to improve HBV and HCV prevention, diagnosis, and care for immigrants and newcomers to Canada, providing actionable guidance for policymakers and public health stakeholders.[23] Several of the recommendations outlined by AHC are echoed throughout this report, such as:

- **Establish policies** to improve competency of healthcare professionals;
- **Provide interpretation services** free of charge at all medical appointments;
- **Offer free, universal, voluntary STBBI testing** for the purpose of linking people to care and treatment.

The prevalence of HBV among non–Canadian-born individuals is approximately ten times higher than among Canadian-born populations.[23]

Community-Based Efforts

Community-based initiatives illustrate the importance of culturally tailored health promotion for improving hepatitis knowledge and uptake of preventative. Noteworthy examples include:

S.U.C.C.E.S.S. “Let’s Talk About B” campaign

In British Columbia, the “Let’s Talk About B” campaign (2014), delivered in partnership with the BC Ministry of Health, reached more than 30,000 individuals across Chinese, Korean, Filipino, and South Asian communities. The program provided first-language workshops to educate participants about HBV transmission, testing, and treatment options.

As a result of the workshops, over half of all participants engaged in follow-up preventive and care-related actions, demonstrating the impact of linguistically and culturally grounded interventions.[24]

S.U.C.C.E.S.S highlighted three key recommendations for sustaining this progress:



Photo credit: S.U.C.C.E.S.S. Hepatitis B Public Education Program

1. **Ongoing public education, awareness building, and outreach** particularly through trusted community channels;
2. **Culturally tailored and targeted programming** that reflects the diversity within newcomer populations; and
3. **Facilitating access to HBV screening,** including through partnerships with primary care and public health.

CATIE "Hepatitis C Ethnocultural Education, Outreach and Social Marketing" Program

In Ontario, CATIE's Hepatitis C Ethnocultural Education, Outreach and Social Marketing Program (2010-2015)[25] focused on HCV awareness among Chinese, Pakistani, Punjabi, and Filipino immigrant communities. Although the program was HCV-specific, its strategies (first-language workshops, targeted outreach, and partnerships with community organizations) offer valuable lessons for HBV education.



Photo credit: CATIE Hepatitis C information for immigrants and newcomers: English and Urdu

The evaluation of this program found that:

1. **Ongoing public education, awareness building, and outreach** particularly through trusted community channels;
2. **Culturally tailored and targeted programming** that reflects the diversity within newcomer populations; and
3. **Facilitating access to HBV screening,** including through partnerships with primary care and public health.
4. **Culturally tailored and targeted programming** that reflects the diversity within newcomer populations; and
5. **Facilitating access to HBV screening,** including through partnerships with primary care and public health.

Together, these initiatives serve as critical reference points for the design and adaptation of HBV interventions in the newcomer space. Importantly, both initiatives received provincial and/or federal funding, demonstrating that such programs/ outreach models require substantial financial support. This is particularly salient as settlement organizations often lack direct health funding, yet play a central role in reaching and engaging high-risk newcomer populations.

Linkage-to-Care Models

Despite the high burden of chronic hepatitis B (CHBV), many individuals are not linked to care or receive treatment, including those who meet the criteria for treatment under the Canadian Association for the Study of Liver (CASL) guidelines.[26]

Research from British Columbia shows that only 52% of people diagnosed with CHBV and cirrhosis were receiving treatment;[27] in Ontario, a study found that only 4% of individuals continued HBV treatment after initiation;[28] and in Alberta, a cohort study of 4 years revealed that only 12.9% of patients had seen a specialist during the 4 year time period after initial diagnosis.[29]

Across Canada, several emerging models illustrate effective strategies for linking high-risk populations to care and improving continuity of treatment:

- **The Mosaic Refugee Health Clinic in Calgary** implemented a shared-care model that combines screening, registry-based follow-up, specialist mentorship, and patient navigation for chronic hepatitis B newcomer patients. The model yielded strong monitoring and specialist-linkage outcomes, demonstrating that with the right infrastructure, including primary-care engagement, specialist mentorship, registry tracking and culturally-responsive support, effective and comprehensive care can be realized.[30]

- **The CUPS Liver Clinic team in Calgary** provides screening and treatment for Hepatitis C and consultation through an infectious disease specialist for Hepatitis B and cirrhosis management. The Liver Clinic's services are provided both on-site at CUPS and through outreach in the community by an interdisciplinary team including a pharmacist, nurses, and infectious disease specialists. For Hepatitis B, CUPS' role is primarily around consultation and then connection to a family doctor, who can manage continuity of care.

- **In Toronto, the Viral Hepatitis Care Network (VIRCAN)** is an integrated community program developed by hepatologists from the Toronto Centre for Liver Disease at the University Health Network (UHN) to address gaps in the care of viral hepatitis throughout Toronto. The program provides education, research, screening, diagnosis, and linkage to care. Although not specific to newcomer and immigrant populations, VIRCAN holds partnerships with newcomer-serving agencies, such as St. Stephen's Community House.

