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POPULATION-SPECIFIC HIV/AIDS STATUS REPORT

People from Countries where HIV is Endemic - Black people of African and Caribbean descent living in Canada



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FOREWORD

The Public Health Agency of Canada (PHAC), with the support of many partners, is pleased to release this status report as the first of eight reports intended to summarize current evidenceⁱ about the impact of HIV/AIDS among key populations in Canada. Communities, governments, public health practitioners, non-governmental organizations, researchers and others are encouraged to use this report to inform the future direction of HIV/AIDS policy, programming and research to positively affect the health and well-being of people from countries where HIV is endemic.ⁱⁱ

This series of status reports was initiated to support the actions set out in the Federal Initiative to Address HIV/AIDS in Canadaⁱⁱⁱ, the Government of Canada's framework for federal investment in HIV/AIDS, and to provide a comprehensive evidence base for other partners and stakeholders involved in the Canadian response. Launched in 2005, the Federal Initiative identifies the need for more effective interventions and improved HIV/AIDS prevention, research, diagnosis, care, treatment and support initiatives for specific populations living with, or at risk of, HIV and AIDS. These populations include people living with HIV/AIDS, gay men, people who use injection drugs, Aboriginal peoples, federal inmates, youth at risk, women and people from countries where HIV is endemic.

In addition, these status reports support the objectives of the report *Leading Together: Canada Takes Action on HIV/AIDS (2005-2010)*.^{iv} Developed and launched by

stakeholders in 2005, *Leading Together* renews Canada's collective efforts to deal with not only HIV/AIDS but also with the underlying health and social issues that contribute to new infections and have devastating effects on people who are living with HIV/AIDS. *Leading Together* encourages collaboration and the sharing of knowledge, skills and resources so that, together, we can stop HIV.

This status report was guided by a national working group with expertise in research, epidemiology, community development, policy and program development and the lived experiences of people from countries where HIV is endemic. Their input and advice was instrumental in ensuring that the report presents the most current, relevant evidence and innovative responses that exist in Canada today.

This first population-specific HIV/AIDS status report focuses on people from countries where HIV is endemic, specifically Black people and communities of African and Caribbean descent living in Canada. This is the first time PHAC has attempted to present HIV/AIDS-related information relevant to this population in a comprehensive manner. The decision to focus on Black people living in Canada in the first report stems from the fact that the HIV/AIDS epidemic among Black people in Canada needs to be better understood, and the community's readiness to be involved, including its strategic efforts to address the issue through the project *Springboarding a National HIV/AIDS Strategy for Black Canadian, African and Caribbean Communities*^v and its recently released report *Taking Action on HIV and AIDS in Black Communities in Canada: A Resource for Moving Ahead*.^{vi}

The preparation of this first report yielded a number of lessons that will influence future reports in this series, including the next version of this report, expected in 2012. As is the case in any work of this nature, limitations

i There are many different forms of evidence including research evidence, anecdotal reports, and personal experience which can be disseminated to improve practices. These include but are not limited to: (1) research evidence including findings from individual studies, systematic reviews, and primary research including community-based research; (2) informed practices including "best" practices and "wise" practices; (3) expert opinion from researchers and service providers; (4) lived experience from people living with HIV/AIDS; (5) reports and evaluations from a range of sources including government, community-based agencies, universities and funding agencies; and (6) practice-based evidence including programming materials informed by practice such as training manuals, guidelines, and position papers.

ii Refer to Appendix A for a list of HIV-endemic countries.

iii More information on The Federal Initiative to Address HIV/AIDS in Canada is available at www.aidsida.com.

iv More information on *Leading Together: Canada Takes Action on HIV/AIDS (2005-2010)* is available at www.leadingtogether.ca.

v More information on *Springboarding a National HIV/AIDS Strategy for Black Canadian, African and Caribbean Communities* is available at http://icad-cisd.com/content/pub_details.cfm?ID=242&CAT=15&lang=e

vi More information on *Taking Action on HIV and AIDS in Black Communities in Canada* is available at http://icad-cisd.com/content/pub_details.cfm?ID=243&CAT=15&lang=e

FOREWORD

were encountered in the data gathering, analysis and reporting phases. Nevertheless, the report is comprehensive and includes valuable information to further our knowledge and understanding of the epidemic. PHAC welcomes comments on the report to assist with the development of future population-specific HIV/AIDS status reports.

After 25 years of collective commitment and investment, HIV/AIDS continues to be a major public health challenge that requires a concerted, collaborative response. Examining the underlying factors and conditions that create resiliency or increase vulnerability to HIV is the key to understanding how best to structure an efficient and sustainable response to the epidemic. It is with this objective in mind that this report was prepared.

EXECUTIVE SUMMARY

The health of people from countries where HIV is endemic continues to be threatened by the high incidence of HIV/AIDS within this population.

The epidemiological term “People from countries where HIV is endemic” refers to a population that is largely composed of Black people of African and Caribbean descent. This group forms a diverse community, which largely came to Canada through the immigration waves of the last five decades, although a number of Black Canadians trace their roots in Canada to the early 1600s and 1700s. Census data shows that the Black population is increasing faster than the overall population and that it is distributed among Canada’s largest provinces (Ontario and Quebec) and in major urban centres across the country. HIV infections and AIDS cases follow a similar distribution pattern, with newly diagnosed infections and reported cases concentrated in Ontario (Greater Toronto Area) and Quebec (Montreal), and to a lesser extent, in key urban centres across the country, such as Vancouver, Calgary and Ottawa.

HIV infections in the HIV-endemic subcategory of the heterosexual contact category are diagnosed at a younger age than in the general population and affect a high number of women. Surveillance data from Ontario shows significant infection rates among Black men who have sex with men (MSM), however, little is known at this time about the overall number of Black MSM who are infected with HIV nationally. Similarly, rates of HIV infection among Black injecting drug users (IDU) and prison inmates and rates of hepatitis C co-infection are not well documented which limits effective planning of prevention, care, treatment and support activities.

Immigration alone cannot explain the high prevalence of HIV and AIDS in this population. Canada is now able to identify, through testing, immigrants and refugees who are HIV positive and link them with appropriate services. For those who are tested in Canada, surveillance data cannot identify whether HIV transmission occurred abroad or in Canada. Achieving a better understanding of the patterns and locations associated

with the acquisition of infection could lead to better prevention, diagnosis, care, treatment and support services among people from countries where HIV is endemic.

Understanding factors, such as age, religious beliefs and cultural influences of immigrants from countries where HIV is endemic, whether 1st, 2nd or 3rd generation Canadians, affects our collective ability to provide effective and specific HIV/AIDS services. For instance, understanding and adapting to Canada’s cultural norms and practices is not always possible in the short term for some new immigrants recovering from traumatic experiences in their country of origin or trying to cope with and navigate Canada’s immigration system. These factors relegate HIV/AIDS prevention to a lower priority and, without proper support, may place them at even greater risk for HIV infection.

The determinants of health clearly influence the Black population’s vulnerability to HIV/AIDS. A person’s vulnerability increases or decreases based on income, education, unemployment, housing, early childhood development (e.g. history of child abuse), physical and social environments, access to health services, support networks, gender, a history of sexual violence, and, for this population in particular, having experienced racism and difficulties with the immigration process. The report details the lived experience of the population in relation to these determinants and supports an approach that addresses the root causes of HIV/AIDS. Culturally appropriate services can also help mitigate the impact of some of these determinants and contribute to developing coping skills and resiliency in individuals, which can lessen their vulnerability to HIV/AIDS. Not surprisingly, the majority of community projects reviewed for this report focus on improving the Black community’s or individual’s coping skills and resiliency, by building on the experiences, knowledge and skills found in Black communities across the country.

Some cultural practices and norms in the Black community increase this population’s vulnerability to HIV and constitute barriers to services for Black persons

living with HIV/AIDS. Similarly, these individuals face stigma and racial discrimination from Canadian society in general.

Mirroring the Black population's geographic distribution and the prevalence of HIV and AIDS across the country, HIV/AIDS services and activities for people from countries where HIV is endemic are concentrated in Canada's larger urban centres. In smaller centres, community-based AIDS organizations are increasingly offering services to try to meet the needs of people from countries where HIV is endemic. The report found that beyond the services delivered through regular governmental public health and health and social services systems the following four types of organizations are delivering prevention, care, treatment and support services to the Black community in Canada: community-based HIV/AIDS organizations; ethnocultural HIV/AIDS organizations; broader ethnocultural organizations, and others such as community health centres. The response to HIV/AIDS in the Black population is consistent with classic community development models, which actively engage community members and affected populations in the development and implementation of projects and activities.

In Toronto, an unparalleled number of diverse organizations have built networks to meet the HIV/AIDS needs of the Black community and to ensure services are culturally appropriate. The model, promoted by the African Caribbean Council on HIV/AIDS in Ontario's (ACCHO) *Strategy to Address Issues Related to HIV Faced by People in Ontario from Countries Where HIV is Endemic* emphasizes the importance of partnerships in building cultural competencies and meeting the needs of key populations. ACCHO's efforts have led to the creation of additional stakeholder networks across the province and to the establishment of national and international networks.

While the report was able to map out where key activities are taking place across the country, very little research (including community-based research) and comprehen-

sive evaluations have been conducted to determine their effectiveness in preventing new HIV infections or responding to the needs of those living with HIV/AIDS in this population. Such information is integral to developing future evidence-based interventions. However, research on this population is increasingly taking place in a number of urban centres such as Vancouver, Calgary, Edmonton, Winnipeg, Windsor, Hamilton, Toronto, Ottawa/Gatineau, Montreal, and Halifax and should inform future interventions and activities.

Communities across Canada have taken up the challenge and are doing their part to reduce the growing number of infections in this population and to meet the needs of Black people living with, or at risk for, HIV/AIDS in Canada. Despite these important and significant efforts, much remains to be done. Effective and continued efforts in preventing the transmission and acquisition of HIV/AIDS and improving the quality of life of Black people living with HIV/AIDS are required to successfully address the epidemic among this population. Canada has the capacity and a strong foundation from which to act.

ACKNOWLEDGEMENTS

PHAC would like to acknowledge the individuals, population representatives, community representatives, researchers and government officials who contributed their time, expertise and experience to the development of this population-specific HIV/AIDS status report. Special mention goes to consultants Dionne A. Falconer from DA Falconer & Associates Inc, Joni Campbell, Dr. Lynne Leonard, Dr. Robert Remis, and to PHAC staff in the Centre for Communicable Diseases and Infection Control (CCDIC), as well as regional staff for their insightful contributions at various stages of the report.

Working Group Members

PHAC also acknowledges and thanks working group members for their exceptional commitment and for ensuring that this report accurately reflects the reality of the HIV/AIDS epidemic among people from countries where HIV is endemic.

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- Michael O'Connor, Interagency Coalition on AIDS and Development (Ottawa, ON)
- Dr. Robert Remis, University of Toronto (Toronto, ON)
- Wangari Tharao, African and Caribbean Council on HIV/AIDS, Women's Health in Women's Hands Community Health Centre (Toronto, ON)
- Geneviève Tremblay, HIV/AIDS Policy, Coordination and Programs Division, CCDIC, PHAC (Ottawa, ON)

vii The Centre de ressources et d'interventions en santé et sexualité no longer exists.

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LIST OF ACRONYMS AND INITIALISMS

ACCHO	African and Caribbean Council on HIV/AIDS in Ontario
AIDS	Acquired immunodeficiency syndrome
ARV(s)	Antiretroviral(s) (treatment)
CAHR	Canadian Association of HIV Research
CAS	Canadian AIDS Society
CCDIC	Centre for Communicable Diseases and Infection Control
CHTN	Canadian HIV Trials Network
CIC	Citizenship and Immigration Canada
CIHR	Canadian Institutes of Health Research
F/P/T AIDS	Federal/Provincial/Territorial Advisory Committee on HIV/AIDS
HIV	Human immunodeficiency virus
HR Hetero	High-risk heterosexual (exposure category)
ICAD	Interagency Coalition on AIDS and Development
IDU(s)	People who inject drugs / Injecting drug user(s)
IME	Immigration Medical Examination
LR Hetero	Low-risk heterosexual (exposure category)
MSM	Men who have sex with men
OHTN	Ontario HIV Treatment Network
PHAC	Public Health Agency of Canada
PLWHA	People living with HIV/AIDS
SRAD	Surveillance and Risk Assessment Division
SSHRC	Social Science and Humanities Research Council of Canada
UNAIDS	Joint United Nations Programme on HIV/AIDS

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CHAPTER 1 - Introduction

1

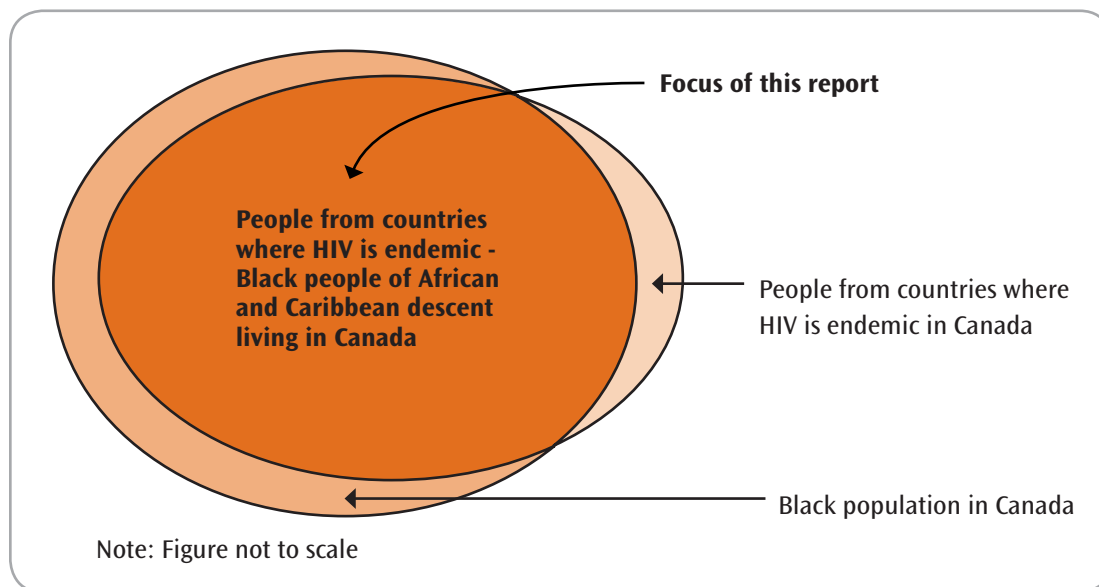
1.1 Background

This report focuses on Black people of African and Caribbean descent living in Canada from countries where HIV is endemic. Most of the sources of data and information used for this report do not necessarily refer to this population but rather to the Black population in Canada or to the epidemiological term “people from countries where HIV is endemic.” The decision to include information related to the Black population in this report was guided by data indicating that over the period of 1998 to 2006 in Canada, the vast majority of individuals with a positive HIV test and whose exposure was associated with heterosexual contact within the epidemiologic HIV-endemic subcategory are reported

as having an ethnic origin associated with the Black population (92.7%) [1].

As shown in Figure 1, people from countries where HIV is endemic—Black people of African and Caribbean descent living in Canada (the focus of this report) are represented in the overlap of these two primary sources of data or population categories. Given limited data related to this specific population, the report will at times present information on the Black population in Canada, principally to assist in identifying the conditions or factors that increase vulnerability to HIV and AIDS, and on people from countries where HIV is endemic, particularly when describing the status of the epidemic.

Figure 1: Population Categories



The term “people from countries where HIV is endemic” is an epidemiologic term often used in HIV/AIDS surveillance and research activities. “HIV endemic” refers to countries or populations where there is:

- a male-to-female ratio of 2:1 or less, or
- HIV prevalence of 2% or greater among women receiving prenatal care, or
- a high prevalence^{viii} of HIV infection in the adult population (generally, 1% or greater) and the predominant mode of transmission is heterosexual contact [1].

viii Prevalence: The total number of people with a specific disease or health condition living in a defined population at a particular time; i.e. the total estimated prevalence of people currently living with HIV/AIDS in Canada to the end of 2005 is 58,000.

According to surveillance data reported to the Joint United Nations Programme on HIV/AIDS (UNAIDS), the countries where HIV is endemic are mainly located in the Caribbean and sub-Saharan Africa, where populations are predominantly Black. Based on UNAIDS reporting and other data, PHAC has developed a list of countries where HIV is endemic to assist its surveillance efforts (see Appendix A for list of countries).

Canada's Black communities are diverse – ethnically, culturally, linguistically and religiously. They comprise individuals that have been established in Canada for many generations, as well as more recent newcomers. Acknowledgment of this diversity is necessary to reduce potential stereotyping, stigma and discrimination, while recognizing both the commonalities and differences that exist within and between Black communities. For example, immigration challenges are common to many newcomers to Canada, including Black people, regardless of their country of origin. However, the realities of third- and fourth-generation Black people living in Halifax, for example, are different from those of recent African and Caribbean immigrants living in Toronto or Calgary.

As a general rule, retrieved information addressing HIV/AIDS in broader ethnocultural, immigrant, ethnora-racial or refugee communities that did not specifically mention Black, African, Caribbean or people from countries where HIV is endemic was not included in this report to maintain its specificity.

This status report presents current evidence about the factors and/or conditions, which increase or decrease vulnerability, and to a lesser extent, resiliency to HIV infection and AIDS. Vulnerability is defined as a variety of social and economic factors that increases a person's susceptibility to HIV infection, including stigma and discrimination, gender inequity, poverty, human rights violations, and lack of HIV/AIDS awareness and access to education, health and other services [2]. When these factors are present, individuals may engage in behaviours such as unprotected sex or use contaminated needles that put them at higher risk of becoming infected with

HIV. In this context, risk is not certain, but based on probability. Therefore, not everyone who is exposed to these factors will experience adverse outcomes [3].

It is important to note that an individual, a group or community can successfully adapt to vulnerabilities through their innate capacity for resiliency, which operates best when resiliency-building conditions that contribute to healthy coping skills are present [4]. According to Mangham et al (1995), the term "resiliency" has been traditionally used to describe an individual's ability to manage or cope with significant adversity or stress in ways that are not only effective, but also may result in increased ability to respond to future adversity [3].

Characteristics of resilient individuals have been studied in populations exposed to war, poverty, and chronic illness. Balancing stress and adversity with ability to cope and access support mechanisms produces resilient behaviour. While this balance is ideal, it may not exist forever. When stress becomes overwhelming, even individuals who have displayed resilience in the past may suffer consequences that increase vulnerability. It has been noted that during times of transition when stress accumulates, resiliency is even more important [3]. This may be particularly relevant to this report as many have had to cope and recover from major shocks or trauma related to their experiences with war, violence, refugee camp conditions and the immigration process. The community response outlined in Chapter 6 of this report includes several examples of projects that illustrate the resiliency of the Black population.

1.2 Methodology

To support the development of this status report, PHAC contracted DA Falconer & Associates Inc.^{ix}, and established an expert working group comprising

^{ix} Team members were Dionne A. Falconer, Keisa Campbell and Alexander Lovell.

non-governmental organizations, community representatives, population representatives, researchers, and policy and program experts. Community representatives were selected from the national steering committee for *Springboarding a National HIV/AIDS Strategy for Black Canadian, African and Caribbean Communities*, which offered its support for the development of this status report. The expert working group acted as an advisory body and provided guidance and feedback on the report process, themes and drafts.

The methodology for each chapter was designed to ensure that the most current and relevant evidence was summarized and presented. Development of the report took place between January 2007 and July 2008. Demographic and research data were extracted from various sources including Statistics Canada (2001 and 2006 Census). Data and information on HIV/AIDS and vulnerability were extracted from PHAC, published research from the Canadian Institutes of Health Research (CIHR), the Ontario HIV Treatment Network (OHTN), Citizenship and Immigration Canada (CIC), Health Canada, the provinces and territories, non-governmental organizations, and universities. Input was also provided directly from key experts in this field.

Epidemiologic information and surveillance data were gathered from published reports by PHAC, provinces and territories, UNAIDS and other existing published data. Provincial estimates were also collected through published reports and further analysis of Ontario data was provided by Dr. Robert Remis.

