

Culturally appropriate sexual health interventions for STBBI and HIV among racialised immigrant communities in Western nations: A scoping review protocol

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BMJ Open Culturally appropriate sexual health interventions for STBBI and HIV among racialised immigrant communities in Western nations: a scoping review protocol

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ABSTRACT

Introduction Racialised immigrant communities in Western nations face disproportionate risks for sexually transmitted and blood-borne infections (STBBIs) due to systemic barriers, including racism, stigma and limited access to culturally appropriate care. While the need is well-established, a comprehensive synthesis of effective, culturally responsive sexual health interventions is lacking. This scoping review aims to map the available evidence on sexual health intervention needs and protective factors of racialised immigrants, and to identify and describe existing culturally appropriate programmes in Western nations.

Methods and analysis The review will follow the JBI methodology for scoping reviews and be reported as per the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidelines. A systematic search strategy, developed and peer-reviewed by a health sciences librarian, will be executed in MEDLINE, Embase, CINAHL and Scopus, alongside grey literature sources, with no date limit. Two independent reviewers will screen titles/abstracts and full texts against the inclusion criteria. Data will be extracted using a standardised tool, analysed via narrative synthesis and framed by a socio-ecological model to categorise interventions across individual, interpersonal, community and structural levels.

Ethics and dissemination Ethical approval is not required for this review. Findings will be disseminated through a peer-reviewed publication, academic presentations and tailored summaries for community organisations and policy-makers to ensure practical application.

Review registration Open Science Framework (<https://osf.io/9qah6>).

INTRODUCTION

The prevalence of sexually transmitted and blood-borne infections (STBBI), including HIV, among racialised immigrants and sexual

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ A significant methodological strength of our review is the implementation of a systematic, librarian-designed search process with screening guidance, conducted in accordance with JBI methodology and the PRISMA-ScR reporting standards, thereby ensuring the inclusion of relevant studies as well as methodological transparency and reproducibility.
- ⇒ Utilising a screening tool, a uniform data extraction sheet and a dual, independent reviewer process for screening and data extraction minimises bias and enhances the reliability of findings.
- ⇒ Involving community partners and the use of the socio-ecological model will result in rigorous findings with a critical impact on sexual health service delivery.
- ⇒ A potential limitation is the heterogeneity of included studies, which may challenge the direct comparison of interventions; however, the scoping review methodology is ideally suited to map this diverse evidence landscape.
- ⇒ By focusing on Western nations, some important interventions and sexual health practices from other contexts may be missed, potentially introducing publication bias, which we intend to mitigate with the support from an experienced librarian. We will incorporate relevant studies outside the Western context into the background and discussion and include variations in how cultural appropriateness is defined across studies, an undertaking that may be daunting.

minorities in Western nations is on the rise due to systemic and structural barriers, including racism, stigma, poverty, acculturation, medical mistrust and discrimination.^{1–3} In Canada, the Public Health Agency of Canada (PHAC) highlights a concerning



trend in the HIV positivity rates among immigrants. In 2012, 534 immigrants tested positive for HIV, which increased dramatically to 2119 in 2022, a trend that may reflect both rising incidence and changes in testing and reporting patterns.⁴ Also, in the United Kingdom (UK), healthcare data sharing policies prevent many immigrants from accessing sexual health services for fear of immigration enforcement.⁵ Again, studies have identified a lack of culturally sensitive sexual health interventions targeted at prevention, testing and treatment services and inadequate community engagement in HIV intervention development and sexual health education initiatives as drivers of sexually transmitted infections (STIs), including HIV, among this population.^{6 7} Other immigration-related challenges, mental health stresses and language barriers contribute to limited access to healthcare and support services, which further predispose many immigrants, refugees and ethnic minority groups to diverse STIs and HIV.^{8 9} As such, minimising the barriers to and exploring culturally appropriate strategies to enhance sexual health is paramount among this population.