Together, these initiatives illustrate promising approaches that can be leveraged and adapted as models for improving linkage to care and treatment continuity for people living with chronic hepatitis B across Canada. Sustained investment and dedicated resourcing for programs like these are essential to ensure their impact can be expanded and sustained nationally.

5. Provider Perspectives on the Current Landscape and Sticking Points

To better understand current perspectives and key "sticking points" in the viral hepatitis space, specifically HBV, we conducted 10 interviews with subject matter experts, specialists, family physicians, pharmacists, and representatives from community organizations. Key themes that emerged include:

Patient Engagement and Education

- There is a strong need for multilingual and culturally appropriate educational materials to improve community awareness and normalize prevention, testing, and long-term care.
- Many patients are unfamiliar with Hepatitis B, often confusing it with HIV or believing it is curable. Providers must emphasize that it is a chronic but manageable condition.
- Cultural differences in healthcare engagement are significant. While North America emphasizes preventative care, many newcomers are accustomed to episodic, symptom-driven care. Once the rationale for prevention and early testing is clearly explained, most patients become receptive to screening and treatment.
- Pharmacists play a key role in patient education, destigmatization, medication adherence, and ongoing support while patients await treatment. They spend more face-to-face time with patients than most physicians and are highly accessible.
- Ultimately, there is a large gap in public education and early awareness campaigns focused on Hepatitis B prevention and early identification.

> How do providers communicate a viral hepatitis diagnosis to patients?

> How can we leverage initiatives like Shopper's Primary Care Clinics?

> Are there opportunities to leverage past initiatives like S.U.C.C.E.S.S " Let's Talk About B?

System Navigation and Access to Treatment

Access to treatment and drug reimbursement in Canada is highly fragmented - a patchwork system where patients frequently fall through the cracks.

- Programs such as Fair Pharmacare require individuals to have filed taxes and completed financial verification, which can delay eligibility and access to coverage.

- Many family doctors lack knowledge of how to apply for special authority drug coverage, which allows patients to access funded treatment. As a result, they frequently refer to specialists.

Providers may prescribe treatments only to discover that patients lack sufficient insurance or reimbursement, causing further delays or discontinuation of care.

- Some patients must pay out-of-pocket with no coverage for drugs like Entecavir. After moving to Canada, they may be unable to continue treatment and face the choice to return home or discontinue therapy.

Long wait times to see a specialist raise ethical concerns as patients are left unsupported with a new diagnosis.

- In Alberta, hepatologists are the primary prescribers for Hepatitis B treatment, which is a major limiting factor due to specialist shortages and long wait times. In other provinces, infectious disease specialists or family physicians may have prescribing authority.

- Even within Alberta, differences exist, for example, Calgary relies on hepatologists, whereas Edmonton often involves infectious disease specialists.

- If more people are screened, the system must have the capacity to ensure timely treatment access.



Clinical Practice Supports and Education

Population-based screening (asymptomatic, public health process) should be clearly distinguished from symptom-based screening (clinical process). The majority of providers are testing patients once symptoms appear.

- In the absence of data linkages (e.g., immigration status and provincial health data) when onboarding new patients, advocate for the pre-selection/ screening for viral hepatitis

Providers need to be better informed on high endemic countries. They would like to see educational resources, such as FAQs, consensus statements, evidence syntheses, and guidelines for screening, diagnosing, and treating hepatitis B.

- Explore opportunities to publish in journals such as Canadian Family Physician (CFP) to increase reach, credibility, and adoption.

Consider opportunities to learn from HCV - family physicians have low comfort levels prescribing HCV treatment, and anticipate that HBV will face similar if not greater challenges as testing and treatment are more complex.

Given the shortage of family doctors, pharmacists often serve as the first point of contact for HBV related questions. If a patient does not have a family doctor, pharmacists typically help connect them to one to initiate treatment access.



Summary of Recommendations Across the Care Pathway

- ✓ Patient awareness & de-stigmatizing education
- ✓ Fund Newcomer SPOs to support health literacy & navigation
- ✓ Interpretation services offered
- ✓ Fund non-newcomer SPO's & Medical prof. working in health space to increase cultural responsiveness, readiness

Prevention

Advocate for HBV infant birth dose in alignment with WHO recommendation and publicly-funded "catch-up" vaccinations for unvaccinated adults.

⚠ Educate family physicians on high endemic countries in the absence of immigration and health data linkages

HCPs should review immunization status of persons new to Canada to avoid gaps in vaccination & those travelling to endemic countries

Screening

Establish national screening guidelines for hepatitis B beyond prenatal testing.