Research and response data were collected from peer-reviewed publications and grey literature published from January 1, 2002, to January 1, 2008, using the following search terms: “HIV,” “AIDS,” “Canada,” “Black,” “African,” “Caribbean,” “endemic,” and the names of African and Caribbean countries where HIV is endemic (see Appendix B for the list of key words, databases and principal Internet sites searched). Both quantitative and qualitative information was gathered and analyzed.

An information-gathering template was developed (see Appendix C) and circulated to PHAC, the Canadian AIDS Society (CAS), the Interagency Coalition on AIDS and Development (ICAD) and the Canadian HIV Trials Network (CHTN). Through their respective listservs, the template was sent to approximately 250 organizations, individuals and researchers involved in the HIV/AIDS response in Canada, who in turn circulated the template within their own networks. Twelve weeks after the initial launch of the template, 28 responses were received, primarily from organizations working with Black communities, including five from PHAC. Responses were also received from British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec and Nova Scotia. PHAC approached the Federal/Provincial/Territorial Advisory Committee on HIV/AIDS (F/P/T/AIDS) and received more specific information from all provinces and territories. A detailed analysis of PHAC national and regional HIV/AIDS funding programs was also conducted to obtain information about projects supported to address HIV/AIDS and people from countries where HIV/AIDS is endemic. More information on how the analysis was conducted can be found in Chapter 6.

Information included in this status report was drawn from public sources and published data. Limitations due to the paucity of data specific to the health of Black people in Canada [5] hindered the final analysis. Furthermore, specific data analyses from the 2006 Census of Canada relating to this population were not released in time to be included in this status report, save for a few exceptions.

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CHAPTER 2 - Demographic Profile

This chapter provides an overview of selected demographic characteristics of the Black population in Canada (as noted in Chapter 1, 92.7% of the people associated with the HIV-endemic exposure subcategory in Canada are reported as having an ethnic origin associated with the Black population). It aims to provide

a better understanding of the Black population’s size, growth, geographic distribution and immigration patterns. Because data from the 2006 census is still being analyzed, unless otherwise mentioned, information from the 2001 census was primarily used to prepare this section of the report.

2.1 A brief history

1600s	The first Black person in the territory that is now Canada was reported in 1605. From 1628 to the early 1800s, Black slavery existed in Canada, particularly in Eastern Canada, where United Empire Loyalists often brought slaves with them when emigrating from the United States.
1700s and 1800s	Canada became home to Black Loyalists who had been promised land grants for supporting the British during the American Revolution. Many chose to remain in Canada and founded settlements in Nova Scotia, Ontario and, later in Western Canada with the opening of the frontier in the mid-1800s.
1900s	During the early 1900s, the growth in the Black population did not keep pace with that of other visible minority groups. Most Black people living in Canada during this time resided in south-western Ontario or the Atlantic provinces. During the next several decades, the number of Black people in Canada grew slowly. In the 1960s, immigration policy reforms eliminated preferences for immigrants of European origin and implemented a points-based system for economic immigrants to ensure maximum employability in an economy where skilled labour was becoming a priority. Consequently, the source countries of immigrants became more diversified, resulting in increasing numbers of Black immigrants from the Caribbean and Africa.

(Source: [1] pp. 1-3).

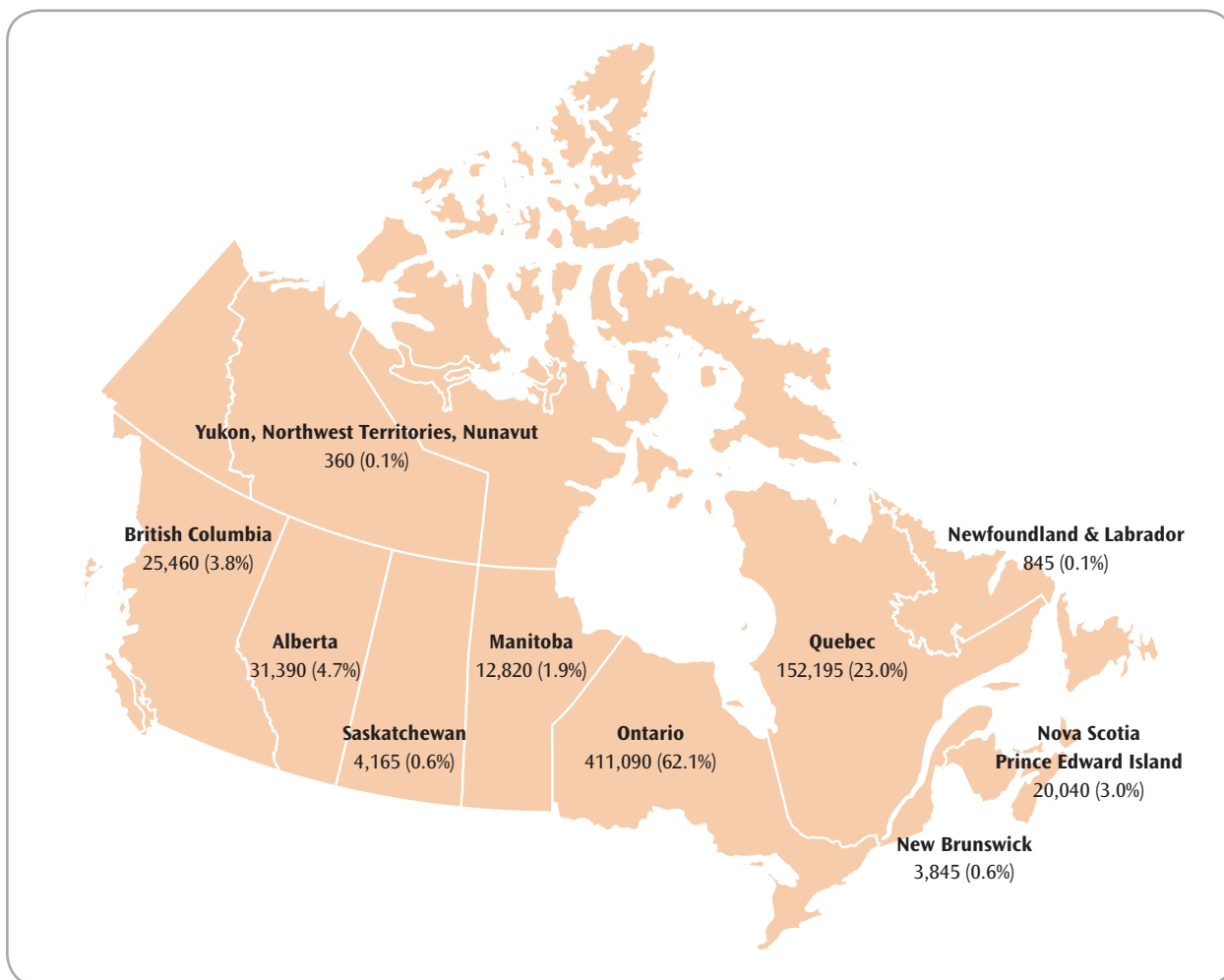
2.2 Population size and projected growth

According to the 2006 census, 783,795 Black people comprised 2.5% of the country’s population and 15.5% of the visible minority population [2]. Black people are the third largest visible minority group in Canada. From 1991 to 2001, the Black population in Canada increased by 31%, while the country’s population grew by 10% and the visible minority population grew by 58% [1].

2.3 Geographic location

In 2001, the majority (97%) of Black people in Canada lived in urban areas, with nearly one-half (47% or 310,500), living in the Toronto metropolitan area. Montreal had the second largest Black population in the nation (139,300), representing over 4% of its population [1]. It is estimated that by 2017, 27% of Montreal’s visible minority population will be composed of Black people [3]. Figure 2 depicts the geographic distribution of the Black population in Canada.

Figure 2: Distribution of the Black population by provinces/territories and national proportional distribution (%), 2001 (n=662,215)



(Source [4] no p.).

2.4 Generational differences

This report compares the proportion of Black people who were first-generation^x immigrants (born outside Canada) with that of those who were born in Canada. Table 1 presents the Black population by immigrant

status and age group in 2001. Note that 8.2% of Black immigrants to Canada were less than 15 years of age, compared to 54.9% of Black non-immigrants. This is explained by the fact that almost all third-generation^{xi} and many second-generation^{xii} individuals within the Black population were born in the late 1980s and 1990s.

x Person born in Canada with both parents born outside; or naturalized immigrant.

xi Persons born in Canada with both parents born inside Canada.

xii Persons born in Canada with at least one parent born outside Canada.

Statistics Canada estimates that in 2001, 344,000 Black people, or 52% of the Black population of Canada, were first-generation. This figure may actually be somewhat higher because a significant number of immigrants from the Caribbean and sub-Saharan Africa may not have identified themselves as being Black in the census. Upon clarification from Statistics Canada, it would appear that up to 60,000 additional immigrants from Africa and the Caribbean are likely Black, but not counted as such [5].

A substantial number of second- and third-generation individuals within the Black population in Canada have their origins in the Caribbean. There are likely fewer third-generation Black people in Canada with origins in sub-Saharan Africa, given the relatively small number who arrived before 1980 (40,000 compared to 174,000 from the Caribbean). Among the Black population aged 15 years and older, second-generation Black people in

Canada, or those who were Canadian-born with at least one parent born outside Canada, accounted for 19.5% of the Black population [1].

A small, but distinct subpopulation, made up of the descendants of Black people who arrived in Canada from the United States in the 19th century, have lived in this country for many generations. This subpopulation lives mostly in Nova Scotia and in communities in southwestern Ontario, stretching primarily from Windsor to the Niagara region, and in smaller numbers in Western Canada. While there is no precise estimate of the size of this population, it is known that 18,000 Black people were living in Canada in 1951 [1], before the first wave of immigration from the Caribbean began. Based on available data and modelling, the estimated number of the “indigenous” Black population in Canada in 2001 was unlikely to be greater than 30,000, or about 5% of the total Black population [6].

Table 1: Black population by age group and immigrant status, Canada 2001

Age Group	Immigrant Status						Total Black Visible Minority Population
	Immigrant population	%	Non-immigrants	%	Non-permanent residents	%	
Less than 15 yrs.	28,320	8.2%	163,590	54.9%	3,210	16.1%	195,120
15-24 yrs.	42,265	12.3%	63,165	21.2%	5,180	25.9%	110,610
25-34 yrs.	66,025	19.2%	33,685	11.3%	6,230	31.2%	105,935
35-44 yrs.	82,590	24.0%	15,855	5.3%	3,515	17.6%	101,960
45-54 yrs.	60,240	17.5%	9,465	3.2%	1,190	6.0%	70,895
55-64 yrs.	39,130	11.4%	5,665	1.9%	325	1.6%	45,110
65-74 yrs.	17,425	5.1%	3,850	1.3%	205	1.0%	21,485
75 yrs. and over	8,255	2.4%	2,715	0.9%	125	0.6%	11,095
Total	344,255	100.0%	297,985	100.0%	19,970	100.0%	662,210

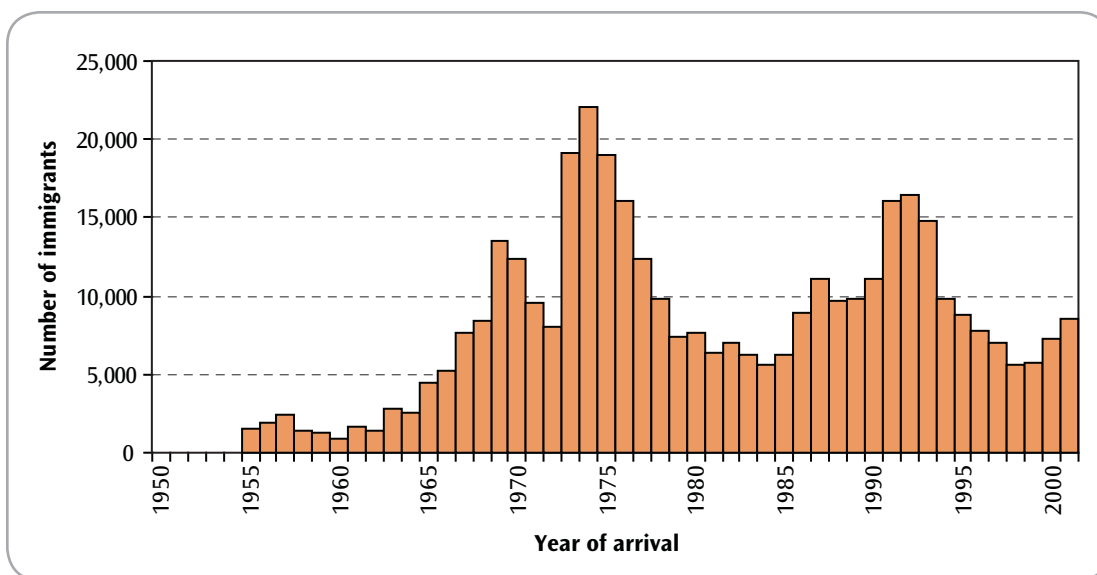
(Source: [7] no p.).

In 2001, 10% of Canada’s Black population were third-generation Canadian. In areas that have a long history of Black settlement, more than four in five (84%) Black residents were at least third-generation Canadian. More than 90% of Black people living in Halifax in 2001 were Canadian-born, the highest proportion among census metropolitan areas [1]. It is important to note that this group has no relation to the epidemiologic definition of people from countries where HIV is endemic.

2.5 Trends in immigration

Figure 3 shows the number of immigrants to Canada from the Caribbean by year of immigration since 1950 [8-9]. A substantial immigration wave began in the late 1960s, peaking in the 1970s, followed by second smaller wave in the late 1980s and early 1990s. Jamaica was the leading source of Black immigrants during this period, accounting for 30 - 40% of the total. Haiti was the second largest, accounting for nearly 20% of Black immigrants during the 1970s and 1980s [1].

Figure 3: Annual number of immigrants to Canada from the Caribbean Countries, 1950-2001

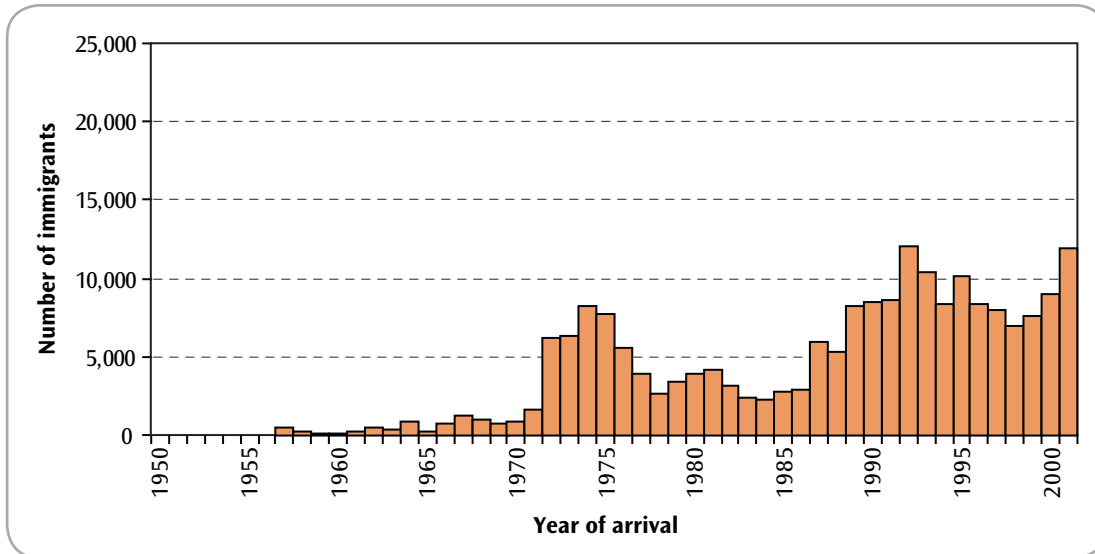


(Source: [8-9] no p.).

The pattern of immigration from sub-Saharan Africa is different as shown in Figure 4. Relatively few Black Africans immigrated to Canada before the 1970s, with numbers starting to increase in 1972. Following a mod-

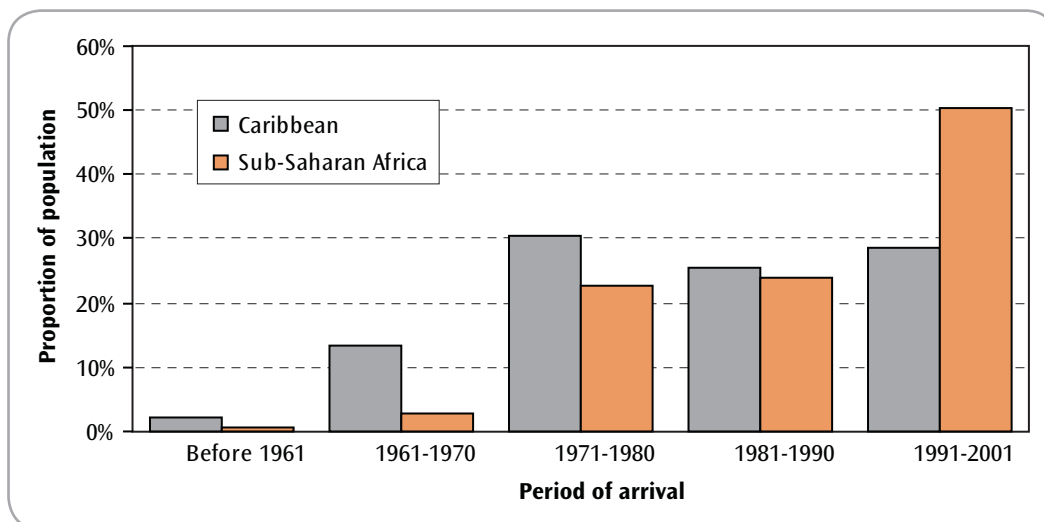
erate peak of immigration in the mid-1970s, the number of arrivals decreased again until a second, much larger wave took place in the 1990s. This wave continued until 2001, the latest year of available data [8-9].

Figure 4: Annual number of immigrants to Canada from sub-Saharan Africa, 1950-2001



As shown in Figure 5, the region of origin of Black immigrants has shifted dramatically over the past several decades. Before 1961, only 1% of Black people who came to Canada were born in Africa, while 72% were from the Caribbean and Central and South America. Less than 5% of Africans living in Canada in 2001 arrived before 1971, while slightly more than 50% arrived between 1991 and 2001. By comparison, only 29% of people from the Caribbean living in Canada in 2001 arrived in the previous decade. For Black people emigrating from Africa, the median year of arrival was 1991 and 1982 for those from the Caribbean [10].

Figure 5: Proportion of immigrant population by period of arrival and region of origin, Canada 2001



(Source: [10] no p.).

Data from the 2006 census show that 1,109,980 immigrants came to Canada between 2001 and 2006. Of these, 87,190 (7.9%) came from countries where HIV is endemic. Immigrants from Caribbean countries represented 2.8% (30,680) of the total number, coming mainly from three countries: 0.96% from Haiti (10,690), 0.85% from Jamaica (9,435) and 0.37% from Trinidad and Tobago (4,080). For the same period, the 56,500 immigrants from sub-Saharan Africa accounted for 5.1% of the total number. They came primarily from the following countries: Nigeria 0.7% (7,285), Ethiopia 0.6% (6,650), Sudan 0.6% (6,495), Kenya 0.4% (4,285), Somalia 0.3% (3,865), and Ghana 0.3% (3,775) [11].

In Toronto, 57% of people in the city’s Black community were born outside Canada. Almost three quarters (73%) of the 178,200 foreign-born Black people in Toronto were born in the Caribbean and South and Central America, predominantly Jamaica, Trinidad and Tobago and Guyana [1].