The term immigrants, as used in this study, refers to diverse international migrants, including refugees, asylum seekers, temporary workers, long-term and recent arrivals and individuals with and without legal immigration status living in Western nations.¹⁰ Between 2016 and 2021, the population of racialised immigrants has grown exponentially in Canada, primarily from Asia, Africa and the Middle East, with many of these immigrants settling in cities and provinces based on provincial governments' resettlement programmes.^{11–13} This demographic change resulting from immigration policy change has also resulted in an increased risk for STIs, including HIV, among these immigrants.^{9 14} Similar trends are reported in the UK, as data show that 55% of newly diagnosed positive HIV cases and 55% of people accessing HIV care in England in 2016 were migrants.⁵

Immigration is a known determinant of STBBI and STIs, and it is a significant predictor of HIV infection among many immigrants.^{5 15–17} Limited sexual health knowledge, language barriers, sexual exploitation, experimentation, the assumption that HIV is not a problem in Canada, and other challenges in accessing sexual health and HIV care services are also known to be significant risk factors for HIV and other STBBI among immigrants.^{18 19} Injection drug use is also an increasing concern for immigrants, which predisposes them to HIV infection.^{16 19} While some newcomers have prior HIV infection before immigration, others contract the infection after arriving.¹⁵ There are reports of immigrants contracting HIV after immigrating to Canada,²⁰ especially immigrants who come from countries where HIV is endemic, who may be ill-informed to think Canada is an HIV-free country and therefore may not be inclined to engage in safer sex practices.^{18 19} However, research demonstrates that robust social support networks, including connections with family, friends and social groups, play a crucial role in safeguarding immigrants

from STBBI and high-risk sexual behaviours.²¹ Hence, these relationships are essentially protective factors against HIV and other STBBI.

In addition to behavioural exposure risks, temporary residents seeking employment-related sponsorship to obtain permanent residency status report sexual exploitation in exchange for permanent residence sponsorship.²² These temporary residents are likely to perceive themselves as having limited legal protection against diverse forms of exploitation and are unlikely to report these experiences.^{23 24}

Immigration to Western countries provides an opportunity for racialised immigrants to engage in sexual practices, such as anal sex, that may be prohibited in their countries of origin, and they may not have the requisite knowledge on how to protect themselves from HIV infection. Racialised immigrants, who are sexual minorities, including gay, bisexual, transgender and men who have sex with men (gbMSMs), experience a heightened level of vulnerability due to the convergence of racism, xenophobia, homophobia and transphobia.^{15 25 26} They may also experience multilayer stigma arising from their ethnic community regarding sexuality and also from their host society regarding race/immigration status.^{18 16}

Furthermore, disaggregated HIV data by ethnicity may be lacking, which limits relevant and appropriate programming.²⁶ Since the data collection practices and policies are unlikely to change, community-driven interventions must be innovated immediately to protect the racialised immigrant community. Again, racialised immigrants face several determinants of health that impede their access to sexual health services. These barriers include stigma, language proficiency issues, discrimination and a deficiency in culturally sensitive and safe sexual health services.^{15 16 18 19} Racialised immigrant communities may lack awareness of available STIs and HIV prevention programmes, such as PrEP and PEP, and may not have the sufficient knowledge to navigate the sexual health landscape in their host countries.^{18 19} Again, racialised immigrants, including those who are sexual minority groups, may struggle to access sexual health services, which may be impacted by geography, programme availability and their population in the region. Besides, the experiences of racialised immigrants who are gay men or transgender women are uniquely shaped by the convergence of racism, xenophobia, homophobia and transphobia.