Offer free, universal, voluntary screening for newcomers from high-endemic countries

⚠ Need for clearer guidance on population-level screening vs. clinical diagnosis

Diagnosis

Educate providers on best practices for communicating results to patients! ⚠

⚠ Consider the role of allied healthcare professionals in supporting patients while waiting for treatment and how to prepare (drug coverage)

Treatment

Advocate for broad public coverage to treatment options - public coverage for HCV treatment.

Improve provider knowledge of drug coverage by immigration status

How can we support individuals currently on treatment to stick to their treatment plans?

6. Policy & Awareness Recommendations: Advancing Equitable Hepatitis B Care for Newcomers in Canada

The following recommendations are informed by our learnings and insights from community and health system partners, as well as guidance from organizations such as Action Hepatitis Canada and S.U.C.C.E.S.S. BC. They highlight key opportunities to advance equitable hepatitis B care through advocacy and awareness initiatives.

1 Improve Access to Prevention and Screening

- Adopt WHO recommendations by advocating for universal birth-dose HBV vaccination and comprehensive catch-up programs for unvaccinated individuals.
- Establish national screening guidelines for hepatitis B beyond prenatal testing, including offer free, universal, voluntary screening for newcomers from high-endemic countries.

2 Ensure Affordable and Equitable Access to Drug and Health Coverage

- Like HCV advocate to expand public and private drug coverage to include all approved HBV antiviral therapies, regardless of immigration status or insurance eligibility.
- Establish national standards to ensure affordable or no-cost access to treatment for uninsured and underinsured individuals, including those covered under the Interim Federal Health Program (IFHP) and provincial drug plans.

3 Expand Access to Care

- Fund virtual consultation networks to reduce wait times and connect community clinicians to specialists.
- Enable primary-care providers and nurse practitioners to manage stable HBV cases through a shared-care model with specialist support.

4 Support Knowledge Mobilization and De-Stigmatizing Community Education

- Strengthen community-led, culturally-informed communication and education, addressing stigma and misinformation.
- Improve health system capacity to deliver accessible, equitable HBV information and support, recognizing that health-seeking practices are impacted by previous health system experiences.

5 Create a More Culturally Responsive Health System by Supporting Evidence-Based Approaches

- Mandate cultural safety and anti-stigma training for providers involved in viral hepatitis and infectious disease care.
- Invest in community-based navigation models by partnering with immigrant-serving and settlement organizations to embed cultural brokers and health navigators within care teams, supporting clients through diagnosis, referral, follow-up, and communication.

6 Strengthen Provider Knowledge and Confidence in HBV Prevention, Testing, and Management

- Enhance provider knowledge of viral hepatitis risks and appropriate testing, including high-endemic regions, at-risk populations, and the distinction between population-based screening and symptom-based testing.
- Equip providers with practical tools for patient care and preventive measures, such as effective communication about risk and results, and assessing/updating vaccinations for newly arrived persons.

7 Strengthen Data Systems and Accountability for Equitable Hepatitis Care

- Establish a national Hepatitis B Equity Strategy with measurable targets for timely and culturally safe care, supported by the integration of immigration and health data systems to inform evidence-based policies, identify inequities, and improve outcomes for diverse populations.
- Provide sustained public health funding to support integrated referral and tracking systems across public health, primary care, and specialist services, and to enable disaggregated data collection by immigration status and ethnicity

Appendix A:

Cultural and Social Understanding of Preventative Health From Key High-Endemic Countries

Introduction

Globally, patterns of preventative healthcare are deeply influenced by social, cultural, and structural factors unique to each country and community. For newcomers arriving in Canada, these health beliefs and system experiences profoundly shape engagement with preventative services, including hepatitis B screening, vaccination, and treatment.

Many immigrants and refugees come from regions where HBV is endemic–particularly parts of Asia and Sub-Saharan Africa–and where health systems have faced historic barriers to health service delivery. In such contexts, preventative care may be limited by cost, distance, health infrastructure, and social factors such as stigma, mistrust, and cultural beliefs around illness and medicine. Understanding these influences is critical to designing culturally responsive and effective HBV awareness, screening, and care programs in Canada.

The following profiles of China, Nigeria, and the Philippines provide an overview of the social and cultural dimensions of preventative healthcare in major countries of origin for newcomers to Canada. The profiles will highlight the following:

- The organization of health systems;
- Cultural beliefs and practices that shape prevention and care-seeking behaviours;
- Barriers and facilitators to service use; and
- Community-based approaches that can inform HBV engagement in Canada.