Similarly, the majority of people in Montreal’s Black community (55%) were foreign-born and came to Canada predominantly from the Caribbean and South and Central America. In 2001, 78% (76,200) foreign-

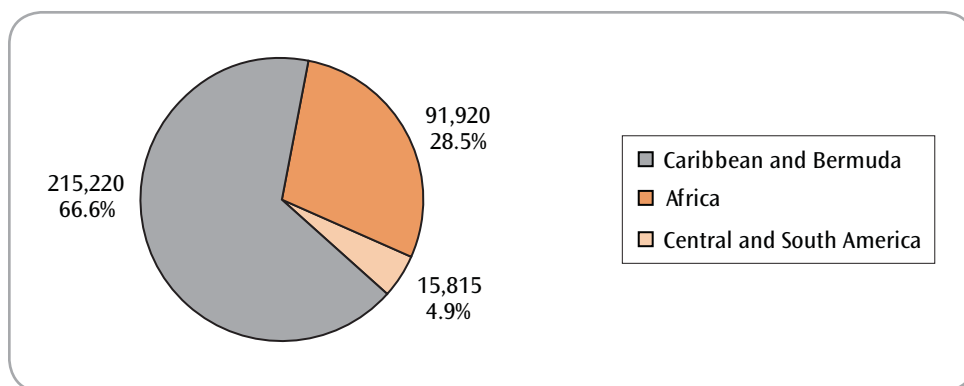
born Blacks in Montreal were born in these regions, primarily Haiti. Less than one-fifth (18%) of the foreign-born Black people in 2001 were born in Africa [1].

According to Statistics Canada [12] 48% of immigrants from sub-Saharan Africa and 61% of immigrants from the Caribbean were Black. Thus, a substantial proportion of immigrants from the Caribbean and sub-Saharan Africa are not Black. The majority of non-Black immigrants from these two regions were of South Asian ethnicity (25% for sub-Saharan Africa and 12% for the Caribbean) or were non-visible minorities (20% for sub-Saharan Africa and 6% for the Caribbean).

Conversely, not all Black immigrants are of Caribbean or sub-Saharan African origin. About 7% of Black immigrants to Canada were born in other regions, with substantial numbers arriving from the United Kingdom and the United States. These two countries alone accounted for almost 60% of Black immigrants from regions other than sub-Saharan Africa and the Caribbean [12].

As shown in Figure 6, 66.6% of Black immigrants were born in the Caribbean and Bermuda, 28.5% in Africa and 4.9% in Central or South America [12].

Figure 6: Regions of birth for Black immigrant populations, Canada 2001



(Source: [13] no p.).

2.6 Age

In 2001, the Black population in Canada was younger than the Canadian population as a whole. Children under the age of 15 years accounted for 29.5% of the Black population, compared with 19.3% of Canada's total population. In addition, 16.7% of Black people were aged 15 to 24 years, compared with 13.5% of the overall population. Only 4.9% of Black people were aged 65 years or over, less than half the proportion of the Canadian population (12.2%) [12].

2.7 Gender

Women and female children constitute over half (52.3%) of Canada's Black population. This percentage is comparable to the general population [13].

2.8 Language

According to the 2001 census, a larger proportion of Canada's Black population (72.3%) reported speaking English most often at home than was the case for the overall population (66.7%). The census also revealed that 14.3% of Black people spoke French most often at home, compared to 21.8% of the total population. Approximately 9.1% of Black people in Canada (60,490) reported speaking a non-official language most often at home, which is comparable to the national average of 9.7% [14].

2.9 Education

According to the 2001 census, 28.2% of Black people aged 15 years and over reported having less than a high school graduation certificate, compared to 31.3% for the total population. A slightly smaller proportion of Black people in Canada age 15 years and over (12.7%) reported having a university degree compared to the Canadian population as a whole (15.4%) [15].

Foreign- and Canadian-born Black people of prime working age were just as likely to have a university education as the overall population aged 25 to 54 years (about one in five). However, foreign-born Black people were much less likely to have a university education than other immigrants. In 2001, 20% of Black people born outside of Canada of prime working age had a university education, compared with 32% of all prime working-age immigrants. On the other hand, recent Black immigrants – admission of immigrants has increasingly emphasized skills, which promote economic independence once in Canada – tend to be better educated and more highly skilled than Canadian-born Black people [1].

2.10 Employment

During the 1990s, employment rates for Canadian-born Black people improved, while those of foreign-born Black people remained the same. In 2001, the age-standardized employment rate of prime working-age, Canadian-born Black people (76%) was lower than the rate for all Canadian-born persons of prime working age (81%). Although foreign-born Black people aged 25 to 54 years were substantially less likely to be university educated than other immigrants, employment rates were the same for both groups in both 1991 and 2001, at about 77% [1].

National unemployment rates were lower in 2001 than in 1991, but unemployment rates for Black people were higher than for all prime working-age adults. In 1991, Canadian-born and foreign-born Black people of prime working age both had age-standardized unemployment rates of 12.5%. By 2001, Canadian-born Black people had a 7.9% unemployment rate, compared with 9.6% for foreign-born Black people [1].

2.11 Income

Although Canadian-born Black people aged 25 to 54 years were just as likely to have a university education as all Canadian-born persons in this age group, the

average employment income of Canadian-born Black people in 2001 was substantially lower, at \$29,700, than for Canadian-born persons as a whole, at \$37,200. The younger age distribution of the Black population may contribute to the earnings gap, as younger people usually have lower earnings. Age-standardizing the average employment income of Canadian-born Black people in this age group increases it to \$32,000 and reduces the earnings gap. From 1991 to 2001, the age-standardized average employment income of Canadian-born Black people aged 25 to 54 years increased by 7%, compared with a 9% increase for all Canadian-born persons in this age group [1].

In the case of foreign-born Black people aged 25 to 54 years, although they were less likely to be university educated than foreign-born persons as a whole, the earnings gap between the two groups was narrower than for Canadian-born Black people and Canadian-born persons as a whole. Foreign-born Black people in this age group had an average employment income of \$28,700 in 2000, compared to \$34,800 for foreign-born persons in this age group as a whole. Age-standardizing the average employment income of foreign-born Black people increases it to \$29,200. From 1990 to 2000, the age-standardized average employment income for foreign-born Blacks aged 25 to 54 years decreased by 5%, while it decreased by less than 1% for all foreign-born Canadians in this age group [1].

2.12 Marital status

In 2001, 47% of Black people over the age of 15 in Canada were single, 35% were married, 3% widowed and 9% divorced. These figures did not include Black people in Canada who were separated but legally married [14]. Of the nearly 118,000 couples involving Black people in 2001, 57% involved two Black partners and 43% were composed of a Black person and a non-Black person (most often a Black male and a white female) [1]. Insufficient data were found to quantify the status of Black same-sex or same-gender partnerships in Canada.

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standard/themes/RetrieveProductTable.cfm?Temporal=2001&PID=68533&APATH=3&GID=517770&METH=1&PTYPE=55496&THEME=43&FOCUS=0&AID=0&PLACE_NAME=0&PROVINCE=0&SEARCH=0&GC=0&GK=0&VID=0&VNAMEE=&VNAMEF=&FL=0&RL=0&FREE=0 [cited 2007 Dec]; 2003 Mar.

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CHAPTER 2 - Demographic Profile

<http://www12.statcan.ca/english/census01/products/standard/themes/RetrieveProductTable.cfm?Temporal=2001&PID=68642&APATH=3&GID=517770&METH=1&PTYPE=55496&THEME=44&FOCUS=0&AID=0&PLACENAME=0&PROVINCE=0&SEARCH=0&GC=99&GK=NA&VID=0&VNAMEE=&VNAMEF=&FL=0&RL=0&FREE=0>
[cited 2007 Sep]; 2007 Mar.

CHAPTER 3 - Status of the HIV/AIDS Epidemic Among People From Countries Where HIV is Endemic

3.1 Introduction

This chapter summarizes the most recent data available on the HIV/AIDS epidemic in Canada among people from countries where HIV is endemic. It also presents specific data on the Black population in Canada, including people of African and Caribbean communities using surveillance ethnicity data.

It begins with an overview of the HIV/AIDS epidemic in sub-Saharan Africa and the Caribbean, before focusing on the epidemic in Canada in persons from countries where HIV is endemic, including geographic information as reported by the provinces and territories. Data surrounding gender, perinatal transmission, immigration, location of infection acquisition and virus strains will also be discussed, as these influence and impact prevention, treatment, and response strategies for this population.

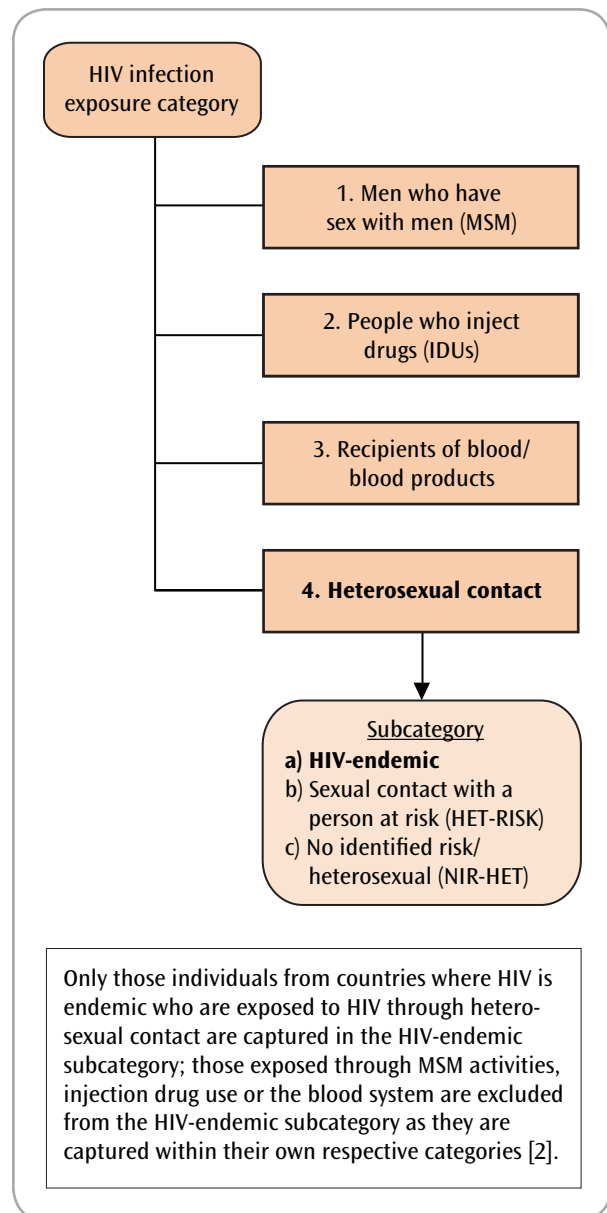
PHAC uses various types of epidemiological information, including surveillance, research data and estimates, to monitor HIV infections and AIDS cases in Canada. There are benefits and limitations to each type of information requiring their combined use to create a more comprehensive picture of the concentrated^{xiii} HIV/AIDS epidemic in Canada.

Surveillance data are provided voluntarily to PHAC by the provinces and territories, and comprise reported HIV-positive test results and diagnosed AIDS cases. As HIV and AIDS are reportable in all Canadian jurisdictions, case reporting standards have been developed by PHAC to facilitate data sharing at the national level. While a minimum amount of information is provided for each case (the “Core Set” of variables), the amount of supplementary data provided varies between provinces and territories [1]. In particular, important missing surveillance

xiii Concentrated HIV epidemics occur where HIV has spread rapidly in one or more defined subpopulations but is not well-established in the general population. (Available from: http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2008/20080609_Providing_leadership_in_countries_with_concentrated_epi.asp)

data can include country of birth, ethnicity and exposure category. Country of birth and ethnicity can help organize data according to the HIV-endemic country list (Appendix A), while exposure category refers to the most likely route by which a person became infected, as defined by a hierarchy of risk.

Figure 7: Hierarchy of Risk



As illustrated in Figure 7, the first four categories in the hierarchy of risk are 1) men who have sex with men (MSM), 2) people who inject drugs (IDUs), 3) recipients of blood and blood products, and 4) heterosexual contact. The category “Heterosexual contact” includes a subcategory specific to those whose likely route of HIV exposure is connected to an HIV-endemic country (person is a heterosexual from an HIV-endemic country). This is the subcategory that will be referenced throughout this chapter. The first three categories are generally accepted to be higher risk activities than heterosexual contact [2].

Due to the considerations listed above, to individuals’ reluctance to report risk factors, to the fact that many Canadians do not routinely undergo test for HIV testing and that cases are not always reported immediately to PHAC, surveillance data alone do not reflect absolute numbers of HIV/AIDS cases in Canada at any given time. Statistical modelling (i.e. estimates) is thus used to calculate the number of HIV infections and AIDS cases in Canada. By using statistical formulas and secondary sources of data, estimates of the number of new infections (incidence^{xiv}) and the number of people living with HIV infection (prevalence) can be obtained. In fact, PHAC is responsible for reporting Canadian estimates of national HIV incidence and prevalence rates to UNAIDS [2].

The methods used to estimate HIV incidence and prevalence at the national level bring together all available forms of data and are subsequently used in this report.

3.2 Overview of the HIV/AIDS epidemic in Sub-Saharan Africa and the Caribbean

Unlike Canada, where HIV is mainly concentrated in specific populations, some countries have experienced

^{xiv} HIV incidence is the number of new HIV infections occurring in a specified period of time in a specified population.

HIV infection rates of significant proportions in the general population. This is also known as a “generalized epidemic” where the main route of transmission is through heterosexual sex, thereby affecting the general population. PHAC defines an HIV-endemic country as a country that has an HIV prevalence rate of 1.0% or greater in adults (ages 15-49) and any one of the following:

- a male-to-female ratio of 2:1 or less among prevalent infections;
- HIV prevalence greater than or equal to 2.0% among women receiving prenatal care;
- 50.0% or more of HIV cases are attributed to heterosexual transmission [2].

In much of sub-Saharan Africa and the Caribbean, countries report endemic levels of HIV. In 2007, it was estimated that out of 33.2 million (30.6 – 36.1 million) adults and children living with HIV worldwide, 22.5 million (20.9 – 24.3 million) were living in sub-Saharan Africa. The approximate HIV prevalence rate in adults was 5% (4.6% - 5.5%). The Caribbean had an estimated 230,000 (210,000 – 270,000) adults and children living with HIV, with an estimated adult prevalence rate of 1% (0.9% - 1.2%). Prevalence in this region was highest in the Dominican Republic and Haiti, which together accounted for nearly three quarters of the 230,000 (210,000 – 270,000) people living with HIV in the Caribbean, including the 17,000 (15,000 – 23,000) who were newly infected in 2007 [3].

3.3 Overview of the epidemic in Canada: people from countries where HIV is endemic

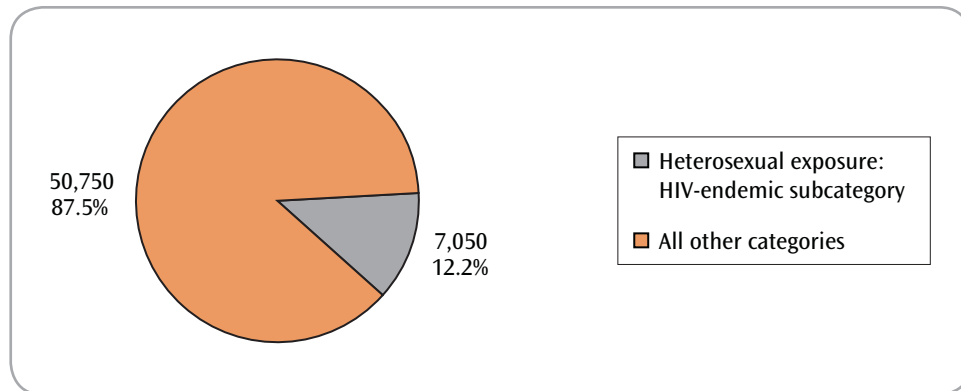
In 2005, there was an estimated 2,300 to 4,500 new HIV infections in Canada, of which 400 to 700 (16%) were attributed to the HIV-endemic exposure subcategory. The infection rate among individuals from HIV-endemic

countries was estimated to be at least 12.6 times higher than among other Canadians in 2005 [2].

PHAC estimates that at the end of 2005, 58,000 (48,000 – 68,000) people in Canada were living with HIV (including AIDS). The HIV-endemic exposure subcat-

egory was estimated to account for approximately 7,050 (5,200 – 8,800) of these HIV infections. If using the mean estimates provided (7,050 / 58,000), in 2005 approximately 12.2% of HIV infections in Canada were attributed to the HIV-endemic exposure subcategory (see Figure 8) [2].

Figure 8: Estimated number of prevalent HIV cases in Canada by exposure category, 2005 (n=58,000)

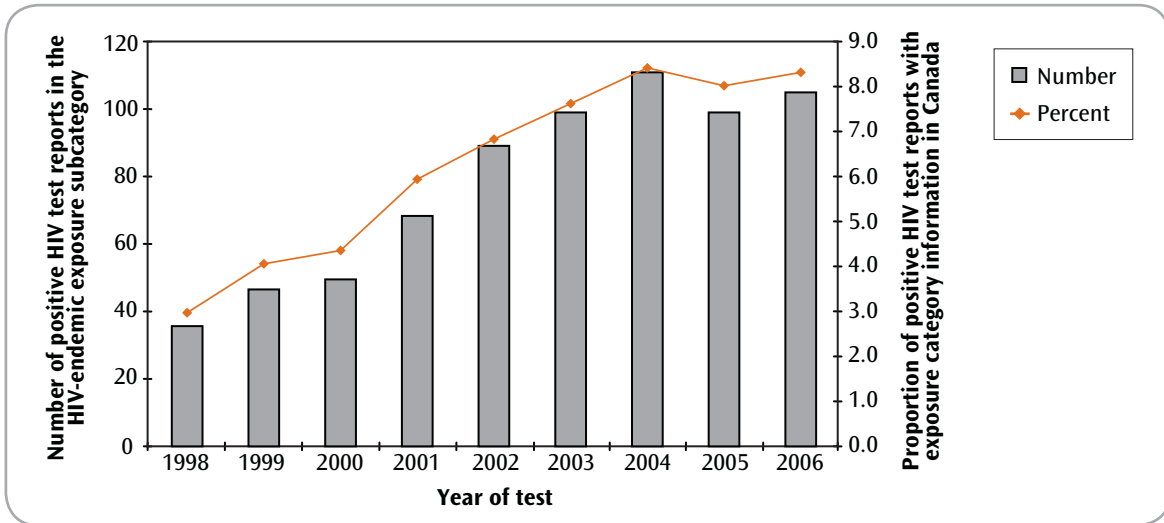


Legend: *Heterosexual exposure: HIV-endemic* = origin in a country where HIV is endemic. *All other categories* include MSM = men who have sex with men; IDU = people who inject drugs; *Heterosexual/non-endemic* = heterosexual contact with a person who is either HIV infected or at risk of HIV or heterosexual as the only identified risk; recipients of a blood transfusion or clotting factor, and occupational transmission (Source: [2], p. 3, table 1).

As shown in Figure 9, the absolute number of positive test reports in the HIV-endemic exposure subcategory increased from 36 in 1998, to a peak of 112 in 2004. In 2005, this exposure subcategory accounted for 100

positive test reports and for 106 in 2006. The proportion of overall positive test reports attributed to the HIV-endemic subcategory increased from 3.0% in 1998 to a peak of 8.5% in 2004 and more recently to 8.4% in 2006 [2].