Saskatchewan, a province in Canada, has 14.4% of the population self-identifying as racialised immigrants and also has an HIV prevalence of 19.3 cases per 100 000 population. However, it lacks service organisations for persons living with HIV or that address the needs of racialised immigrant groups, leaving a critical gap in support for this vulnerable population. Individuals at risk of or living with HIV in such a province face challenges that impact their care, including limited access to peer support services from relatable individuals.¹⁶ These challenges influence their ability to access care and achieve optimal clinical outcomes. The inadequate HIV support

programming in these regions limits the involvement of people living with or at risk of HIV infection in HIV-related work.^{16 26}

HIV and STBBI evoke a strong stigma among racialised immigrants. Innovative ways to talk about STBBI need to be developed and should be nested within broader sexual health discourses. For instance, Dela Cruz and colleagues acknowledged the impact of stigma and the fear of social isolation as a compounding factor compromising access to existing services for HIV among African Caribbean Black Canadians.²⁷ Moreover, racialised immigrants face multi-layered stigma from their ethnic community regarding sexuality, and stigma from the host society regarding race/immigration status. As such, sexual health programming that is relevant to racialised immigrants must be culturally safe, community-driven, addressing sexual health literacy, STBBI prevention, testing and linkage to care for this community, and addressing marginalisation that impacts access to care.^{16 18 19 28} A systematic review of immigrant women's sexual and reproductive health determinants reported that many racialised immigrant women face diverse barriers to accessing sexual health services, which include long wait times, quick hospital discharge, difficulties finding female family doctors, language barriers, challenges navigating the healthcare system, racism and others.¹⁶

Therefore, to create and advance meaningful and culturally appropriate sexual health interventions for racialised immigrants, the sexual health and STI literature related to this population needs to be explored to identify comprehensive and functional interventions and programmes from which we can learn. As such, we propose undertaking a scoping review to examine culturally appropriate sexual health interventions or programming that can enhance racialised immigrants' access to sexual healthcare, including STI testing, treatment, prevention services, linkage to care and protective factors.

Our preliminary search for existing systematic and literature reviews on the sexual health needs and interventions for racialised immigrants found a few results, the majority of which are dated,^{7 29} non-immigrant gender-focused reviews on men who have sex with men in the United States of America,^{30 31} focused only on couples,³² or exploring HIV education as an intervention approach among older adults.³³ The only recent scoping review on this topic is also limited to Francophone African, Caribbean and Black people in Canada and is also focused on barriers to accessing HIV care.⁸

Given the limited focus of these previous reviews and the lack of recent scoping review studies on the topic, our proposed scoping review fills a critical gap by providing a synthesis on recent comprehensive data and descriptions of interventions that address HIV and STBBI needs of racialised immigrants and identity strategies to implement culturally appropriate sexual health interventions that target STI and HIV prevention, testing, treatment and linkage to care for this population.

Review question(s)

Our scoping review will be guided by the following research questions.

1. What are the sexual health intervention needs for racialised immigrants in Western nations?
2. What is known about culturally appropriate sexual health interventions for racialised immigrants in Western nations?
3. What protective factors (eg, social support, religious community or resilience) are identified in the literature that can be leveraged in interventions?

Inclusion criteria

Participants

The scoping review will consider studies that examine racialised immigrants' sexual health needs, protective factors and the interventions that can fulfil those needs.

Concept

Our proposed scoping review will consider studies that explore sexual health interventions, programming and educational strategies for preventing and managing HIV and other STBBI among racialised immigrant populations. We will focus our attention on interventions that are community-driven (eg, developed by racialised immigrant communities) and culturally appropriate (materials available in multiple languages or that use cultural metaphors) to meet the sexual health needs of racialised immigrants.^{7 29} Community-driven programmes are community-based interventions led by lay people and/or community-based organisations in the community to enhance the sexual health of community members (see⁷ for examples). Also, culturally appropriate healthcare programmes or interventions are those that recognise and accept cultural diversity and differences among care users.³⁴ Broadly, we will consider sexual health programmes and STBBI prevention interventions that are sensitive to the cultural differences of service users. Such programmes are safe and culturally responsive to the sexual health needs of migrants and ethnic minorities, empowering them to harness their protective factors.

Context

Our review will include studies that explore the sexual health needs and programming among the identified population in community settings across high-income Western nations, including Canada, Australia, New Zealand, the United Kingdom and the United States.