By understanding the preventative health contexts from which newcomers arrive, Canadian health providers and policymakers can advocate for and design HBV programs that are not only evidence-based but also culturally grounded.

a) China

China's health system is a hybrid public-private structure, reformed extensively since 2009, featuring universal insurance (for urban and rural residents), layered hospital networks, and an expanding primary care focus. The "Triple-Medical Linkage" reform deepens coordination among health insurance, pharmaceutical, and care delivery sectors, seeking efficiency, drug access, and value-based payments.[30]

There is now greater integration of public health (preventive care) and primary care, coordinated through comprehensive policies, though disparities persist. For example, utilization of preventive healthcare services in China is notably lower among rural, unmarried, and low-income populations, largely due to awareness deficits, transportation challenges, financial barriers, and limited local healthcare capacity.[31]

Additionally, primary care faces significant challenges, including workforce shortages, misaligned incentive structures, and mixed evidence supporting Traditional Chinese Medicine in prevention. Also worth noting is that persistent stigma around mental health and substance use, coupled with rapid urbanization, further strain the continuity and effectiveness of care.[32]

Cultural Beliefs and Practices Influencing Prevention

Preventive health behaviors in China are shaped by close family and social networks—especially among older adults—alongside the country's deep-rooted respect for Traditional Chinese Medicine, but regional differences in health literacy, trust, and cultural beliefs continue to affect the adoption of preventive care and participation in screening programs:[33,34]

- F**amily and social networks** are important drivers of preventive care engagement, with married or cohabiting older adults more likely to seek health checks than those living alone.

- **Traditional Chinese Medicine (TCM)** is deeply valued, shaping dietary, lifestyle and preventive practices; it is promoted alongside biomedical services for both urban and rural populations.

- **Health literacy and trust in government** guidelines are growing, but rural-urban and income gaps moderate uptake. TCM may, in some communities, compete with "Western" approaches; health beliefs about fate can also impact screening compliance.

Key Preventive Health Services

China's health authorities have developed a broad range of preventive services aimed at improving health outcomes through early detection, immunization, and chronic disease management as part of its Healthy China 2030 plan. The 2030 strategy is grounded in four pillars: health priority, reform and innovation, scientific development (balancing prevention and cure, Western and Chinese medicine), and justice/equity, with special attention to rural and vulnerable groups.[35] Other preventative services worth noting include:

- **Immunization:** China provides free and mandatory vaccinations for children under the National Immunization Program, including hepatitis B at birth, measles, polio, diphtheria, and influenza vaccines. These immunizations have significantly reduced childhood infectious disease burden nationwide. In 2024, it was announced that HPV immunization will be rolled out for females of eligible age and included in the National Immunization Program.

- **Annual Health Checkups:** Adults aged 60 and above are encouraged to undergo free annual health screenings that cover hypertension, diabetes, cancers, and other chronic illnesses. This service is being expanded to include middle-aged individuals, particularly in rural and low-income populations, to promote early disease detection and control.

- **Maternal and Child Health:** Programs focus on improving antenatal care, skilled birth attendance, postnatal visits, breastfeeding promotion, and vaccination to reduce maternal and infant mortality rates. Health education campaigns target families and communities to support maternal-child health.

- **Infectious Disease Control:** The Chinese Center for Disease Control and Prevention (China CDC) leads surveillance, vaccination, and rapid response for communicable diseases such as tuberculosis, influenza, and emerging infectious threats.

Cultural Considerations for Engagement

- Leverage family and peer support networks for preventive campaigns, with family-based health check initiatives.
- Integrate trusted TCM practitioners and community elders; provide culturally relevant messaging, especially for NCDs and chronic disease prevention.
- Expand digital health outreach, prioritizing digital literacy for older adults and rural communities.

b) Nigeria

Nigeria operates a decentralized three-tier health system in which responsibilities are shared across federal, state, and local governments. Primary Health Care (PHC) centers—run at the local level—are intended to be the backbone of preventive and community-based care. State governments manage general hospitals that provide secondary-level services, while the federal government oversees policy, regulation, vaccine management, and health workforce training. There are both public and private healthcare sectors in the country, with private healthcare being the most accessed and utilized by Nigerians[36] due to various factors such as travel time, education, age, sex, level of education of household head, household size, and perceived quality of care.[37]

In practice, the system is underfunded and unevenly distributed. Public services are available but often unreliable, pushing many households toward private providers, who are widely perceived as more responsive and better equipped. This preference has reinforced inequities, as most care is paid for directly by households. Historically, 70% of Nigerians paid out-of-pocket for health services, and only 3% of working-age adults (15–49 years) had insurance coverage before recent reforms.[38]

Despite reforms to increase health insurance availability and care access, challenges remain:

- Government health spending remains below Sub-Saharan African averages.
- Distribution of facilities and providers is skewed toward urban centers like Lagos and Abuja.
- The system remains curative, with preventive care chronically underprioritized.

These structural issues set the stage for understanding how preventive healthcare is shaped not only by health infrastructure, but also by cultural norms, economic realities, and trust in community-based sources of care.