Figure 9: Number of positive HIV test reports attributed to the HIV-endemic exposure subcategory and proportion of all HIV-positive test reports by year, 1998-2006

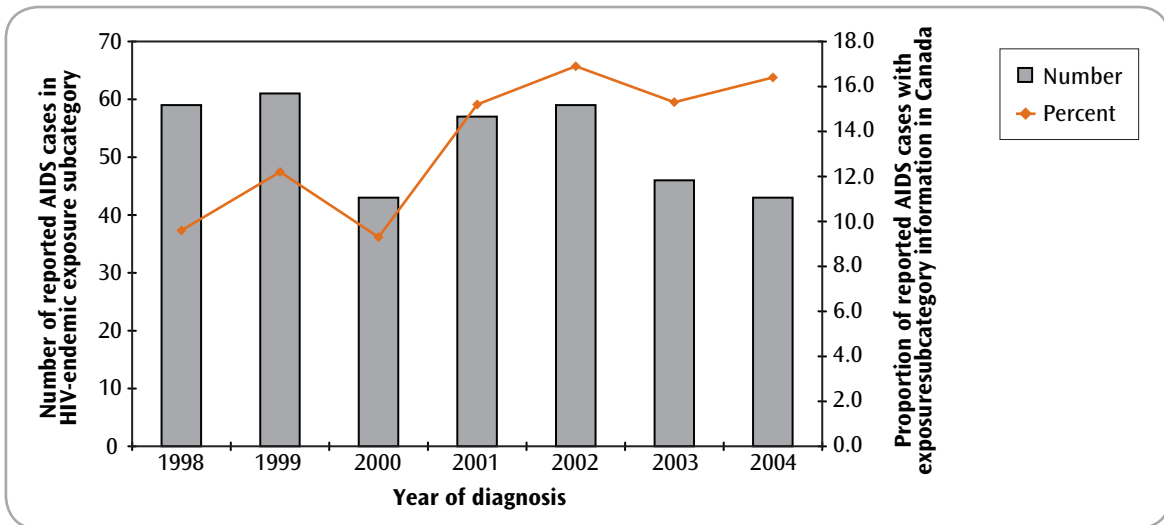


(Source: [2], p. 93, figure 1).

Proportionally, these numbers are comparable to the reported AIDS cases attributed to the HIV-endemic exposure subcategory. As shown in Figure 10, although the total number of AIDS cases per year attributed to

this exposure subcategory has declined (from 66 in 2002 to 63 in 2004), the proportion of overall reported cases increased from 9.6% in 1998 to a peak of 16.9% in 2002 (16.4% in 2004) [2].

Figure 10: Number of reported AIDS cases attributed to the HIV-endemic exposure subcategory and proportion of all AIDS cases by year, 1998-2004



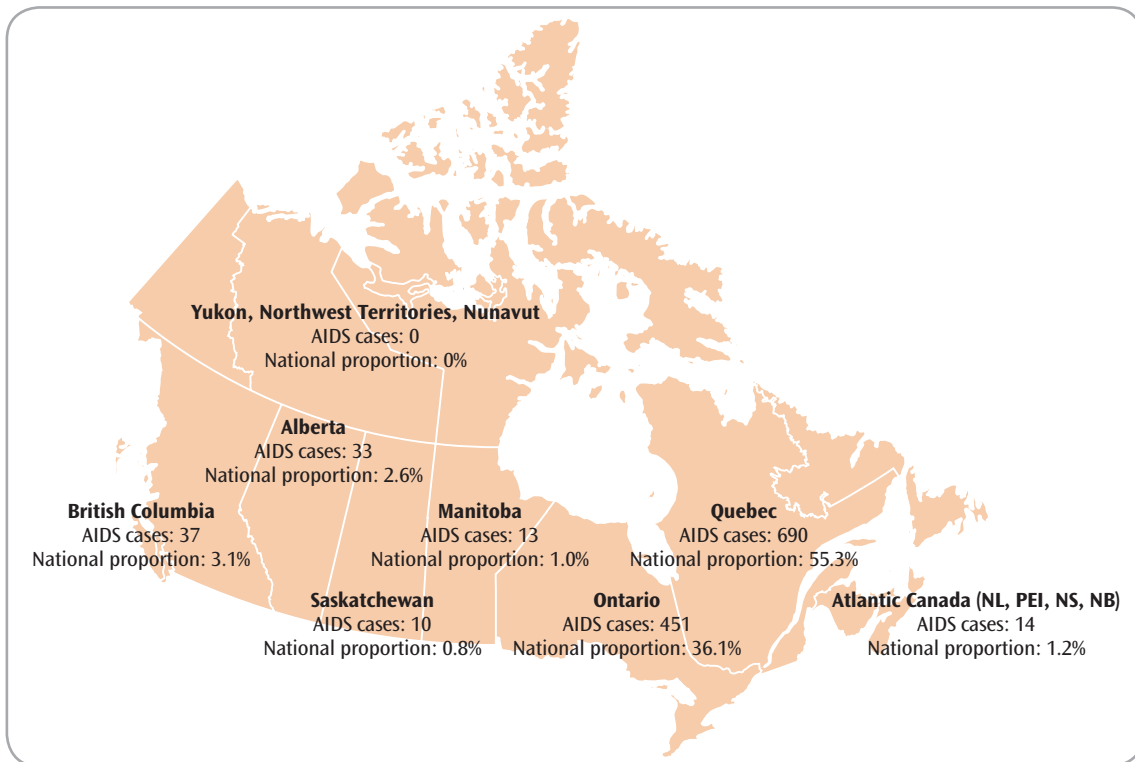
Data excludes the province of Quebec (Source: [2], p. 93, figure 2)

Figure 11 shows the number of reported AIDS cases by province/territory for the HIV-endemic exposure subcategory, as well as the national distribution (%) by province/territory to December 31, 2006^{xv}. Ontario and Quebec share the highest number and proportion of reported AIDS cases for the HIV-endemic exposure subcategory. While it is expected that Ontario and Quebec would have the highest proportion of cases based on the geographic location of the Black population in Canada (see Figure 2), the number of reported AIDS cases are not distributed proportionally between the two provinces. Which approximately 62.1% of the Black population in Canada resides in Ontario [4], the proportion of AIDS cases for the HIV-endemic exposure subcategory is approximately

36.1% [5]. Quebec on the other hand has approximately 23.0% of the Black population in Canada [4], but 55.3% of the national proportion of AIDS cases [5]. This suggests that the Black population in Quebec seems to be over-represented in its proportion of AIDS cases.

Studies and subsequent analysis would be required to better understand this fact, however a plausible explanation points to the fact that Haiti was one of the first countries to be seriously affected by HIV/AIDS. The Black Haitian population living with HIV/AIDS in Quebec was likely diagnosed earlier with a larger number of individuals having progressed to AIDS.

Figure 11: Number of reported AIDS cases by province/territory and national proportional distribution (%) of total AIDS cases for the HIV-endemic exposure subcategory, cumulative to December 31, 2006 (n=1248)



(Source: [5], p. 54, table 19).

xv A similar distinction for positive HIV test reports could not be reported due to data limitations.

When using surveillance data that include ethnic status or country of birth, the provinces and territories show a similar increase in the number of positive HIV tests attributable to persons as having an ethnic origin associated with the Black population:

- In British Columbia, 4.4% (16/360) of positive HIV test reports in 2006 were among persons reported as having an ethnic origin associated with the Black population. From 2004 to 2006, these individuals represented an average of 4.3% (52/1202) of total number of positive HIV reports [6].
- Alberta data from 2007 indicate that 20.4% (46/225) of positive HIV test reports were diagnosed in individuals reported as having an ethnic origin associated with the Black population. From 2004 to 2006, when ethnicity was reported, these individuals accounted for 22.9% (131/571) of the total number of positive HIV reports [7].
- In Manitoba, 15% (12/82) of positive HIV test reports in 2007 were among persons who self-reported their ethnicity as African. From January 1999 to December 2007, 20% (151/756) of positive HIV test reports were among individuals who self-reported their ethnicity as African/African-Canadian [9].
- In Ontario from 1985 to 2005, 2,838 positive HIV diagnoses were attributed to the HIV-endemic exposure subcategory. This represents 10.7% of all positive HIV diagnoses in Ontario for that period [10].
- In Quebec, 16.4% (119/724) of positive HIV reports in 2006 were attributed to people whose ethno-cultural origin was reported as Caribbean or sub-Saharan African. From 2004 to 2006, people from sub-Saharan Africa and Caribbean represented 17.8% (404/2267) of positive HIV test reports in the province [11].

3.4 Representation of Black persons in various positive HIV test reports and AIDS cases exposure categories

As described in Section 3.1, exposure category information is used in HIV/AIDS surveillance to monitor HIV transmission routes and AIDS cases. Due to the hierarchy of risk, persons from HIV-endemic countries who are not exposed to HIV through heterosexual sex are not included in the HIV-endemic subcategory. Therefore, ethnicity data coupled with exposure category data help further characterize HIV infection in Canada.

From 1998 to 2006, 396 HIV-positive test reports identified through the National HIV and AIDS Surveillance System belonging to the HIV-endemic exposure subcategory included information on ethnicity. Of those, 92.7% identified themselves as Black, 3.8% as Asian, 2.0% as White and 1.5% as other. Similarly from 1998 to the end of 2006, for the 334 AIDS cases in the HIV-endemic exposure subcategory and with information on ethnicity, 88.0% identified themselves as Black, 6.9% as Asian, 3.0% as other, and 2.1% as White [2]. In the majority of cases where ethnicity data are collected in this exposure subcategory, ethnicity was described as Black.

The number of HIV positive test reports from 1998 to 2006 by ethnic status shows that the “Black” ethnic status represented 9.7% (608 test reports) of the 6,253 reports with known ethnic status for all ages. Surveillance data indicates that of the total number of reported AIDS cases from 1979 to 2006 in Canada that included ethnic status (16,349), those who identified as “Black” represented 9.4% (1,537 cases) of cases for all ages [5].

Limitations with ethnicity reporting at the national level must be noted. Specifically, two of Canada’s largest provinces, Ontario and Quebec, do not provide ethnic information on positive HIV test reports at the national level. This hinders the national monitoring of the epidemic among persons from countries where HIV is endemic, as the two provinces account for over two-thirds of all positive HIV test reports and include

two large urban centres (namely Toronto and Montreal) both with large Black populations [2].

Related data have, however, been published at the provincial level. The Ontario HIV Epidemiologic Monitoring Unit has collected information looking at Black ethnicity relating to HIV exposure categories. While this information may not necessarily be reflective of the situation across Canada, it does provide a portrait of HIV/AIDS in Black communities in Ontario and could be helpful to other jurisdictions when undertaking data analysis.

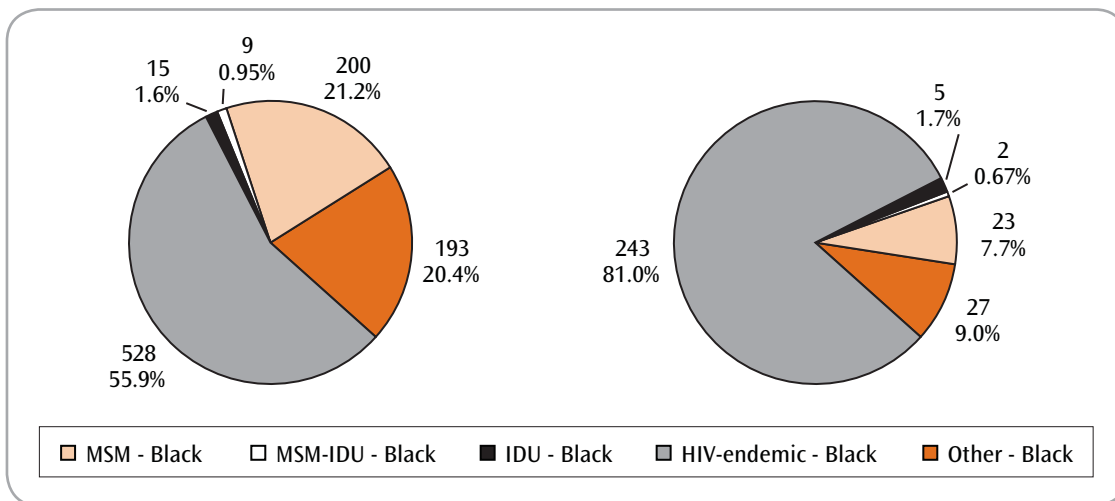
3.4.1 Men who have sex with men and injection drug use exposure categories

According to Lui and Remis [13], from 1980 to 2004, in Toronto, while more than half (56.4%) of all HIV-positive tests in the Black population were attributed to the HIV-endemic subcategory, 21.2% were attributed to the MSM exposure category, 0.95% to the MSM-IDU exposure category, 1.6% to the IDU exposure category,

and 20.4% to other exposure categories. From 1983 to 2004, more than 80% of infections in Ottawa's Black community were attributed to the HIV-endemic exposure subcategory, MSM representing 7.7% of infections (refer to Figure 12). While HIV-positive test results were not available province-wide, Black ethnicity AIDS data for Ontario are discussed in this section.

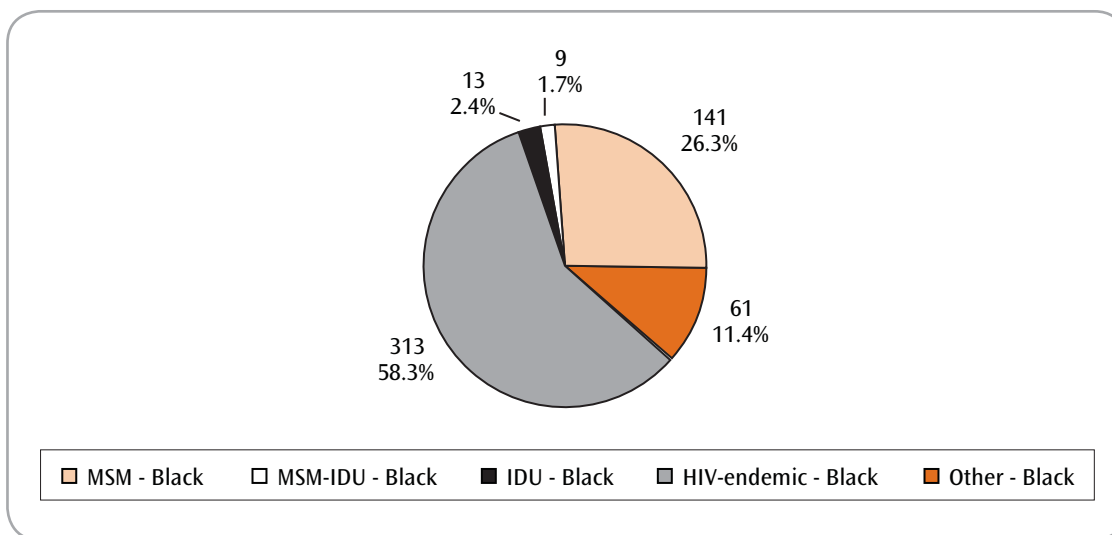
Cumulative Ontario provincial data from 1981–2004 indicate that 58.3% of all AIDS cases with reported Black ethnicity/race were attributed to the HIV-endemic exposure subcategory, 26.3% were from the MSM exposure category, approximately 2% in each the MSM/IDU and the IDU exposure categories, and 11.4% attributed to other exposure categories (refer to Figure 13) [13]. It may not be possible to ascertain whether the Ontario-wide data are skewed by Toronto's large population (thus more closely reflecting the Toronto epidemic), or if time, treatment advancements, and changing immigration patterns have affected the presentation of AIDS cases in the province.

Figure 12: Number and proportion of reported HIV cases by exposure category and race/ethnicity Toronto (1980-2004, n=945) and Ottawa (1983-2004, n=300)



Legend: *Other - Black* exposure category = Heterosexual-Black [Toronto:146, 15.4%, Ottawa: 15, 5%], Transfusion-Black [Toronto: 11, 1.2%, Ottawa: 0, 0%], Perinatal-Black [Toronto: 27, 2.9%, Ottawa: 11, 3.7%], NIR (No identified risk)-Black [Toronto: 9, 0.96%, Ottawa: 1, 0.33%]. (Source: [13], p. 25, table 2.3b).

Figure 13: Total AIDS cases for all exposure categories within the Black race/ethnicity group in Ontario, 1981 to 2004 (n=537)



Legend: *Other - Black* exposure category = Heterosexual-Black [13, 2%], Transfusion-Black [2, 0.37%], Clotting factor-Black [4, 0.74%], Perinatal-Black [25, 5%], NIR (No identified risk)-Black [7, 1.3%]. (Source: [13], pp. 17-19, tables 1.6-1-1.6-3).

3.5 Gender

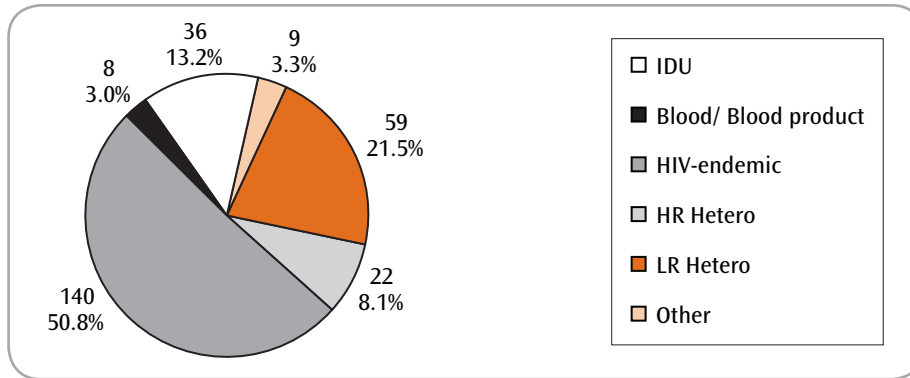
Women are becoming increasingly affected by HIV in Canada. Nationwide data have shown a steady rise in the proportion of reported HIV-positive test results in adult women, climbing from 25.1% (540/1,614) in 2001 to 27.8% (698/1,810) in 2006 [5]. In the HIV-endemic exposure subcategory between 1998 and 2006, women accounted for 54.2% of all positive HIV test reports and 41.8% of AIDS case reports [2]. In 2006 alone, of the 104 reported HIV-positive test results in the HIV-endemic exposure subcategory, only 39 cases were male while 65 were female [5].

While national data illustrate that the HIV-endemic exposure subcategory makes up a cumulative average of 9.0% of newly diagnosed HIV infections in women (from 1985–2006), when separated by year, the 2006 data show the HIV-endemic exposure subcategory represents 20.4% (65/319) of new HIV diagnoses in

women where exposure category was reported [5]. In 2005, women accounted for 63.9% (140) of the 219 people from countries where HIV is endemic who were newly diagnosed with HIV in Ontario, and according to HIV surveillance data from the same year, females from countries where HIV is endemic accounted for 50.8% of all new HIV diagnoses among women in Ontario (see Figure 14).

Similarly 2006 Quebec data reveal that 41.3% of newly diagnosed HIV infections among women were attributed to the HIV-endemic exposure subcategory. While this trend has been observed for the last few years [11], a comparison of the estimated prevalence of HIV infections for the HIV-endemic country exposure subcategory in Quebec revealed an increase from 11% (1,770) in 1999 to 14% (2,500) in 2002. The same study also noted that women from countries where HIV is endemic account for the highest number of AIDS cases among women [14].

Figure 14: Number and proportion of HIV diagnoses among females by year of diagnosis and exposure category, Ontario 2005 (n=276)



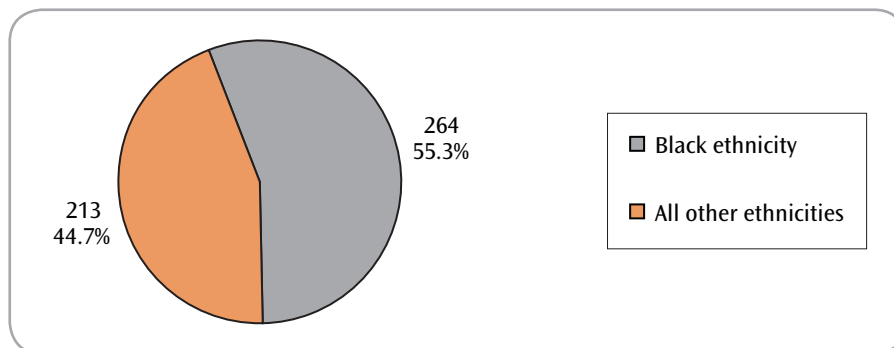
Legend: *Blood/Blood product* = Clotting factor and transfusion; *HR Hetero* = High risk heterosexual contact; *LR Hetero* = Low Risk Heterosexual contact; *Other* = Mother to child transmission, needle stick injury, tattoo, etc. (Source [10] p. 60, table 1.5b).