Types of sources

Our scoping review will consider quantitative, qualitative and mixed-method study designs for inclusion. In addition, we will consider grey literature, such as research reports, theses and dissertations, for inclusion in our scoping review.

METHODS AND ANALYSIS

Scoping review framework

Our proposed scoping review will observe the JBI methodology for scoping reviews³⁵ and other recommendations by Levac *et al*,³⁶ O'Brien *et al*,³⁷ and Pollock *et al*.³⁸ We will report our findings in line with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR).³⁹ The review protocol observes the PRISMA-P guidelines⁴⁰ and has been registered with the Open Science Framework (<https://osf.io/9qah6>).

Search strategy

The search strategy aims to locate both published and unpublished primary studies and reports. An initial limited search of MEDLINE (Ovid) and CINAHL (EBSCO) was undertaken in August 2025 to identify articles on the topic. The text words contained in the titles and abstracts of relevant articles were identified using WordFreq, a word frequency tool in Systematic Review Accelerator (Institute for Evidence-Based Healthcare and Bond University), and the index terms used to describe the articles were used by a health sciences librarian (EL) to develop a full search strategy for MEDLINE (Ovid) (see <https://www.doi.org/10.17605/OSF.IO/D3FXU>), which was peer-reviewed by a second health sciences librarian using Peer Review of Electronic Search Strategies (PRESS).^{41 41} The search strategy, including all identified keywords and index terms, will be adapted for each included information source. We will screen the reference lists of articles included in the review for additional papers.

For articles published in other languages, we will utilise Google Translate for title/abstract screening and DeepL (<https://www.deepl.com/en/translator>) for full-text screening and data extraction as a cost-effective solution. We acknowledge that with the use of this technology, the potential for translation error abounds. We will consider seeking help from bilingual colleagues for key papers as needed. No publication date limitation will be imposed during the database search to help retrieve all relevant studies. However, existing reviews, editorials and commentaries will be excluded. Nonetheless, we will screen reviews for additional sources of studies.

The databases to be searched will include MEDLINE (Ovid), CINAHL (EBSCO), Embase (Ovid), and Scopus (Elsevier). Sources of unpublished studies and grey literature to be searched by EL include ProQuest Dissertations and Theses, WHO International Clinical Trials Registry Platform and ClinicalTrials.gov. Database search for the scoping review will commence on 1 October 2025.

Study selection

Following the search, all identified records will be collated and uploaded into Covidence (Veritas Health Innovation, Melbourne, Australia), and duplicates will be removed. Following a pilot test, two independent reviewers (AK and AAb) will screen titles and abstracts to determine whether

they meet the review's inclusion criteria. Potentially relevant papers will be retrieved in full. The two independent reviewers will assess the full text of selected citations in detail against the inclusion criteria. Reasons for excluding full-text papers that do not meet the inclusion criteria will be recorded and reported in the scoping review. Any disagreements arising between the reviewers at each stage of the selection process will be resolved through discussion or with a third reviewer (GM). The results of the search will be reported in full in the final scoping review and presented in a PRISMA flow diagram following the guidelines established by Page *et al*.⁴²

Data extraction

Two independent reviewers (AK and AAb) will extract data from papers included in the scoping review using a data extraction tool developed for this review (see Appendix A). The data extracted will include specific details including the authors, the year of publication, the country the study was conducted in, study objectives/questions, a summary of the methodology (ie, study design, participants, sample size, data collection tools used, etc.), key findings (types of interventions/programming), conclusions, and gaps/limitations relevant to the review question. We will also extract information on country of origin, immigration status, sexual orientation, gender identity, description of the intervention and why it was deemed 'culturally appropriate' or 'community-driven', the level of the SEM that the intervention primarily targets, and the reported protective factors. This data extraction tool will be modified and revised as necessary during data extraction from each included paper. Modifications will be detailed in the full scoping review, and any disagreements between the reviewers will be resolved through consensus or with a third reviewer.