Cultural Beliefs and Practices Influencing Preventive Health

Preventive health behaviors in Nigeria are deeply influenced by cultural and social dynamics. In many communities, particularly rural ones, limited access to formal services leads people to rely on traditional and informal providers. Key cultural drivers include:

- **Religious influence:** Both Islam (predominant in the north) and Christianity (more common in the south) play central roles in shaping attitudes toward family planning, vaccination, and health-seeking behavior. Endorsement from religious leaders can strengthen uptake of services, while skepticism can contribute to resistance.[39]

- **Traditional medicine:** Herbal remedies such as agbo are widely used for conditions like malaria prevention. Traditional birth attendants and herbalists remain trusted providers, especially in rural settings.

- **Family and gender roles:** Health decisions often require family consensus, with men or elders exercising authority over women's and children's care. Fertility norms valuing large families influence attitudes toward contraception.

- **Mistrust of government-led programs:** Historical controversies (e.g., polio vaccine boycotts in northern Nigeria, COVID-19 vaccine hesitancy) have created lingering doubts about preventive services.

- **Health-seeking behavior:** Many people delay engagement with the formal system until illness becomes severe, reflecting both cost barriers and cultural tendencies to endure symptoms rather than act preventively.

Key Preventive Health Services

Nigeria's preventive health efforts are concentrated in a few priority areas:

- **Immunization:** Nigeria's Expanded Program on Immunization (EPI), launched in 1979, aims to reduce childhood morbidity and mortality from vaccine preventable diseases through routine and supplementary immunization activities.

- **Maternal and child health:** Despite significant national efforts, global partnerships, and strategic frameworks, health outcomes for mothers and children in Nigeria remain unsatisfactory and unevenly distributed across the country.

- **Non-communicable disease (NCD) prevention:** While Nigeria has historically prioritized communicable diseases, the burden of non-communicable diseases (NCDs) is growing and increasingly recognized in policy. Households with NCDs in the country face high out-of-pocket costs and significant financial burden.

- **Reproductive health and family planning:** Family planning (FP) and reproductive health are a prevention priority; according to the FP2030 commitments, Nigeria has targets to train community health workers to support education and deliver a range of contraceptives.

- **School- and community-based programs:** Schools offer an important for preventative health education, screening, and referrals. Community-based outreach offers critical support for underserved and rural populations for preventative services.

Cultural Considerations for Engagement

For preventive healthcare efforts to succeed, they must be designed with cultural and social realities in mind. Effective strategies include:

- Partnering with faith and traditional leaders to counter misinformation and promote preventive behaviors.
- Framing health messages around family protection and community well-being, rather than individual responsibility.
- Recognizing and respecting traditional remedies, while promoting safe integration with biomedical care.
- Expanding mobile and community-based outreach, particularly for rural populations who rarely visit clinics.
- Strengthening the role of midwives and CHEWs, ensuring they have resources and support to serve as trusted local advocates

c) Philippines

The Philippine healthcare system is a hybrid public–private model with overlapping but distinct roles. Public hospitals and clinics focus primarily on preventive and primary care, acting as hubs for health education and outreach, while private hospitals concentrate on specialized services such as cardiovascular care, oncology, pulmonology, and orthopedics. Coordination between these two sectors occurs through Health Management Organizations (HMOs), although integration is uneven.

The passage of the Universal Health Care (UHC) Law in 2019 represented a major step toward equity, extending PhilHealth coverage to all Filipinos, including Overseas Filipino Workers (OFWs). However, gaps remain in awareness, affordability, and effective access.[40] Geographic disparities are stark: urban centers enjoy consistent preventive services and advanced facilities, while rural and island provinces often lack equipment, personnel, and transport infrastructure. Furthermore, a large share of public health investment continues to come from external donors, raising concerns about sustainability.

For preventive health to be more effective, there must be a dual focus on strengthening public sector capacity and increasing trust and uptake among the population.

Cultural Beliefs and Practices Influencing Prevention

Health-seeking behavior in the Philippines is deeply shaped by cultural norms and lived experiences:

- **Familism and collectivism**: Decisions about health are rarely individual. Family consensus and community well-being are prioritized, making family-centered messaging particularly persuasive.

- **Religious influence**: As a predominantly Catholic nation, church teachings shape public opinion on contraception, reproductive health, and even vaccination. Faith-based missions fill critical gaps in rural areas, particularly in preventive outreach.

- **Reliance on alternative healing:** Traditional practices such as hilot (massage therapy), albularyo (herbal/spiritual healers), and herbal remedies (e.g., lagundi, sambong) remain central to preventive care. These practices are tied to cultural identity and longstanding mistrust of formal health systems.[41]

- **Trust dynamics:** Healthcare professionals are not usually the primary sources of health information, especially in underserved communities. Research shows that one-third of individuals do not seek out healthcare professionals, even when ill.[42]

Key Preventive Health Services

The Department of Health (DOH) has developed a suite of preventive programs, though implementation and reach vary:

- **Immunization:** Under the 2011 Mandatory Infants and Children Health Immunization Act, all children under the age of 5 are to be given basic immunization against vaccine-preventable diseases. Hepatitis B vaccination at birth is required.