3.6 Perinatal transmission

Women in the 20 to 39 age group made up more than two thirds (66.9%) of positive HIV test reports among adult women in Canada in 2006 [5]. The high proportion of women in the HIV-endemic exposure subcategory has implications for perinatal transmission. Although provinces and territories offer HIV testing to pregnant women, not all women choose to get tested [15]. Cumulative surveillance data available from 1984–2006

show that nationally, Black infants comprised more than half of the 477 confirmed perinatally exposed HIV cases in Canada (refer to Figure, 15). This trend has, however, decreased over time. In 2006, 97 infants were born to HIV-positive mothers with reported as having an ethnic origin associated with the Black population. Of the 97, only one infant was confirmed to be HIV positive, 83 were not infected perinatally, and the serostatus of 13 infants was unknown at the time of data publication [5].

Figure 15: Cumulative number of Canadian perinatally HIV-exposed infants by ethnic status, 1984-2006 (n=477)



Legend: *Black ethnicity* = For example Somali, Haitian, Jamaican; *All other ethnicities* include: White, Latin American = For example Mexican, Central/South American, Aboriginal = Includes Inuit, Métis, First Nations and Aboriginal unspecified, Asian = For example Chinese, Japanese, Vietnamese, Cambodian, Indonesian, Laotian, Korean, Filipino, Other = 50 children whose ethnic status was undetermined. (Source: [5], pp. 35-36, table 12).

3.7 Age

At the national level, from 1998 to 2006, a substantial proportion of AIDS cases and positive HIV test reports in the HIV-endemic exposure subcategory occurred in young age groups. When the HIV-endemic exposure subcategory is broken down by age, 78.2% of positive HIV test reports from 1998 to the end of 2006 occurred in those less than 40 years of age (34.2% among those under 30 years of age and 44.0% among those aged 30 to 39). From 2001 to 2006, when age was known, 59% of all positive test reports were among those less than 40 years of age (22% among those under 30 years of age and 37.2% among those aged 30 to 39) [2].

For the same exposure category, 43.9% of AIDS cases from 1998 to the end of 2006 were diagnosed in individuals between the ages of 30 and 39, another 15.3% were under the age of 30 [2], while the 30 to 39 age group represented 38% of the total reported AIDS cases from the same time period [5].

HIV/AIDS appears to be affecting younger persons in this subcategory. Again, this re-emphasizes the importance of considering women of childbearing age from countries where HIV is endemic (ages 15 to 44) for prevention and testing initiatives, as well as for potential risks for perinatal transmission of HIV [2].

3.8 Immigration and HIV/AIDS surveillance

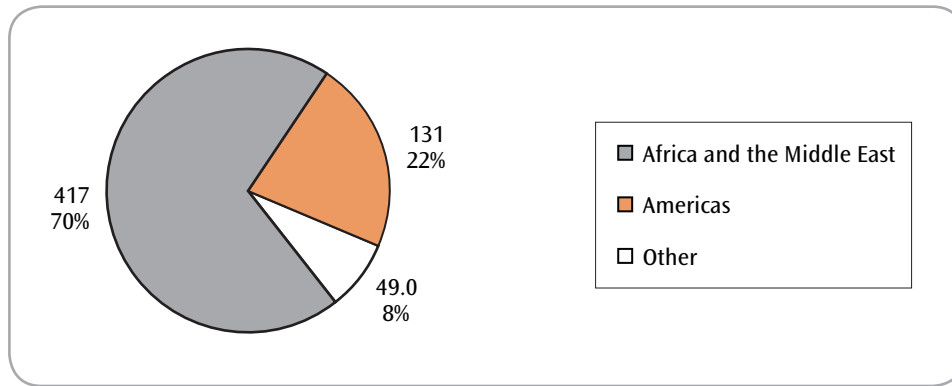
Routine HIV testing of immigrants was implemented in January 2002 by the CIC. All individuals applying to come to Canada permanently and, some applying for temporarily status, are required to undergo an immigration medical examination (IME) and are tested for HIV if aged 15 years and older (or at any age if they present a known risk factor such as a blood transfusion). To be inadmissible under health grounds, an applicant must have a condition that is likely to be

a danger for public health, or public safety, and/or is likely to create an excessive demand on Canadian health and social services [16].

HIV is generally not considered a danger to public health and safety. However, if the HIV-positive applicant's medical requirements are likely to create an excessive demand on the Canadian health care system, the applicant may be deemed inadmissible to Canada under health grounds. The *Immigration and Refugee Protection Act* [17] exempts certain groups of applicants from the excessive demand determination. These groups include refugees, the sponsored spouse of a Canadian permanent resident/citizen and their dependent children. The vast majority of persons diagnosed with HIV during the immigration medical process fall within these groups. Consequently, the majority of HIV-positive applicants are admissible to Canada.

From January 15, 2002, to December 31, 2006, 2,567 applicants who underwent an IME tested positive for HIV. In 2006 alone, 597 applicants tested HIV-positive through this process. As illustrated in Figure 16, their distribution is such that 417 (69.8%) were born in Africa and the Middle East, 131 (21.9%) in the Americas, 29 (4.9%) in Asia and 20 (3.4%) in Europe. These 597 positive tests can be further characterized by testing location as 215 (36%) were from persons who were tested outside of Canada and 382 (64.0%) who were tested in Canada. The 382 HIV-positive tests identified in Canada in 2006 through the IME process represent 14.9% of the total number of HIV-positive tests reported to PHAC through the national HIV/AIDS surveillance system (i.e. a total of 2,558 HIV positive tests were reported to PHAC in 2006) [5].

Figure 16: Proportion (%) of HIV-positive tests received through IME and geographic location of birth of applicant, January 15, 2002 to December 31, 2006 (n=597)



Legend: *Other* = Asia [29, 4.9%] and Europe [20, 3.4%]. (Source: [2], p. 97).

It is not possible to differentiate between infections acquired abroad from those acquired in Canada for individuals tested in Canada. The methods and data currently used by PHAC to estimate the number of new infections in Canada do not allow for this type of analysis. However, this has been the subject of some research.

Data collected in 1999 by Adrien et al. [18] showed an overall HIV prevalence rate of 1.3% among Montrealers of Haitian origin who were either born in Haiti or had at least one parent who was born in Haiti. This study further noted that HIV prevalence was lower among individuals born in Canada and those who had had a longer residence in Canada. In another study, in an attempt to differentiate between the sources of HIV infection in Ontario, a modelling exercise completed by Remis and Merid [19] in 2002 suggested that 20% to 60% of new infections in the HIV-endemic group in Ontario occurred after arrival in Canada. Strain isolation supports this theory, indicating that infections in this population are occurring on Canadian soil, the extent of which is uncertain. More data on HIV transmission needs to be collected to truly understand these trends.

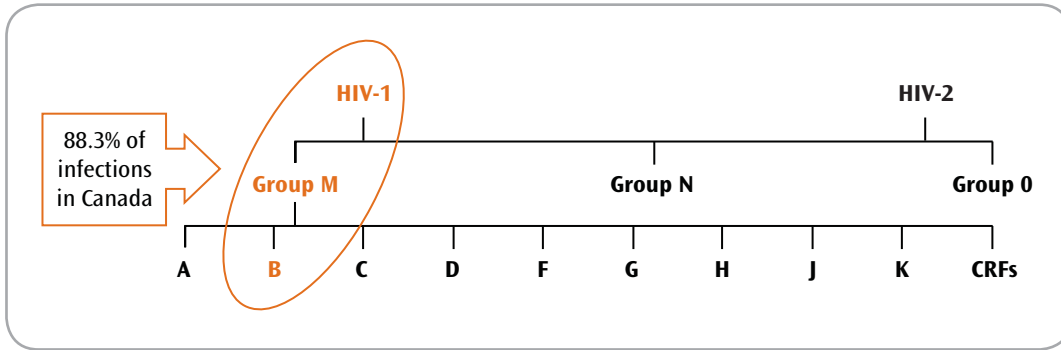
Test results for HIV-positive applicants diagnosed through Canadian laboratories are reported to

provincial and territorial public health officials. Currently, test reports for HIV-positive applicants diagnosed overseas are not reported to provincial and territorial surveillance systems. However, since 2004, jurisdictions wishing to receive this information are notified by the CIC of applicants diagnosed abroad who have entered Canada [20]. The objective of the notification process is to link HIV-positive newcomers to the Canadian health care system upon arrival.

3.9 Virus strain and drug resistance

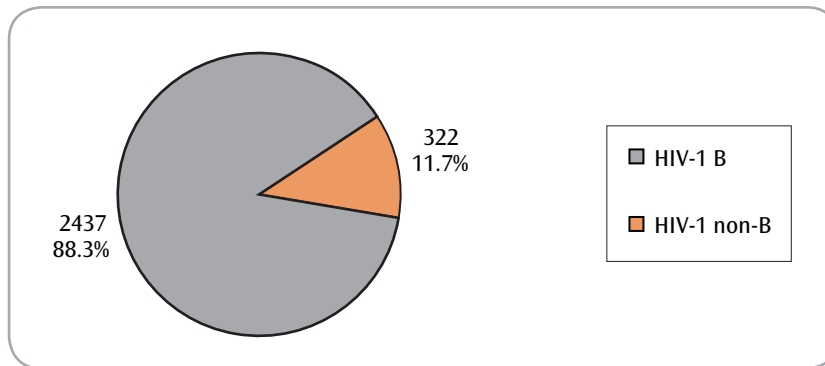
Two types of human immunodeficiency virus (HIV-1 and HIV-2) cause illness in humans. Of the two strains, HIV-1 is responsible for the majority of HIV/AIDS cases worldwide. HIV-2 is much rarer, much less lethal and currently mostly limited to Western Africa [21]. Different subtypes or “clades” of HIV-1 have been discovered and are known to be distributed around the world (see Figure 17). The most common strain in Canada is HIV-1, group M, subtype B, representing 88.3% of infections (refer to Figure 18) [21].

Figure 17: HIV strains



Legend: *Group M* = main; *Group N* = new, non-M, non-O; *Group O* = outlier, *CRFs* = circulating recumbent forms i.e.: subtype AB, BD, or AG. (Source [21], p. 3).

Figure 18: HIV-1 B and non-B strain distribution in Canada 1984 – March 31, 2005 (n=2759)

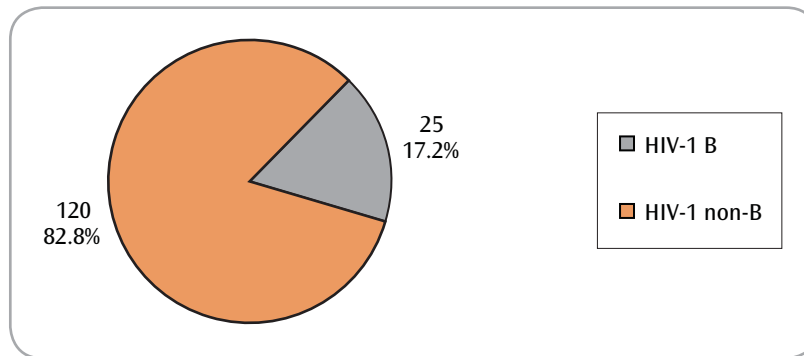


Legend: *HIV-1 Non B* = HIV-1 A, C, D, F, G, H, K, AB, AC, AD, AE, AG, BC, BD, B/AG, K/AE, and K/AG (Source: [21], p. 10, table 6).

Research indicates that 82.8% of cumulative HIV cases reported in the HIV-endemic exposure subcategory were non-B clades of HIV-1 (see Figure 19). Similar numbers are present when analyzing ethnicity data. For example, 74.5% of cumulative cases identified as African or Caribbean were infected with a non-B subtype of HIV. Comparatively, HIV-1 B makes up 97.7% and 96.8% of the MSM and IDU exposure categories, respectively, and 96.1% of cases identified among Caucasians [21].

Higher proportions of non-B subtype infections were detected among females, compared to males which is reflective of the high proportion of females in the HIV-endemic exposure subcategory. Subtypes vary across Canada, likely reflecting travel and migration from regions where other subtypes are dominant [21].

Figure 19: HIV-1 B and non-B strain distribution in the HIV-endemic exposure subcategory in Canada 1984 – March 31, 2005 (n=145)



Legend: *HIV-1 Non B* = HIV-1 A, C, D, F, G, H, K, AB, AC, AD, AE, AG, BC, BD, B/AG, K/AE, and K/AG (Source: [21], p. 10, table 6).

All HIV subtypes are currently showing drug resistance in countries where antiretroviral therapies (ARVs) are widely used, and drug resistance patterns, developing in Canada, are similar to the prevalence of resistance rates observed in other countries where ARVs are used. Data indicating primary drug resistance have been found among the following main exposure categories: MSM, IDU, and heterosexual contact [21]. Additional data are needed at this time to follow patterns and trends in drug resistance in Canada to identify if certain subtypes develop greater resistance than others. Subtypes greatly affect future prevention efforts, such as vaccine development, as any HIV vaccine developed will likely be strain specific [2, 21].

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CHAPTER 4 - Vulnerability to HIV/AIDS

“The communities of people from countries where HIV is endemic are diverse, reflecting variations in historical backgrounds, language and cultural traditions. Unfortunately, these communities are disproportionately affected by many social, economic, and behavioural factors that not only increase their vulnerability to HIV infection, but also act as barriers to accessing prevention, screening and treatment programs” [1].

4.1 Determinants of health

The links between the determinants of health and the well-being of individuals and communities are well documented. “There is very little literature, however, that places HIV/AIDS in this broad population health context. Instead the literature most often explores the association between a particular social determinant and the behaviour that places a person at risk of HIV infection” [2].

This section of the report examines the vulnerability of Black communities in Canada to HIV/AIDS, using a determinants of health lens [3]. Other risk factors, such as sexual violence and racism, are also examined as conditions that increase vulnerability to HIV/AIDS in this community.

4.1.1 Income, education and employment

“Health status improves at each step up the income and social hierarchy. High income determines living conditions, such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies which are prosperous and have an equitable distribution of wealth. Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security, and job satisfaction. And it improves people’s ability to access and understand information to help keep them healthy. Unemployment, underemployment, stressful or unsafe work are associated with poorer health. People who have more control over their work circumstances and fewer stress-related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities” [4].

People with low incomes or living in poverty are more likely than those with higher incomes to be at risk for HIV infection, to have HIV, to progress from HIV to AIDS and to succumb to AIDS more quickly [2]. In examining the relationship between poverty and HIV/AIDS, the report *Deserving Dignity* noted, “It is not surprising, therefore, that the impacts of poverty on the health of people living with HIV are also severe. Inadequate nutrition, poor housing, stress, inadequate access to medications and complementary therapies, and limited social support networks can all have an adverse effect on the health of someone with a compromised immune system.... Another important context of the relationship between poverty and HIV is that HIV infection can often lead to poverty. The disabling effects of the disease – or of the side effects of HIV medications – can affect employment opportunities; the cost of treatments and related therapies can also lead to poverty” [5].

The 2001 census [6] revealed that the Black population in Canada had lower levels of income and higher unemployment rates than the overall Canadian population, even though levels of schooling were comparable. The Black population’s experience in this regard has also been documented elsewhere [7-10]. In 2000, the incidence of low income was substantially higher among Black families (33%) than among the nation’s families as a whole (13%). In addition, a greater number of unattached Black individuals experienced low income in 2000, compared to unattached individuals as a whole (51% versus 38%) [6]. An examination of rates of low income and poverty among ethno-racial groups in Montreal, Toronto and Vancouver found that the rates were higher in the Black population (African and Caribbean groups), compared to a number of other populations (e.g., European ethno-racial groups) [8-9].

The literature notes that many Black people work long hours in more than one job, are given unpopular shifts and experience frequent layoffs. Studies on the effects of shift work indicate that it increases the risk of injury and can lead to poor health outcomes [10].

The majority of us are poor and even if we are working...we are just working for survival... the majority of Black women...that I know are working 1½ jobs plus caring for homes, parents, families, husbands and anybody else. HIV/AIDS is really low in their list of priorities as a whole because they are working 50-60 hours per week. They are unable to supervise their kids' homework and you know they are doing everything, you know that HIV/AIDS gets dismissed. It's the easiest thing to dismiss. - Jamaican woman [11].

4.1.2 Social support networks

“Support from families, friends and communities is associated with better health. Such social support networks could be very important in helping people solve problems and deal with adversity, as well as in maintaining a sense of mastery and control over life circumstances. The caring and respect that occurs in social relationships, and the resulting sense of satisfaction and well-being, seem to act as a buffer against health problems” [4].

The literature on HIV/AIDS and health determinants identifies social support networks as being particularly important for marginalized groups at high risk of contracting HIV and for people living with HIV/AIDS. It has been noted that such supports can improve the quality of life and the life expectancy of people living with HIV/AIDS [2].

As is the case for many immigrant and refugee communities, Black immigrants often experience a loss of support, particularly extended family support, when they arrive in a new country like Canada. The immigration and settlement process sometimes separates

partners as well as parents from their children for extended periods of time. This can leave families fragmented and vulnerable [10].

For Black people living with HIV/AIDS, accessing support services can lead to a number of concerns, particularly around issues of confidentiality, anonymity, privacy, stigma and discrimination. Fear and anxiety about these issues can make individuals reluctant to disclose their HIV status, because of the potential negative impacts on relationships and livelihoods. By neglecting to seek support to help them better live with HIV/AIDS, people become socially isolated, which may, in turn, compromise their health [12].

Fear holds me all the time, you know? I don't want to be judged, I don't want to be outcast. You know? That's really tough.
- HIV-positive Ethiopian man [12].

4.1.3 Social environments and culture

“The array of values and norms of a society will influence in varying ways the health and well-being of individuals and populations. In addition, social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health. Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions, such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services” [4].

In the literature, the social environment for HIV/AIDS is characterized by the discriminatory behaviours of people and governments. According to Spigelman [2], “Prejudice, discrimination and stigma have played a central and defining role in the history of HIV/AIDS in Canada and historically, where discrimination exists,

the virus is more likely to proliferate. Discrimination occurs when particular aspects of some people with HIV/AIDS, such as sexual orientation or drug use, are magnified to the exclusion of the individual humanity of each person with HIV/AIDS and the diversity of all people with HIV/AIDS.”

A significant issue in the social environment of Black communities is the stigmatizing attitudes towards HIV-positive people within the community itself, based on assumptions about the infection (e.g., HIV/AIDS is a “gay disease,” promiscuity leads to infection, HIV is associated with death). This results in denial, whereby HIV is viewed as something that happens to “others.” Gossip, verbal harassment or ridicule, and ostracism are the frequent community responses to HIV. There is also stigma from outside the community, where HIV is often viewed as a Black or African disease. This, too, contributes to the denial of HIV within the community and increases its vulnerability [12].

Everybody in the community, they know I’m HIV positive and they talk bad about me. You know, they even call me names. They don’t know me, they don’t know anything about me, but still, because they found I’m HIV positive, they think I’m a bitch lady. -HIV-positive Kenyan woman [12].

I think part of the denial around HIV, the reason why the mainstream Black community doesn’t want to deal with it, is because AIDS has been portrayed as something from Africa. And like, well, they don’t want the community, the mainstream world, the European white world, to pin this on Black people. So there’s a sort of [view that] it’s homosexual and it’s from sin. It’s not from Africa. -Trinidadian woman [12].

The nurse at the [HIV] clinic, she made a very sarcastic statement. She said she always tells her daughters that everybody from Africa is HIV positive... You know, that is not helping us. We don’t need rejection like that. - HIV-positive Kenyan woman [12].

Another significant issue characterizing the social environment around HIV/AIDS in Black communities is homophobia or the denial of the existence of homosexuality within the community. HIV is often viewed, mistakenly, as a gay disease, and people who are HIV-positive are therefore perceived to be deserving of their situation. Consequently, people who identify themselves as lesbian, gay, bisexual, transgender or queer often do not “come out” for fear of being stigmatized or ostracized within the community. Instead, they keep their sexual orientation or gender identity a secret, and may also engage in relationships with people of the opposite sex [11].

Being homosexual you’re the bottom of the barrel. You add AIDS on to that, you’re underneath the damn barrel. Like, you can be the bottom of the barrel, and then there’s the underside of the bottom of the barrel. And then you’re just totally shunned. -HIV-positive Trinidadian man [12].