Collating, summarising and reporting of results

Extracted data will be analysed using basic descriptive statistics and thematic analysis, and the results will be presented narratively. We will use the socio-ecological theoretical framework to guide the analysis of the extracted data. For instance, extracted data on barriers and interventions will be coded and categorised into intrapersonal (knowledge, attitudes and beliefs), interpersonal (family, peers and sexual networks), community/organisational (cultural norms, community organisations and service provision), and structural/policy (laws, policies on health data sharing and immigration status) level barriers, and the protective factors across these levels. This will provide a powerful, structured framework for presenting your results. This approach will help us to identify the factors that determine racialised immigrants' knowledge of and access to sexual health services. Also, the included study characteristics will be summarised using tables, charts and graphs. Identified STBBI programming and interventions relevant to our study objectives will be presented thematically, describing them and examining their relative importance concerning the target population.

Patient and public involvement

The research team for this study included people with lived experiences of STBBI and community partners. Their inputs and suggestions shaped the protocol objectives and research questions. Furthermore, these members will work with the research assistants to extract and organise data from included studies for analysis. Their input and feedback will further inform how the review findings are disseminated, as well as which intervention programmes could be extended and modified for racialised immigrant communities.

DISCUSSION

We hope that the review will provide a robust evidence base for guiding culturally appropriate and community-driven sexual health interventions for racialised immigrant communities in Western nations. By synthesising existing programmes and strategies, the review will offer a typology of intervention models, detailing their core components, target populations and implementation approaches. This evidence will be critical for service providers, public health units and community organisations who might be able to adapt effective interventions to local contexts. To ensure a focused and meaningful synthesis, we anticipate the information about cultural adaptation strategies is expected to emerge, such as interventions that incorporate multilingual resources, culturally safe practices and materials tailored to diverse cultural norms. Second, we believe that evidence for community-driven models, which emphasise participatory approaches and peer-led programmes will be unearthed. Such models will foster trust, reduce stigma and empower communities by involving individuals with lived experience in programme design and delivery.

Third, we believe that the review will likely identify structural and policy barriers that impede access to sexual health services and how interventions seek to address them. These may include healthcare access limitations and data-sharing practices that discourage service utilisation. Protective factors, such as social support networks, religious communities and resilience strategies will become explicit. Additionally, findings may underscore intersectionality and vulnerability of immigrants, revealing how overlapping stigmas related to race, immigration status, sexuality and gender identity shape experiences for subgroups such as gay, bisexual and transgender immigrants.

We believe that beyond informing academic discourse, the review findings have practical implications. Community-based organisations and settlement agencies can adapt successful programme elements, such as peer navigators, multilingual and low-literacy resources, and strategies to integrate sexual health into broader settlement services. At the policy level, insights will guide provincial and federal health authorities by exposing structural barriers—such as restrictive data-sharing policies and inadequate

funding for ethno-specific organisations—and recommending equity-focused strategies for STBBI prevention and care.

Ethics and dissemination

No ethical approval is applicable because no primary data will be collected from participants. We will publish the findings of the study in a peer-reviewed journal, and plain-language summaries and policy briefs will be published. Also, these summaries will be shared at community forums to target community and policy audiences.

Anticipated limitations

Some limitations of the review are anticipated. These include the heterogeneity of the evidence, as research publications involving different research methods will be included. Another limitation is the focus on Western nations, as potentially relevant studies can be excluded. Also, is the potential pitfalls of using machine translation for non-English papers. While cost-effective, machine translation tools can make errors, especially with colloquialisms or complex concepts, potentially leading to the inappropriate inclusion or exclusion of studies. Finally, how cultural appropriateness is defined across studies may vary, which can make our study selection tedious. Nonetheless, care will be taken (including seeking help from bilingual colleagues for key papers) to minimise the effects of these limitations on the review outcomes. Furthermore, relevant publications that fall outside the Western nations' context will be reviewed in the background and discussion sections of our manuscript.

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