- **Maternal and child health (MCH):** Programs cover prenatal and postnatal care, nutrition, and breastfeeding. However, use is strongly stratified by income and maternal education, reinforcing inequities.[43]

- **Non-communicable disease (NCD) prevention:** Screening for hypertension, diabetes, and certain cancers is available, though services remain concentrated in urban centers. Government implemented the Sin Tax on alcohol, tobacco, sugar-sweetened beverages, and vapors products to reduce consumption.[44]

- **Family planning:** Contraceptives and counseling services are widely available on paper, but political and religious resistance continues to limit reach and acceptance.

- **School-based health programs:** Partnership between the Department of Health and the Department of Education launch an initiative to address the growing concerns around child malnutrition and health issues in schools through early detection, intervention, and education.[45]

Cultural Considerations for Engagement

- **Engage faith leaders and community influences** to endorse services and reduce resistance; bottom-up approaches.

- **Use family-centered messaging,** framing prevention as safeguarding loved ones rather than only individual responsibility.

- **Respect and integrate traditional practices** where possible, offering biomedical care alongside folk remedies rather than in opposition.

- **Prioritize community-based delivery models**, especially mobile and Barangay-level outreach, to reduce reliance on clinic-based access.

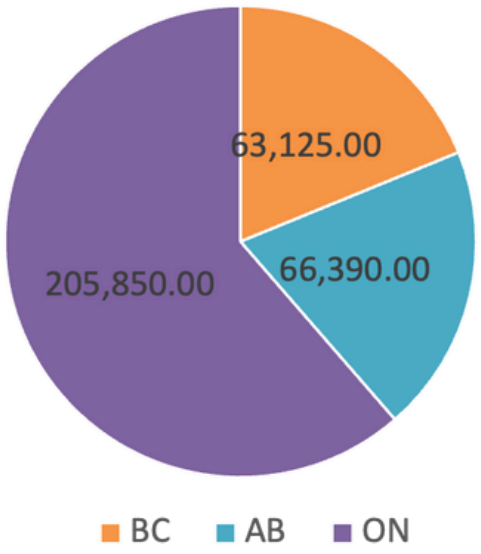
Appendix B:

Immigration Flows & Demographics: British Colombia, Alberta, and Ontario

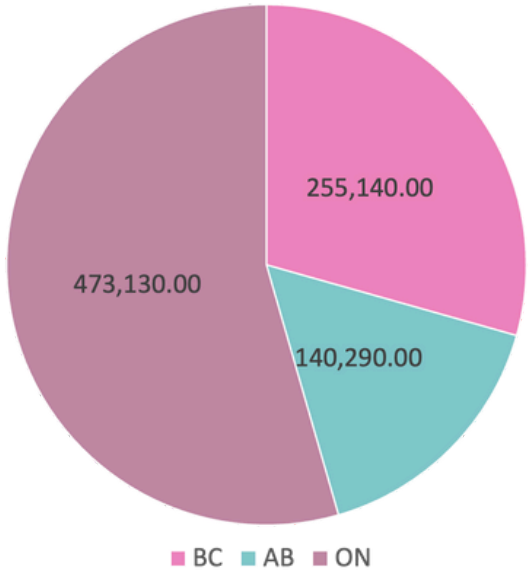
a) Number of Arrivals to Permanent and Temporary Arrivals to British Colombia, Alberta, and Ontario in 2024

The following visuals illustrate the proportion of new arrivals to the target provinces in 2024, under each the temporary and permanent resident streams. Notably, there are more than double the number of people who arrived as temporary as compared to permanent residents in 2024 (note: some permanent residents already reside and are transitioning from temporary status). Although temporary residents may not remain in Canada, many will return over time and others will transition to permanent status according to the pathways available to them. The proportion of transitions varies year-on-year according to the pathways available; longitudinal research shows an average of about 20%.
In both the PR and temporary groups, more than half of arrivals settled in Ontario; a comparable number of PR's arrived in Alberta and BC, however BC saw a larger share of temporary residents than Alberta. It should be noted that there were reductions in all categories on non-PR's in 2025.