A homosexual man will not be accepted by his family, he’s cursed. Because most Ethiopians are very religious and follow the Orthodox religion... these kinds of things are not acceptable. - Ethiopian woman [11].

4.1.4 Physical environments

“Physical environments are an important determinant of health. At certain levels of exposure, contaminants in our air, water, food and soil can cause a variety of adverse health effects, including cancer, birth defects, respiratory illness and gastrointestinal ailments” [4].

The physical environment in which people at risk for, or living with, HIV/AIDS live is closely tied to their income and employment/working conditions. People who have low incomes tend to live and work in places that put them at greater risk of exposure to contaminants that are harmful to their health, as well as to violence. This includes living on the street and being homeless.

Due to low income and poverty, many Black communities in Canada have limited access to safe, affordable housing and instead live in segregated neighbourhoods with limited access to services and greater incidences of violence. According to Galabuzi [13], “In Canada’s urban areas, the spatial concentration of poverty or residential segregation is intensifying along racial lines.” This dimension of social exclusion increases vulnerability to HIV and compromises the health of Black people living with HIV/AIDS.

The physical environment associated with incarceration also places Black communities at particular risk of HIV. A disproportionate number of Black people are incarcerated in Canada and people in prison are 7 to 10 times more likely to be infected with HIV than people who are not incarcerated [14].

In order to establish a profile of visible minority offenders in Canada, a one-day snapshot was taken of all offenders under the responsibility of the Correctional Service of Canada (including offenders incarcerated in federal correctional facilities and those being supervised in the community) in November 2002. For the purposes of this study, offenders were grouped into one of four groups: Caucasian, Black, Asian and “other visible minority”^{xvi}. The study [15] found that:

- In comparison to the Canadian population, Black people were disproportionately represented in the offender community. While representing 2.2% of the Canadian population at this time, Black people made up 6% of offenders incarcerated in federal correctional facilities and 7% of those serving time in the community.

xvi The Caucasian and Black groups were not modified due to their substantial population size in the federal offender population, relative to the other visible minority offender populations. Asian, Chinese, Japanese, Korean, South Asian and South East Asian offenders were grouped into the “Asian” category. Arab/West Asian, Hispanic, Filipino, Latin American, East Indian and “Other” offenders were grouped into the “other visible minority” category.

- In relation to specific groups, Black offenders were more likely to be incarcerated in the Ontario region (56%), followed by the Quebec (19%), Atlantic (12%), Prairies (10%) and Pacific (3%) regions.
- At the time of admission to a federal correctional facility, visible minority offenders were younger than Caucasian offenders. Caucasian offenders had the highest mean age at the time of admission (35 years), followed by “other visible minority” (33 years), Asian (31 years) and Black (30 years) offenders. Similar results were evident among those serving time in the community.
- Although, no significant differences were found in gender among incarcerated offenders (98% of Caucasian and 97% of visible minority offenders were male), a larger proportion of women serving time in the community were Black (11%) when compared to the Caucasian (4%), Asian (7%) and “other visible minority” groups (6%).

4.1.5 Personal health practices and coping skills

“Personal health practices and coping skills refer to those actions by which individuals can prevent diseases and promote self-care, cope with challenges, and develop self-reliance, solve problems and make choices that enhance health” [4].

Black communities are diverse and various personal health practices and coping skills contribute to making Black people vulnerable to HIV/AIDS. Difficulties in discussing or silence around health, sex and sexuality have affected Black communities’ ability to access and receive HIV/AIDS information, whether it is for prevention purposes or targeted at people living with HIV/AIDS [16].

HIV is associated with sex. So in my culture, sex is a taboo, people don’t really talk about their sexual life no matter what, it is not normal.

- Somali woman [11].

Based on factors such as life circumstances, relationship status, housing and immigration status, among others, certain individual risk-taking behaviours in Black communities contribute to the vulnerability to HIV/AIDS, namely:

- sex without condoms;
- sex in rushed and secretive circumstances, which may not allow for negotiation of condom use;
- choosing not to be tested for HIV;
- denial of HIV status and choosing not to disclose HIV status to sexual partners;
- drug use, such as marijuana, which may reduce ability to make decisions around protected sex; and
- involvement in sex work to earn a living [12].

It's against their ethic, it's against everything they believe in, it's like having a plastic on the body and having sexual intercourse, they don't want to do that. And some people, like, they're not even gonna give you a chance to explain it to them. So that's kind of a big problem. - Ethiopian man [12].

I would not go for testing, I know a lot but I wouldn't go to be tested. Because there is... I think that if I test positive now, I can't handle it, I have so many other problems to handle. It's like, okay, maybe I'll wait. Maybe I will feel differently soon but now I wouldn't go. I have too many problems right now to deal with. - African women [11].

Very little information exists on substance use and addictions, including injection drug use, in Canada's Black population [10]. According to a 2001 Health Canada report [17], key representatives from the Black and Caribbean community noted the following trends for substance use and addictions among Black people in Canada:

- Consumption of alcohol is seen as a way of socializing with friends and excessive drinking is not recognized as a health concern. "Closet" alcoholism, particularly among males over 50 years, is attributed to frustration "because these men are highly educated and suffer from unemployment or underemployment." Alcohol is used as a coping mechanism. Alcoholism is seen as a "hidden disease" among Black women, and its impact on family life is going unrecognized.
- Drug addiction – the use of marijuana, hash, crack, cocaine and prescription drugs, as well as the chewing of khat/miraa^{xvii} – is often hidden. Marijuana is seen as an herb that is good for your body [10].
- Smoking is socially acceptable and not viewed as a serious health concern that can lead to lung disease or cancer. It is used to relieve stress [10].

The use of traditional rituals, therapies and treatments can also affect vulnerability to HIV. In the case of Black communities, these include vaginal cleansing (drying out vaginal secretions) and douching, unsafe male circumcision and female genital mutilation [16].

Lack of time and financial limitations have been identified as reasons why Black people often do not see a doctor until they are very ill. They rely instead on home remedies to address symptoms as they arise [10]. This behaviour manifests itself for Black people living with HIV/AIDS. Denial of one's HIV status also results in delaying consulting a doctor until one is very ill, resulting in greater disease progression and the possibility of having developed AIDS.

The majority of Black people in Canada have some religious affiliation. The basic lack of knowledge about HIV coupled with a strong self-identity as being religious appears to inform views about HIV/AIDS and coping

xvii Khat/miraa: a leafy, green shrub whose leaves, when chewed, produce psychotropic, euphoric, metabolic and cardiovascular effects similar to amphetamine.

strategies. This results in particular beliefs – and consequently, behaviours – that may increase the vulnerability of Black communities to HIV/AIDS. Of particular importance are beliefs around sex, sexuality and death. Sex is often a taboo subject that warrants limited or no discussion with or among religious leaders, and also limits discussions about HIV prevention and support to people who are HIV positive. People living with, or affected by, HIV/AIDS are often isolated, as they fear the impact disclosure will have on their involvement and participation in their religious community. Within some religious contexts, there is a view that HIV-positive people have ignored the limits around sex or violated a “moral code,” bringing shame on themselves, their parents and their families: HIV is seen as a punishment. On the other hand, religion can play a positive role in helping people cope with HIV/AIDS [12].

We've found that...women seem to be more religious. This is the observation we've made: more women attend religious services than men. The woman might be an ardent believer and the husband is not. So the women may think that fidelity within the marriage is okay, so they are less prone to involve themselves in extra-marital sexual relationships, where as the husband who is not very religious finds that it's okay to go outside to other women. So we found the...women, inasmuch as they are following their belief system ardently are still becoming infected with HIV.

- Faith-based AIDS service provider, [11].

4.1.6 Healthy child development

“New evidence on the effects of early experiences on brain development, school readiness and health in later life has sparked a growing consensus about early child development as a powerful determinant of health in its own right” [4].

The literature on HIV/AIDS and health determinants makes little reference to healthy child development specifically, but does refer to early childhood experiences. A

history of sexual abuse is clearly associated with risk-taking behaviours; namely, children who experience sexual abuse, and other forms of abuse for that matter, are more likely to engage in behaviours that place them at greater risk of contracting HIV [2].

There is little discussion about childhood sexual abuse in Black communities (in general, the issue of sexual violence is seldom discussed). When documented, it was noted that childhood sexual abuse may directly lead to HIV infection or, in its aftermath, compromise one's ability to practise HIV prevention [16].

Two groups within Black communities that have received little attention but are particularly vulnerable are children and youth who were born and are living with HIV/AIDS and children and youth who have been orphaned as a result of AIDS. Within this context, particular issues surface for parents that inform their children's development. For example, HIV-positive parents are concerned about disclosure and who will care for their children in the event of illness or death. This added stress can affect the rearing of their children. HIV-positive parents may be separated from their children, may care for children who are also HIV-positive, and may experience guilt associated with having an HIV-positive child [12].

It's tough without your family. I have nobody. Like I think sometimes now if something happened to me, what would happen with my kid? I don't like to talk about it too much because it makes me feel like crying because I really love my family so much. And I'm thinking I hope God will help me to bring them here to be with me.

- HIV-positive Kenyan woman [12].

4.1.7 Biology and genetic endowment

“The basic biology and organic make-up of the human body are a fundamental determinant of health. Genetic endowment provides an inherited predisposition to a wide range of individual

responses that affect health status. Although socio-economic and environmental factors are important determinants of overall health, in some circumstances, genetic endowment appears to predispose certain individuals to particular diseases or health problems” [4].

While there is no evidence demonstrating that Black people are genetically predisposed to HIV, it seems biologically plausible that susceptibility to HIV might differ between populations. According to Pepin [18], to some extent, the high HIV prevalence among African-Americans is certainly a result of poverty, behaviour and higher rates of STIs. However, a 2004 study of gay men in seven American cities showed that differences in risky behaviours could not explain the racial/ethnic disparities in HIV prevalence among these men, therefore reinforcing the plausibility of the hypothesis that population genetic susceptibility could be one of many determinants.

Also, there appears to be some differences in the response to various HIV/AIDS treatments and therapies between Black people and other populations. Studies conducted in the United States have shown that:

- People of African descent are seven times more likely than white people to carry a specific variant of the gene controlling expression of the CYP2B6 isoenzyme. As a result, Black people, as a group, eliminate efavirenz more slowly, potentially leading to more intense side effects but also greater efficacy. P-glycoprotein expression also varies by racial/ethnic group [19].
- People of Black African descent (often lacking the genetic marker HLA B7501) have lower rates of hypersensitivity reaction to abacavir. As a result, the use of zidovudine/lamivudine/abacavir may be the appropriate regimen for an African-American, treatment-naive person with initial drug resistance and a low-baseline viral load [20].

Issues related to the influence of biology and genetics need to be further investigated through research to fully assess their influence on HIV/AIDS prevention, care, treatment, support and diagnosis services.

4.1.8 Health services

“Health services, particularly those designed to maintain and promote health, to prevent disease, and to restore health and function contribute to population health” [4].

The literature on HIV/AIDS and health determinants notes that the assumption that most people have considerable faith in the health care system and seek its services may not hold for many of those at risk of HIV infection or living with HIV/AIDS. Further, it states that the health system itself is partly responsible for the poor health outcomes evident in these populations, as people often face barriers to accessing the care and treatment they need [2, 21]. For many newcomers to Canada, their perception of what is adequate in the Canadian health care system will vary depending on their experience in accessing services in their country of origin.

For Black communities, numerous barriers to accessing appropriate and responsive health services have been documented, including:

- institutional discrimination and the poor representation of Blacks among health care personnel, especially at the decision-making levels;
- lack of culturally sensitive and appropriate information;
- demeaning treatment and lack of cultural understanding by health care staff;
- low-quality or no health services in areas with large Black populations (e.g., in parts of Halifax and Windsor);

- lack of awareness by community members of the services available to them;
- lack of counselling around HIV;
- a shortage of translators and the lack of information available in appropriate languages other than English or French; and
- difficulties communicating with health care personnel because of differences in language, accent, terminology used to describe body parts and illnesses, and ways of communicating [10].

The larger agencies providing HIV/AIDS services often do not have culturally appropriate services...the few agencies we do have offering culturally appropriate and contextualized services often don't have the personnel and the facilities to provide adequate services for the people...People have a dilemma, that those services that are available they can't access them effectively because they are not appropriate to their context, and those that are appropriate don't have all the resources or facilities to provide the services.

- Faith-based AIDS service provider [11].

Research conducted on the location and distribution of HIV service providers in Toronto found that communities with less access to HIV-related services were characterized by higher levels of concentrated economic disadvantage, immigration and percentage of the Black population in Canada [22]. Other research has noted that Black people living with HIV/AIDS received very high-quality health care in Toronto, and that experiences with AIDS service organizations had been generally positive, as these were seen as places to access support, experience a sense of community and access opportunities for volunteering and employment [12].

4.1.9 Gender

“Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. “Gendered” norms influence the health system’s practices and priorities. Many health issues are a function of gender-based social status or roles” [4].

The literature on HIV/AIDS and health determinants notes that women’s gender-based biological susceptibility to HIV/AIDS is exacerbated by their social and economic circumstances [2].

Gendered norms in Black communities make both men and women vulnerable to HIV. They prescribe roles based on male domination over women (patriarchy) and characterize the associated behaviours as “cultural” or “religious” norms. There tends to be a double standard regarding the practice of having multiple sex partners, in that this behaviour is allowable and sometimes expected of men but not of women. While female partners may be aware of this behaviour and its potential risk for HIV infection (because of lack of condom use), they may accept to maintain a relationship for financial, emotional or social reasons. This behaviour may also be accepted if the female partner is dependent on the male partner during the immigration process or is not able to communicate in either English or French [11].

In literature specific to HIV/AIDS in Black communities, identified gender differences include a tendency for Black heterosexual men to be more likely to deny being HIV-positive, a negative impact on intimate relationships after diagnosis for many women, and the threat and experience of physical and sexual violence against women [12].

You don't want to get in that. Because you meet somebody, what are you going to tell them, 'I'm HIV positive?' Nobody's going to want to be with you unless it's another HIV-positive person. Right?
- HIV-positive Jamaican woman [12].

4.2 Other factors that increase Black people's vulnerability to HIV/AIDS

4.2.1 Sexual violence

While sexual violence is linked to other determinants of health, it warrants special attention both for its gendered nature and for its particular manifestation in Black communities.

According to the *HIV Prevention Guidelines and Manual: A Tool for Service Providers Serving African and African Caribbean Communities Living in Canada* (2006) [16]:

- Sexual and physical violence against women and children has a direct impact on the ability of women and children to practise HIV prevention. In many African and African-Caribbean cultures, underlying issues of violence are never discussed within the family and/or community. The few girls or women who come forward often face stigma and reprisal from family for speaking out and/or seeking support, particularly if the perpetrator is a member of the immediate or extended family or part of the larger African and African-Caribbean community.
- Forced sex, rape, childhood sexual abuse and incest may directly lead to infection, while fear of sexual and physical violence limits women's ability to negotiate condom use. Many African women have fled persecution from war-torn countries of sub-Saharan Africa, where they may have been raped and tortured, which may have resulted in physical injury, pregnancy and exposure to HIV.
- Girls; young women; lesbian, gay, bisexual, transgendered and queer people; and people living with disabilities are often targeted for physical and sexual victimization. Although boys and men also experience sexual violence, it is important to acknowledge that girls and women are disproportionately affected by sexual and physical violence regardless of their country of origin, culture, social class,

religion or ethnic group. Their ability to practise HIV prevention may be affected by the aftermath of sexual violence (e.g., depression, loss of value, loss of sense of well-being). Research findings also indicate that sexual abuse in childhood may place survivors at risk for physical and sexual abuse in adulthood, which may limit their ability to negotiate safer sex and/or identify their right to protect their body. The impact of sexual violence must be recognized in designing practical primary and secondary HIV prevention activities, such as outreach programs and HIV testing campaigns.

4.2.2 Racism

Racism, like sexual violence, is linked to other determinants of health. However, to gain a comprehensive understanding of the other determinants of health and the particular vulnerability of Black communities to HIV/AIDS, it is necessary to understand what it means to be Black in Canada.

With a history that dates back to the 1600s, the Black communities in Canada have long had to endure systemic exclusion, marginalization and discrimination based on race. This has limited opportunities in many areas, such as education, employment, housing and civic participation, which, in turn, has compromised good health for Black community members. The existence and devastating impact of racism in Canada has been recognized by the Government of Canada and is reflected in its document *A Canada for All: Canada's Action Plan Against Racism* [23].

The experience of racism actively intersects and interacts with other systemic issues, such as those based on gender, sexual orientation and socio-economic status, to produce particular risks of HIV infection and a particular experience of living with HIV for Black community members. What this highlights is that Black people's risk of HIV infection is not simply a matter of individual behaviour, but rather is part of a larger system that informs that behaviour. This message is

echoed in two recent publications specific to HIV/AIDS in Black communities:

African and Caribbean participants told us that HIV stigma and discrimination are produced and reproduced in broader social processes and structures, cultural and religious beliefs, and in everyday interactions. The intersecting sites of discriminatory attitudes and practices have profound effects on people who live with HIV, and who are forced to negotiate a host of relationships and services to maintain safety and confidentiality....The Stigma Study further provides insights into how gender, race and poverty intersect with HIV/AIDS-related stigma, denial, fear and discrimination. An understanding of these multiple issues is not limited to local experiences, but is situated in global processes, such as crossing borders in search of better opportunities, safety and security; the isolation of living in a foreign place; the loneliness from missing loved ones, the difficulty of trying to establish new relationships and networks, and the decision to shield family 'back home' from an HIV-positive diagnosis received in Toronto [12].

... individual sexual behaviours are directly influenced by broader multiple intersecting factors, such as gender, race, economic, socio-cultural, religious and sexual orientation. The intersectionality of these factors increases African and Caribbean women's risk of contracting HIV and compound HIV-positive women's ability to cope with the impacts of the disease [11].

Racism and discrimination leave groups of people particularly vulnerable to HIV infection by excluding them from the social and economic mainstream and by denying them the social supports needed to enhance and preserve life [2].

A study on *Health Promotion and Population Outreach in the Black and Caribbean Canadian Community* (2001)

[17], noted that all of the key informants stated that racism has a negative effect on determinants of health, such as self-esteem, education, employment, income, housing and living standards. This is contributing to high dropout rates from schools, under-employment of immigrant professionals, unemployment, career stagnation and low incomes. Low incomes mean that many cannot afford proper housing or healthy, nutritious foods. The key informants also identified living with racism as a source of stress.

According to Statistics Canada [24], Blacks are more likely to feel that they had been discriminated against or treated unfairly by others because of their ethnicity, culture, race, skin colour, language, accent or religion. Nearly one third (32%) of Blacks aged 15 and over said they had had these experiences sometimes or often in the past five years, compared with 20% of all visible minorities and 5% of those who were not a visible minority. Another 17% of Blacks rarely reported these experiences, compared with 15% for all visible minorities and 5% of those who were not a visible minority.

A five-year study is currently underway with African-Canadian community members in Halifax, Toronto and Calgary to study the impact of violence – including the violence of racism – on their health and well-being. Some of the key themes to have emerged from various community forums include:

- racism makes Black people sick – it is a disease that eats away at community members' physical, mental, emotional and spiritual well-being. It is destructive, demeaning, dehumanizing, frightening and painful;
- although it manifests itself differently than in the past, racism occurs daily in the workplace, in the educational system, in the streets, and in the popular culture. This was echoed in Toronto and Calgary; and
- racism is subtle and, therefore, hard to detect, particularly when it is institutionalized [25].

Racism within the different systems, particularly the health care system, determines women's health. Racism influences access to...things such as education, jobs...all that Canadian society has to offer. Issues of poverty that are connected to access, issues of health that are connected to access, issues that are often overlooked and those connections are generally not made. I think that racism is a big determinant of health. Above issues come before thinking about HIV/AIDS and certainly these issues would sort of rank up there and HIV/AIDS would be something in the distance.

- Jamaican woman [11].

4.2.3 Immigration

The introduction in January 2002 of the mandatory medical screening of immigrants to Canada for HIV infection has had an impact on the Black community. For some Black people, they became aware of their positive HIV status through this process. The potential implications are numerous, particularly if persons testing positive are unaware of their rights, fear that the positive diagnosis will jeopardize their chances of staying in Canada, or are unable to access care and services. A positive diagnosis in Canada may also pose challenges around disclosure and reunification with children and family, and may affect a person's ability to work and send money to family outside of Canada [12]. Issues such as these highlight the transnational realities of HIV/AIDS for many Black people in Canada, as they are often linked, through ancestry or current relatives, to other countries.

The immigration law here in Canada changes like every six months. So even if you apply for something, within six months they can change it. Then that's it. That's your bad luck. I'm not even going to [apply for legal residence status] because the fact that even if you go and say, 'you know, if I go to Jamaica I'm going to die because they don't have any resources.' That's a good point to take to them but they don't care really.

- HIV-positive Jamaican woman [12].

People were overwhelmed by basic needs issues so they were having trouble maintaining housing, finding housing, feeding their children, employment and paying immigration lawyers so they are leaving [their appointment] with a lot of family depression around their HIV. - Public health provider [11].

Canada's decision to screen potential immigrants for HIV/AIDS may also have had unexpected effects on the attitudes of young Black people, as demonstrated in a study of vulnerability and sexual risk among African youth in Windsor, Ontario. The study found that "both male and female participants felt that they were less vulnerable to HIV in Canada....participants generally agreed that the Canadian immigration service only awards visas to immigrants who have a clean bill of health" [26].

The Committee for Accessible AIDS Treatment identified challenges for people living with HIV/AIDS associated with access to health care and treatment, such as lack of health insurance, including ineligibility for provincial assistance with drug costs; and community social and legal services, e.g. concern around being "discovered" and potentially deported because of sharing of information between agencies. The committee mentioned the need for a supportive environment for people living with HIV/AIDS who are immigrants, refugees or without status [27]. This has also been highlighted by a Montreal research team that has identified the importance of access to appropriate health care services for refugees and persons seeking asylum to address the multilayered level of stress and burdens of this population [28].

ICAD identified the relationship between international migration and effects on HIV/AIDS as an issue of concern. The effects of regional conflict, globalization, environmental disasters and a global reduction in public spending on health care have had a major impact on both HIV/AIDS and migration. For instance, the search for work and the possibility of a better life in a country like Canada have shaped labour migration. As is the case with many mobile populations, migrant workers are susceptible to health problems, including HIV infection [29].

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CHAPTER 5 - Current HIV/AIDS Research

5.1 Funded research

HIV/AIDS research in Canada extends to behavioural, biomedical, clinical, economic, epidemiological, legal and psychosocial fields of studies.

A review of the priorities of HIV/AIDS research funding bodies revealed that the CIHR and the OHTN had identified people from countries where HIV is endemic and Black communities as a priority.

A review of funded research specific to HIV/AIDS and Black communities in Canada identified 19 research projects. Of the 19 projects identified, most are taking place at the municipal level in Alberta, Ontario and Quebec. The research taking place in Alberta focuses on newcomers/recent immigrants from countries where HIV is endemic, particularly those from Africa. Only two research projects explicitly focus on people living with HIV/AIDS – one on women living with HIV/AIDS in Quebec, the other on recent immigrants living in rural Alberta. Three research projects focus on women and two focuses on Black gay, bisexual and other Black MSM. In the majority of cases, collaboration between academics and community service providers was identified. In general, the research projects identified are conducting psychosocial and behavioural research, which will allow for the description of experiences and the identification of needs, issues, challenges and solutions by community members, and, in some situations, service providers. The following are general areas of investigation:

- Knowledge of, and attitude towards HIV/AIDS;
- Risk-taking behaviour – contributing factors and mitigating strategies;
- Community needs and priorities for HIV/AIDS programs and services;
- Strategies for increasing access to programs and services; and

- Strategies to enhance design and delivery of programs and services.

The following is an annotated listing of currently or recently funded research projects referenced above.

1. **Title:** *A prospective study to explore the impact of housing support and homelessness on the health outcomes of people living with HIV/AIDS in Ontario*

Researchers: Ruthann Tucker (University of Toronto), Saara Green (York University, Toronto), Steve Byers (AIDS Niagara), James R. Dunn (Centre for Research on Inner City Health [CRICH], St. Michael's Hospital, University of Toronto), Dale C. Guenter (McMaster University), Stephen W. Hwang (CRICH, St. Michael's Hospital, University of Toronto), Jay Koornstra (Bruce House, Ottawa), Laverne E. Monette (Ontario Aboriginal HIV/AIDS Strategy, Toronto), Lea A. Narciso (Ontario AIDS Network, Toronto), Sean B. Rourke (CRICH, St. Michael's Hospital, University of Toronto), Michael Sabota (AIDS Thunder Bay).

Description: Security and quality of housing is an important determinant of health, although its impact remains poorly understood. There is little information about the housing status of people living with HIV/AIDS (PHAs) in Ontario; about the housing-related supports that are required by PHAs to ensure safety, health and dignity; and the effect of housing situation on health and on health and social service utilization. We propose to expand and enhance the work of a 2-year study (start Apr. 2005) that explores the housing status and issues for PHAs, in order to achieve the following main objectives: 1) to understand factors that affect housing status of PHAs; 2) to understand quality of housing, level of housing security, and related supports impact the mental and physical health of PHAs; 3) to understand how these factors impact the access to and utilization of health and social services; and 4) to highlight similarities and differences between

particular groups of PHAs including aboriginals, ethnic minorities, women, sexual minorities, youth, and ex-prisoners with regard to their experiences of housing and homelessness. Our overarching hypothesis is that good housing quality and security is an important factor contributing to the mental and physical health of PHAs, and to their access to health and social services. We also hypothesize that good quality and security of housing decreases unnecessary health and social service utilization, and results in cost savings. Finally, we hypothesize that there are risk factors, including demographic characteristics and health status that play a role in the housing and homelessness of PHAs. We will collect both qualitative and quantitative data in a longitudinal, province-wide study design in which PHAs will be followed for up to three years. Changes in housing status will be observed, along with factors that play a role in these changes, and outcomes resulting from these changes.

Funder: Canadian Institutes of Health Research (CIHR), 2005 – 2008

Reference: <http://www.hivresearch.ca/index.asp?navid=17&csid1=1203>

2. **Title:** *Advancing HIV services research: Expanding Andersen's health services utilization framework*

Researcher: Catherine A. Worthington (University of Calgary)

Description: The goal of this three year research program is to conduct a series of collaborative and interdisciplinary research projects to improve HIV health services for specific groups, including HIV prevention and care needs of newcomers to Calgary from HIV-endemic countries in sub-Saharan Africa. This collaborative study will benefit from the direct participation of service providers and members of the populations under study to ensure knowledge exchange and timely uptake of research results.

Funder: Alberta Heritage Foundation for Medical Research (AHFMR), 2005 – 2008

Reference: <http://www.ahfmr.ab.ca/experts/search.php?researcherid=382>

3. **Title:** *An integrated training program in health and social science research to improve the health of marginalized populations*

Researchers: Patricia O'Campo (Centre for Research on Inner City Health [CRICH], St. Michael's Hospital, University of Toronto), Richard H. Glazier (CRICH, St. Michael's Hospital, Institute for Clinical Evaluative Sciences [ICES], Toronto), Ahmed Bayoumi and Kamran Khan (CRICH, St. Michael's Hospital, Toronto), Donald Wasylenki (Li Ka Shing Knowledge Institute, St. Michael's Hospital, University of Toronto), Blake Poland (University of Toronto), James Lavery (CRICH and Centre for Global Health Research [CGHR], St. Michael's Hospital, University of Toronto), Rosane Nisenbaum, (CRICH, Applied Health Research Centre [AHRC], St. Michael's Hospital, Toronto), Stephen W. Hwang, James Dunn and Janet Smylie (CRICH, St. Michael's Hospital, University of Toronto), Kelly Murphy (Ministry of Health and Long-Term Care, Toronto)

Description: As we enter the 21st century, there are major challenges to improving the health of those Canadians who are disadvantaged and underprivileged: those with HIV/AIDS, Aboriginal peoples, new immigrants, those with mental illness, substance abuse or low socioeconomic status, amongst others. The goal of this CIHR program is to train a new generation of health researchers who will undertake a true transdisciplinary approach, using a variety of methods to understand and impact on the health issues of marginalized populations. We seek to train young investigators with the values and skills to build their own research programs designed to ultimately improve the health of marginalized Canadians.

Funder: Canadian Institutes of Health Research (CIHR), 2003 – 2009

Reference: <http://www.stmichaelshospital.com/crich/training.php>

- Title:** *Building capacity to reinforce adherence to antiretroviral therapy and sexual prevention for patients in or from resource-limited settings*

Researcher: Vinh-Kim Nguyen (Lady Davis Institute, Jewish General Hospital Montreal)

Description: This project aims to respond to the challenges raised by expanding access to anti-retroviral therapy (ART) in Africa and the growing epidemic in women from endemic countries in Canada. Specifically, we are concerned with providing knowledge to more effectively sustain treatment effectiveness and improve prevention measures in patients on treatment, particularly for women in or from endemic countries. Our study will be a prospective multicentre cohort study in 6 sites prescribing ART in Burkina Faso and Mali. We will enroll 800 patients starting ART. In this cohort, we will (1) Describe treatment effectiveness using immunologic and clinical outcome measures (CD4 response, AIDS defining illness and death); (2) Describe adherence to Highly Active Antiretroviral Therapy, using questionnaires we have previously validated in this population, by calculating time to nonadherence; (3) Describe adherence to sexual behaviours that reduce HIV transmission risk by calculating time to consistent condom use for people with regular sexual partners and time to notification of sexual partners for those patients who have not yet notified partners of their HIV+ status. Gender-specific models will be developed to identify factors that influence adherence and preventive behaviour for women and men separately.

Funder: Canadian Institutes of Health Research (CIHR), 2006 – 2009

Reference: <http://www.hivresearch.ca/index.asp?navid=17&csid=1838>

- Title:** *Contextual factors affecting HIV/AIDS treatment and prevention amongst recent immigrants from endemic countries*

Researchers: Tam Donnelly, Daniel W.T. Lai, Paul Schnee and Catherine A. Worthington (University of Calgary)

Description: Over the past few years, Alberta has had an increase in the number of immigrants with HIV or AIDS, who came from countries with high numbers of people with HIV/AIDS. The purpose of this study is to (a) find out how recent immigrants living in small towns in Alberta seek help to manage their HIV/AIDS, prevent the spread of HIV, and deal with social stigma; and (b) find out how to be effective in meeting the needs of recent immigrants living with HIV/AIDS, and in promoting the use of HIV prevention activities. This study asks five questions related to the purpose, as well to what kinds of things influence how recent immigrants access health care and social support services, and what or who encourages them to seek the right kinds of help for their HIV/AIDS and prevent its spread. The research questions will be addressed from both the immigrant and the health care provider's perspectives using interviews. We want to recommend ways to strengthen Alberta's health delivery system and create supportive environments for recent immigrants to seek care and to prevent HIV/AIDS.

Funder: Canadian Institutes of Health Research (CIHR), 2007 – 2009

Reference: http://www.irsc.gc.ca/f/decision_media/2007/200609mopc_f.pdf

- Title:** *Development of migration and reproductive health studies*

Researchers: Anita J. Gagnon (McGill University), Geoffrey Dougherty (McGill University, The Montreal Children's Hospital), Anne M. George (Centre for Community Child Health Research, Vancouver), Jacqueline Oxman-Martinez (Université de Montréal), Jean-François Saucier (Hôpital Ste-Justine, Université de Montréal), Elizabeth A. Stanger (Vancouver Coastal Health), Donna E. Stewart (University Health Network, Toronto General Hospital), Olive Wahoush (McMaster University, Hamilton)

Description: In Canada, as in other countries, successful resettlement of newcomers varies based on bio-psycho-social, migration and resettlement factors. Most vulnerable are: women who have left their countries by force (e.g., war, rape or abuse histories), are separated from their families, have limited knowledge of the official languages, are visible minorities, and are in precarious immigration categories (e.g., asylum-seekers, participants in the “live-in caregiver” program, or “mail-order brides”). The relationship of migration to reproductive health has been relatively neglected. Effective and acceptable family planning and post-abortion care, STI/HIV prevention, and optimal pregnancy and childbirth, and postpartum outcomes are vital to the health of these women and society at large. Studies meant to examine the extent to which characteristics of migration-related vulnerability affect reproductive health and health care, as well as the relative effect of these characteristics when compared to Canadian-born women, have begun. Two pan-Canadian (Montreal, Toronto, and Vancouver) studies are underway. In one, a broad range of reproductive health determinants and outcomes have been identified, questionnaires to measure them located or developed, and extensive translation procedures into 12 different languages begun. In the other, the health and social care needs of mothers and infants at one week postpartum and whether these needs are being addressed in the context of short postpartum stays is being assessed. Both studies are being informed by national and community (based in each city) advisory groups com-

posed of policy-makers, service providers (licensed professionals and non-governmental organizations), and researchers to ensure study relevance to policy development and knowledge transfer. Follow-up studies needed include, “Pregnancy and Childbirth in Newcomers” and “Needs of Newcomer Families One Year after Birth”.

Funder: Canadian Institutes of Health Research (CIHR), 2003 – 2004

Reference: <http://www.mcgill.ca/nursing/research/projects>

- Title:** *Development of tools to support the prevention of HIV, HVC and other STI's among Quebecers of Haitian origin, and care for persons with these infections (Phase 2)*

Researchers: Alix Adrien (Direction de la santé publique Montréal Centre), Valérie Lépine (Direction de la santé publique, Agence de la santé et des services sociaux de Montréal), Joseph Jean-Gilles (GAP-VIES, Montréal), Riyas Fadel (COCQ-sida, Montréal), Carole Morissette (Direction de la santé publique, Agence de la santé et des services sociaux de Montréal)

Description: A knowledge transfer project on sexually transmitted and blood borne infections among Quebecers of Haitian origin is currently underway. It began with the identification of the key needs and issues encountered by workers in these areas. Data from scientific studies was used, semi-structured interviews were conducted with key actors and workshops were held with our partners. The following phases consisted of documenting the state of knowledge and identifying tools for more effective intervention. The project is aimed at developing and disseminating appropriate, culturally adapted tools for preventing sexually transmitted and blood borne infections in this population and caring for people with these infections.

Funder: Ministère de la santé et des services sociaux du Québec – Quebec Ministry of Health and Social Services, 2007–2008

8. **Title:** *Engaging people from HIV endemic countries (Nigeria, Sudan, and South Africa) in Calgary*

Researchers: Nedra Huffey (AIDS Calgary), Catherine A. Worthington and David C. Este (University of Calgary)

Description: This community-based research project is being undertaken by AIDS Calgary and research partners at the University of Calgary to investigate 1) the HIV/AIDS service needs and priorities of African newcomers, 2) how these needs can be met in conjunction with other African newcomer service priorities, and 3) the most appropriate ways for AIDS service organizations in Calgary to engage African newcomer communities in the design and delivery of HIV/AIDS services. The emphasis in this study will be on relationship building and mutual learning among HIV service providers, members of the African newcomer communities, and academic partners.

Funder: Canadian Institutes of Health Research (CIHR), 2006 – 2008

Reference: <http://www.irsc.gc.ca/e/30705.html>

9. **Title:** *Experiences of maternity and antiretroviral treatments among women from Aboriginal, Haitian, African and Quebec backgrounds living with HIV/AIDS*

Researchers: Isabelle Toupin, Joanne Otis and Mylène Fernet (Université du Québec à Montréal)

Description: Few studies in Canada and Quebec in particular, have focused on the representations of antiretroviral treatments for HIV and their impact on the daily lives of women who have the infection. Even fewer studies have involved women from African, Haitian or Aboriginal backgrounds in

a situation of migration (Gallant, 2000; Lévy et al., 2000; Rogers et al., 2000; Sendi et al., 1999). The experience of maternity, which few studies have considered, seems key to constructing the relationship with HIV infection, adherence to treatment and secondary prevention. Given the scarcity of studies aimed at understanding the experiences of women with HIV/AIDS who are on antiretroviral treatment, including their relationships with children (desire to have children, pregnancy, childbirth, maternity, vertical transmission), this study will help advance knowledge which is currently limited. Once the study is completed, we will be able to identify secondary HIV/AIDS prevention strategies and better understand the issues related to adherence to retroviral treatments in the ethno cultural communities targeted by the project.

Funder: Canadian Institutes of Health Research (CIHR), 2006 – 2009

Reference: <http://www.irsc.gc.ca/e/31367.html>

10. **Title:** *Exploring the impact of cultural constructions of disease on community and health care support for immigrant women living with HIV/AIDS in Toronto*

Researcher: Françoise Guigne (Simon Fraser University, Vancouver)

Description: *no abstract provided*

Funder: Social Sciences and Humanities Research Council (SSHRC), 2006 – 2007

Reference: <http://www.hivresearch.ca/index.asp?navid=17&csid1=1601>

11. **Title:** *Getting to know the community: Who are the Black men who have sex with other men?*

Researchers: Clemon George and Sean Rourke (St. Michael's Hospital, Toronto), Winston Husbands

(AIDS Committee of Toronto), Joseph Beyene (Hospital for Sick Children, Toronto), Robert Remis (University of Toronto), Barry Adam (University of Windsor)

Description: Canadian studies of sexual behaviour and determinants of HIV infection among homosexual men have included Black men who have sex with men, but the results and service implications are in determinant for two main reasons: (1) researchers have found it difficult to recruit large enough numbers of Black MSM for studies that are designed for mainstream gay populations; and (2) recruitment is normally done from gay environments that may not be frequented by non-gay-identified Black men. This leaves us with an incomplete understanding of the risk behaviours and sexual relationships of Black MSM. Further, HIV prevention activities that are designed for gay, Caucasian men and target Black MSM may not be particularly well informed. The study seeks to: (1) describe the risk behaviour of Black MSM and variables associated with these behaviours; (2) understand how lived experiences and everyday decision-making are associated with (un)protected sex; and (3) understand how Black MSM interpret and assess the role of AIDS service organizations in their networks or communities.

Funder: Ontario HIV Treatment Network (OHTN), 2005 – 2007

Reference: <http://hivresearch.ca/index.asp?navid=17&csid1=1421>

12. **Title:** *HIV/AIDS Experience of Alberta women who are from countries where HIV is endemic*

Researchers: Aniela dela Cruz and Judith E. Mill (University of Alberta, Edmonton)

Description: The purpose of this study is to explore and understand the experiences of HIV-positive Alberta women who are from Sub-Saharan Africa.

The objectives of this study are: to understand how women experience their HIV diagnosis, treatment and support in their community; and to understand how women's HIV illness impacts their social and familial relationships. There are a number of women from Sub-Saharan African countries living and working in Alberta who may be infected with, or affected by, HIV. The literature shows relatively few studies which explore HIV/AIDS among immigrants to Canada from Sub-Saharan Africa. With evidence showing increased number of positive HIV tests and AIDS diagnoses in Sub-Saharan African Canadians, there is still little known of the experiences of women who are HIV positive and who are living outside of large metropolitan communities.

Funder: Canadian Institutes of Health Research (CIHR), 2007-2010

Reference: <http://www.irsc.gc.ca/e/33364.html>

13. **Title:** *The impact of actual or perceived HIV status on refugee determination*

Researcher: Kristi Kenyon (University of British Columbia)

Description: Although often categorized separately as the outcome of armed conflict and a health crisis, the forced migration of people and the HIV/AIDS pandemic interact in a number of ways, each with the potential to feed the other through direct or indirect means. People living with HIV/AIDS additionally have their rights and their quality of life affected profoundly by their ability or inability to access and afford medical treatment that can slow this deterioration and, by the unprecedented social reactions to HIV which, in their extreme negative can result in stigma, discrimination, harassment, loss of employment, ostracization, physical assault and death. The *1951 Convention on the Status of Refugees* defines a refugee as someone who is outside of their country of nationality or habitual residence,

“owing to a well-founded fear of being persecuted,” on the basis of one of five grounds: race, religion, nationality, political opinion or membership in a particular social group. The last of these grounds is the least precise and most controversial. Decisions such as Ward in Canada and Islam and Shah in the United Kingdom have disputed the initial proposition that the group must be cohesive, and emphasized instead a shared unchangeable characteristic. People living with HIV “form a cognizable social group” and, similarly, the community “responds to [them] on the basis of their HIV status, forming and acting upon stereotyped notions about what the illness signifies.” I intend to examine the extent to which persecution on the basis of HIV status could potentially fit the ‘particular social group’ provision through an examination of case law from the United Kingdom, the United States, Canada, Australia and New Zealand with reference to this provision, as well the small but growing body of case law examining HIV-based persecution specifically. The aim is to discern both actual and potential practices with references to persecution on the basis of HIV status.