PR Arrivals to BC, AB, ON (N=335, 365)

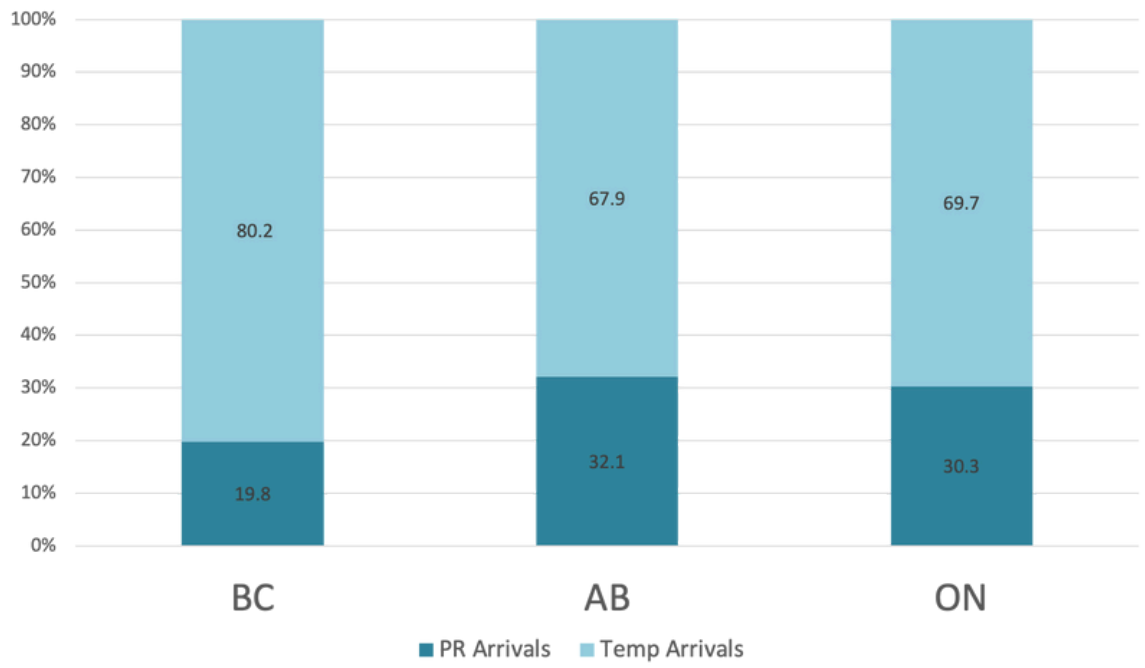


2024 Temporary Arrivals to BC, AB & ON in (N=868, 560)



In BC, 80.2% of 2024 arrivals were temporary whereas in Alberta and Ontario, about two thirds of newcomers were temporary.

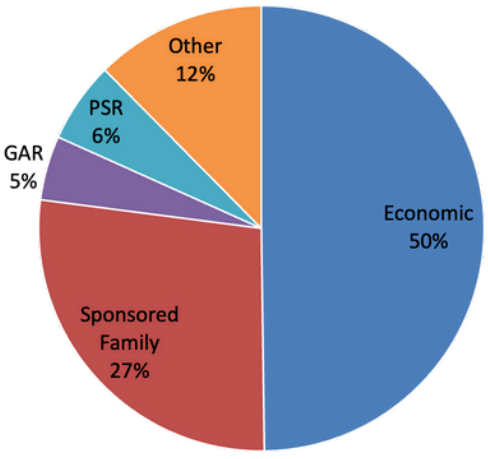
Proportion Permanent Residents (PR) v Temporary Resident Arrivals 2024, by province



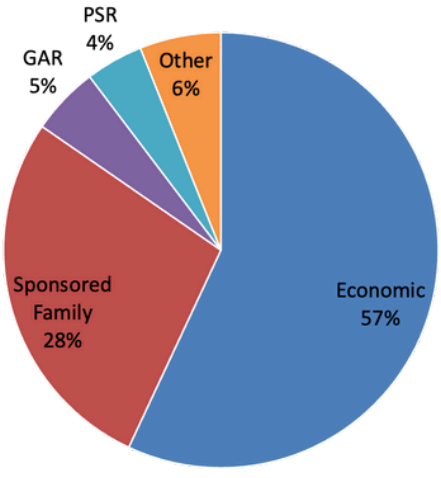
b) Permanent Resident (PR) Arrivals 2024 By Immigration Category

The following visuals illustrate the proportion of permanent resident arrivals, by immigration category, to each province in 2024. Across each province, about ¼ of PR arrivals are sponsored and 5% are GAR. As compared to BC and ON, AB has the highest proportion of PSR's (and the lowest proportion of economic immigrants.

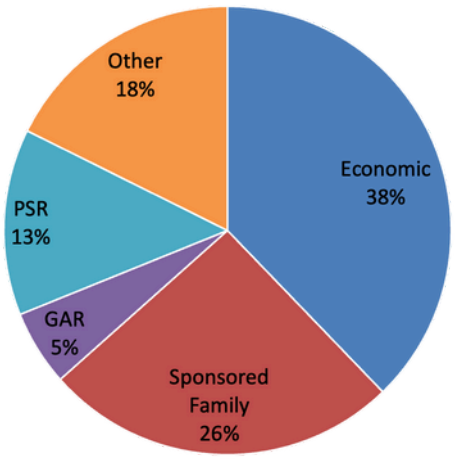
Ontario



British Columbia



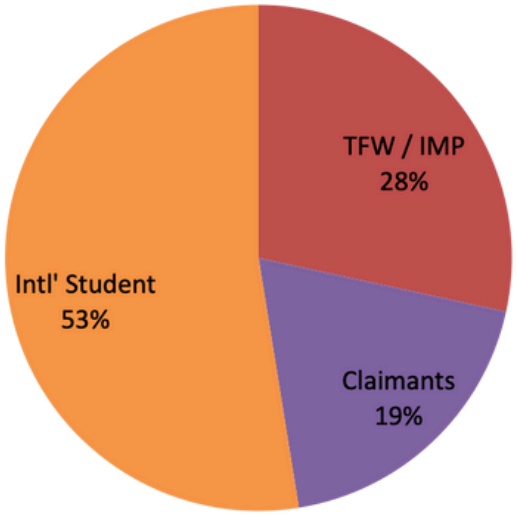
Alberta



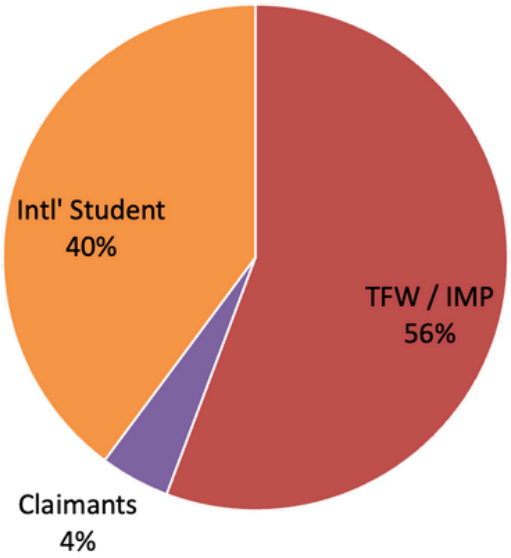
c) Temporary Resident Arrivals 2024 By Immigration Category

The following visuals illustrate the proportion of temporary resident arrivals, by immigration category, to each province in 2024. In both BC and AB, more than half of arrivals were temporary workers, where in Alberta, migrant workers accounted for 65% of arrivals. Ontario had the highest proportion of Internal Students (53%), followed by BC (40%). Ontario also has the highest proportion of refugee claimants (19%) as compared to AB and BC.

Ontario



British Columbia



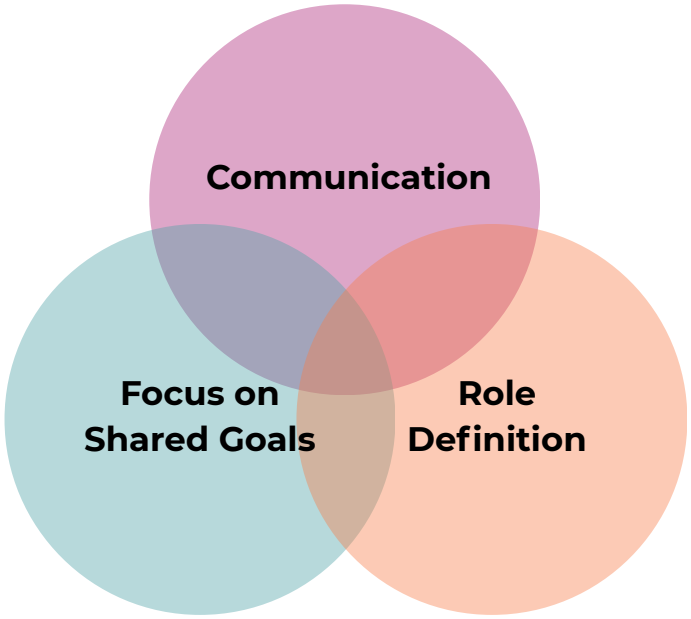
Appendix C:

Principles of Effective Partnership

These principles of partnership were developed through a review of literature and validated through an independent evaluation of CCIS' partnerships. The learnings are summarized here to aid in considering how to develop SPO or other community partnerships that are respectful, not transactional.

At the core of any partnership is the act of collaboration toward a shared goal, leading to mutual benefit and more impact than could be achieved alone.

Foundation of a Successful Partnership



A strong and successful partnership will be built on the following guiding principles:

1. Shared risk and shared resourcing, leveraging each partner's strengths and capabilities.
2. Grounded in trust and a commitment to building strong relationships among partners.
3. Complementary roles and contributions where partners can work together to meet one another's needs and/or the needs of the community.
4. Expectations are clearly outlined and explained to partners.

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