Funder: Social Sciences and Humanities Research Council (SSHRC), 2006 – 2009

Reference: <http://www.hivresearch.ca/index.asp?navid=17&csid1=1616>, *Personal communication, Kristi Kenyon (May 2008)*

14. **Title:** *Knowledge transfer and exchange among researchers and decision makers to improve prevention of sexually transmitted diseases in Quebec ethno cultural communities (Phase 1)*

Researchers: Alix Adrien (Public Health Branch - Montréal-Centre), Witnisse Mereus (Public Health Branch, Montreal Health and Social Services Agency), Joseph Jean-Gilles (GAP-VIES, Montréal), Riyas Fadel (COCQ-sida, Montréal), Carole Morissette (Public Health Branch, Montreal Health and Social Services Agency)

Description: The need for effective sexually transmitted and blood borne infection prevention programming that is genuinely adapted to the situation of ethno cultural communities has been well documented. This programming should be guided by targeted knowledge transfer and exchange among researchers and decision makers. Our goal is to bring about knowledge transfers and exchange among researchers and decision makers who are responsible for improving the health of ethno cultural communities by: defining the terms of this partnership; determining the type of research data that will be most useful to decision makers; and systematically identifying the results of research and experience with sexually transmitted and blood borne diseases in ethno cultural communities and explaining and contextualizing these results in a comprehensible way for groups working with these communities. Finally, we will conduct knowledge transfer activities with these communities. The partnership structure and process will be evaluated. The partnership proposed for the project is made up of three organizations: the *Coalition des organismes communautaires Québécois de lutte contre le sida*, the *Groupe d'Action pour la Prévention de la transmission du VIH et l'Éradication du Sida* and the *Direction de la santé publique de Montréal*. There are several categories of expected benefits and likely implications and repercussions: a) the strengthening and establishment of a sustainable partnership; b) the involvement of actors in concrete, realistic and feasible actions within a reasonable time frame; and c) the sustainable integration of knowledge at all levels of government, especially in the local health care and policy environments.

Funder: Canadian Institutes of Health Research (CIHR), 2006 – 2007

Reference: http://www.cihr-irsc.gc.ca/e/decision_media/2006/200510kad_e.pdf

15. **Title:** *MaBwana Black Men's Study (Getting to know the community: Who are the Black men who have sex with other men in Toronto)*

Researchers: Winston Husbands (AIDS Committee of Toronto/African and Caribbean Council on HIV/AIDS in Ontario, Toronto), Clemon George (St. Michael's Hospital/ African and Caribbean Council on HIV/AIDS in Ontario, Toronto), Barry Adam (University of Windsor), Robert Remis (University of Toronto), Sean Rourke (St. Michael's Hospital, Toronto), Joseph Beyene (Hospital for Sick Children, Toronto)

Description: A study of factors that may make Black/African/Caribbean gay and bisexual men and other Black men who have sex with men (Black MSM) in Toronto vulnerable to HIV/AIDS. The study will include key informant interviews, a survey, and in-depth interviews with Black/African/Caribbean gay and bisexual men and other Black MSM. MaBwana will examine sexual behaviour, relationships, dating, homophobia, racism, community issues and other factors. MaBwana was designed to provide information that would improve HIV prevention programming for Black/African/Caribbean gay and bisexual men and other Black MSM in Toronto and elsewhere in Ontario. The study is a partnership between the AIDS Committee of Toronto, the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO), and researchers from the University of Toronto, St. Michael's Hospital, the University of Windsor and the Sick Kids Hospital. A community advisory committee assists and advises the research team.

Funder: Canadian Institutes of Health Research (CIHR), 2006 – 2008

Reference: <http://www.irsc.gc.ca/e/30705.html>; <http://accho.ca/?page=home.MaBwana>

16. **Title:** *Optimizing prenatal HIV testing in Ontario: African and Caribbean women and prenatal HIV testing*

Researchers: Wangari Esther Tharao (Women's Health in Women's Hands Community Health Centre, Toronto), Stan Read (Hospital for Sick Children, Toronto), Dr. Lindy Samson (Children's Hospital of Eastern Ontario, Ottawa), Mark Yudin (St. Michael's Hospital, Toronto), Dr. Andree Gruslin (Ottawa General Hospital), Dr. Lynne Leonard (University of Ottawa), Frank McGee (AIDS Bureau, Ontario Ministry of Health and Long-Term Care, Toronto), Notisha Massaquoi (Women's Health in Women's Hands Community Health Centre, Toronto)

Description: This study is targeted to African and Caribbean women living in Ontario who have had a pregnancy since 1999 when the Ontario Prenatal HIV Testing Program was initiated. The study will examine their opinions and experiences with the program and the information obtained will be used to build scientific knowledge around prenatal HIV testing and related issues for African and Caribbean women, and identify programming and policy issues in order to make the necessary changes to improve and optimize the delivery of the Ontario Prenatal HIV Testing Program.

Funder: AIDS Bureau, Ontario Ministry of Health and Long-Term Care, 2006 – 2008

Reference: *Personal correspondence, Wangari Esther Tharao (May 2008)*

17. **Title:** *Ottawa inner city health initiative: Narrative methods development*

Researchers: Peter S. Tugwell (University of Ottawa), Raywat S. Deonandan, Ronald Labonte, Wendy L. Muckle, Victor R. Neufeld, Caroline Nyamai, Jeffrey M. Turnbull

Description: The specific aim of this pilot project is to investigate narrative as a tool for ensuring that best evidence leads to improved health for vulnerable populations. This project will examine

narrative methodologies in health intervention programming, evaluation and knowledge translation. The project builds on a global health network (ACANGO) and key initiatives in Ottawa and Kenya. The Ottawa Inner City Health Initiative (OICHI) has proven highly effective in engaging patients, stabilizing and treating health problems of homeless populations and promoting adherence to treatment. Narrative represents a potential tool to engage the client population, as well as the general public and city officials. In Kenya, AfriAfya has demonstrated the effective use of information communication technology for informing vulnerable Kenya communities about HIV/AIDS prevention and treatment strategies. Narrative represents a tool to evaluate current programming and inform planning, as well as continue to engage communities in additional health topics, such as tuberculosis and malaria. Using a combination of methods including critical review, learning forums, and online dialogue, the project will identify key literature and best practices in narrative. Facilitators will be trained in Ottawa and Kenya on the design, implementation and assessment of narrative best practices. The pilot project will be used to design a second study phase in which best practices will be tested and compared in Ottawa and Kenya. We believe narrative methods improve relevance, timeliness and accessibility of knowledge for communities, organizations as well as policy-makers.

Funder: Canadian Institutes of Health Research (CIHR), 2006 – 2007

Reference: <http://www.intermed.med.uottawa.ca/research/globalhealth/innercity.html>

18. **Title:** *Promoting equity in access to post-trial HIV vaccines for Black women in Canada: An exploration of perceived risks, barriers and adoption intentions*

Researchers: Peter A. Newman and Charmaine Williams (University of Toronto), Notisha Massa-

quoi (Women's Health in Women's Hands Community Health Centre, Toronto)

Description: Centre for International Health, University of Toronto in collaboration with Women's Health in Women's Hands Community Health Centre, this multi-method study explores the acceptability of future HIV vaccines and present HIV/AIDS prevention services among Black women of African and Caribbean descent in Toronto. Assessments include knowledge, attitudes, barriers and motivators regarding hypothetical HIV vaccine acceptability, intentions to change HIV risk behaviours in response to hypothetical vaccines, and preferences for HIV prevention. The purpose is to support the design of empirically-based interventions, in collaboration with vulnerable communities, to ensure appropriate and equitable dissemination of, and access to, future HIV vaccines, as well as to facilitate availability and access to culturally competent HIV prevention services.

Funder: Canadian Institutes of Health Research (CIHR), 2004 – 2007

Reference: <http://www.hivresearch.ca/index.asp?navid=17&csid1=718>

19. **Title:** *Understanding HIV/AIDS Issues in East African Communities in Toronto: A Survey of Health-Related Behaviours, Beliefs, Attitudes and Knowledge*

Researchers: Liviana M. Calzavara (University of Toronto), Wangari Tharao (Women's Health in Women's Hands), Ann Burchell (McGill University), Ted Myers (University of Toronto), Robert Remis (University of Toronto), Carol Swantee (Ontario Ministry of Health and Long Term Care), Catherine Chalin (University of Toronto), Kimberly Gray (Study Coordinator), and the EAST Community Advisory Committee.

Description: The East African Health Study in Toronto (EAST), a community-academic partner-

ship, is the first large-scale Canadian survey of African communities from countries where HIV is endemic. EAST was conducted in response to the lack of population-based data necessary to assess HIV-related issues in these communities, and to assist in the development of intervention programs and strategies. The purpose of EAST was to examine HIV/AIDS issues and concerns in the context of general health issues and behaviour present in five East African communities. The survey covered an extensive range of HIV and health-related issues such as immigration and mobility, social support, attitudes and beliefs, screening and testing, health conditions, risk behaviour, and health care utilization. The study, conducted between 2004 and 2006, included 456 participants from the Greater Toronto Area (GTA) who identified as members of the Ethiopian, Kenyan, Somali, Ugandan, and Tanzanian communities. The cross-sectional survey consisted of an interview and HIV screening component. EAST has made contributions in several key areas, including the generation of new research knowledge and provision of a platform on which to base programs, services, policy decisions and further research.

Funder: Ontario HIV Treatment Network (OHTN), 2003 – 2008

Reference: www.hivstudiesunit.ca or www.accho.ca

CHAPTER 6 - The Response to HIV/AIDS Among People From Countries Where HIV is Endemic

6

This chapter offers a brief overview of the coalitions, networks and organizations dedicated to this population and outlines key related strategy documents. Using the information presented earlier in the status report, this chapter attempts to assess whether the response to the HIV/AIDS epidemic among people from countries where HIV is endemic living in Canada responds to identified needs and is evidence-based.

The information gathered for this chapter demonstrates that the response is largely delivered through programs, projects and activities targeting established communities along ethno cultural, ethno racial lines and, to a lesser extent, targeting people from countries where HIV is endemic. Therefore, this chapter tends to look at the response to HIV/AIDS from a broader perspective.

6.1 Methodology

An information-gathering template (Appendix C) was circulated to provincial and territorial officials through the Federal/Provincial/Territorial Advisory Committee on AIDS (F/P/T AIDS), PHAC's national and regional HIV/AIDS program consultants, the Canadian AIDS Society (CAS) and ICAD (the latter two further circulated the template through their listservs) to obtain information on projects, networks, coalitions, committees, strategies, plans and policy initiatives in place between 2006 and 2008 to assist people from countries where HIV/AIDS is endemic. Responses were received from all provinces and territories and projects funded by the Toronto Public Health's AIDS Prevention Community Investment Program and Montreal's Public Health Branch were also included in the analysis. See Appendix D for a complete list of organizations and projects captured in this analysis, listed by region and in alphabetical order. Each project referenced in this chapter is identified by an alphanumeric code starting with the letter E (for Endemic). Information in Appendix D includes project titles, codes and a brief description of each organization.

The response was analyzed according to the evidence previously outlined in the report. It is important to note that some projects, programs or initiatives, such as health care and social services delivered by provinces and territories, may not have been captured through the information-gathering methodology used in this report. Organizations are invited to contact PHAC's Centre for Communicable Diseases and Infection Control if they wish to see their work reflected in future status reports.

Some Quebec's regional health authorities, who manage local community programs, did not complete the data-gathering template. It would, therefore, be inappropriate to draw formal conclusions on the response to HIV/AIDS for this population in Quebec. We hope to address this gap in the future.

6.2 The response to HIV/AIDS in Canada - overview

Canada's response to HIV/AIDS has grown in scope and in complexity since the early days of the epidemic. Governments, non-governmental and community-based organizations, researchers, health professionals and people living with, and vulnerable to, HIV/AIDS are engaged in addressing the disease and the conditions that sustain it.

Through the *Federal Initiative to Address HIV/AIDS in Canada* [1], the Government of Canada monitors the epidemic through its national surveillance system; develops policies, guidelines and programs; and supports the voluntary sector (comprised of national HIV/AIDS organizations, AIDS service organizations and community-based organizations) in the response to HIV/AIDS in communities across the country.

Provinces and territories are engaged in similar activities and, under Canada's Constitution, are primarily responsible for the provision of health care services to

people living with or, at risk for HIV/AIDS^{xviii}. Organizations operate in all provinces and territories to reduce the vulnerability to, and impact of, HIV/AIDS and to provide diagnosis, prevention, care, treatment and support services to those most at risk – they do so with government funds, private funds and through their own fundraising efforts. Depending on the jurisdiction, regional or local public health authorities play a substantial role in addressing the epidemic.

In some jurisdictions, community-based organizations are working through pre-defined structures to determine priorities and allocate resources. Communities and local health authorities, governments, front-line organizations, volunteers and affected populations are uniquely positioned to determine the appropriateness of the response [2].

6.3 Population-specific strategies

The *Federal Initiative to Address HIV/AIDS in Canada* [1] identifies people from countries where HIV is endemic as one of eight key populations at risk for, or affected by, HIV/AIDS. This framework was developed at the same time as *Leading Together: Canada's Takes Action on HIV/AIDS (2005-2010)* [3], a stakeholder-led document, which highlights the importance of community involvement in the response, as well as the need for sensitive and culturally appropriate services for people from different ethno cultural and ethno racial backgrounds.

The stakeholder-led document titled *Taking Action on HIV and AIDS in Black Communities in Canada: A Resource for Moving Ahead* was released in 2008. It presents a snapshot of issues affecting Black communities across Canada, with particular emphasis on Vancouver, Calgary, Toronto, Ottawa, Montreal and Halifax and proposes specific actions to address gaps, barriers and obstacles to

better planning and delivery of HIV/AIDS programs and services to Black communities [4].

While many provincial strategies or advisory committees on HIV/AIDS identify people from countries where HIV is endemic or ethno cultural communities as key populations, Ontario is the only jurisdiction to have developed a population specific strategy for its African and Caribbean Black population. Developed by the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO), the *Strategy to Address Issues Related to HIV Faced by People in Ontario from Countries Where HIV is Endemic* [5] was supported by the AIDS Bureau, Ontario Ministry of Health and Long-Term Care, and is considered a key component of the Ontario HIV/AIDS Strategy. Launched in 2005, this strategy coordinates and guides action to address issues related to HIV faced by people from countries where HIV is endemic living in Ontario. It was developed through a series of consultations with people working with, and/or living in, African and Caribbean communities in Ontario, service providers, researchers, community representatives, as well as people living with HIV/AIDS. Its objectives include coordinating the work of agencies, institutions and policy makers working with, and for, African and Caribbean people and their prevention, education, health, promotion, care and support efforts; facilitating community development in response to HIV/AIDS challenges faced by African and Caribbean people; and identifying research needs, priorities and opportunities.

6.4 Population-specific networks and coalitions

ICAD, through its network of organizations concerned about global HIV/AIDS issues, plays an important role at the national level in bringing stakeholders together to address issues affecting people from countries where HIV is endemic living in Canada. ACCHO plays a similar role at the provincial level in Ontario, in addition to providing leadership in mobilizing communities at the national level.

xviii The federal government is also responsible for the provision of health care services to designated groups such as: the military, on-reserve Aboriginal people and federally incarcerated inmates.

While many HIV/AIDS networks and coalitions have been created since the start of the epidemic, only a few are specific to the Black community or to people from countries where HIV is endemic. One of these is the Outreach to African and Caribbean Churches Working Group established in 2007 by the Ontario Ministry of Health and Long-Term Care AIDS Bureau to develop a testing outreach strategy targeting African and Caribbean churches. The working group is composed of representatives from Black churches, AIDS service organizations, the AIDS Bureau, and other related organizations.

Other networks which may not be specific to people from countries where HIV is endemic or Black communities also focus on issues of importance to this population. An advisory committee on HIV/AIDS provides advice to the Minister of Health and Long-Term Care of Ontario on systemic barriers to health care access for recent immigrants and refugees without legal status. In Quebec, Montreal’s Health and Social Services Agency supports a regional committee responsible for increasing access to testing and case management in Local Community Health Centres, a sub-committee responsible for the development of nurses’ outreach, and a network of executive directors

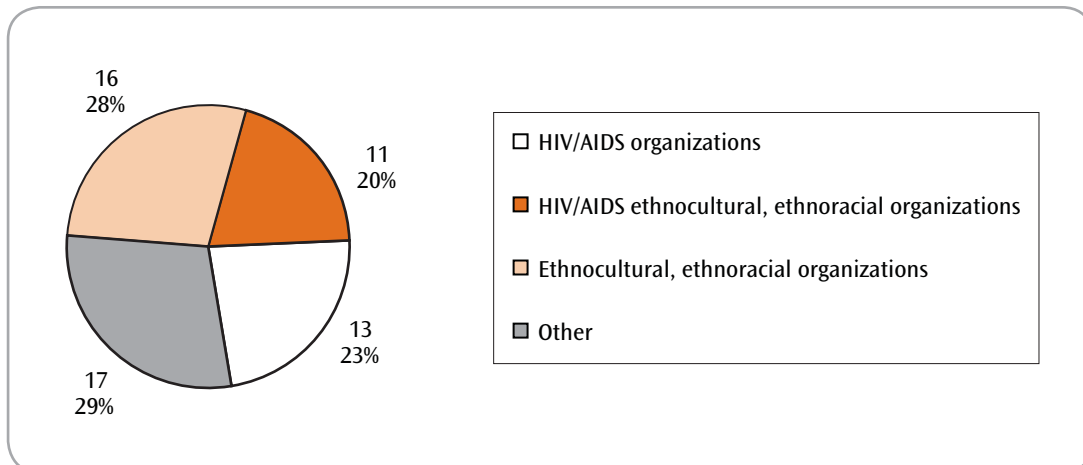
of community-based organizations designed to support planning and training activities for populations affected by HIV/AIDS, including ethno cultural communities. Finally, the Nova Scotia Advisory Commission on AIDS provides HIV/AIDS policy advice to the provincial government and acts as a link between the government and the community, including Nova Scotia’s Black community.

6.5 Response analysis

This section reviews programs and projects identified through the data-gathering process to determine whether the response reflects the realities and needs of the population based on available evidence. It is important to note that the analysis does not include those HIV/AIDS services that have been integrated into regular provincial or territorial health care and social services delivery activities.

Diverse organizations are involved in the HIV/AIDS response for the Black population. Figure 20 shows that 57 projects identified in the data-gathering process are led by 43 organizations, which are grouped into four categories.

Figure 20: Project breakdown according to organization categories (n=57)



6.5.1 Geographic distribution of projects

Canada's Black population predominantly lives in urban centres, particularly in Toronto and Montreal. Accordingly, Ontario and Quebec share the highest number of reported AIDS cases among people from countries where HIV is endemic.

Of the 57 projects reviewed, 70.2% (40) were located in Ontario (77.5% of these in the Toronto area), 12.3% (7) in Quebec (all in Montreal), 7.0% (4) in Alberta, 5.3% (3) in British Columbia, 1.8% (1) in Manitoba, and 3.5% (2) were national in scope [E1, E49^{xix}]. Projects specific to this population were not identified in other provinces and territories.

6.5.2 Age

Taking into consideration the fact that the Black population is younger than the overall Canadian population and that 80% of HIV test reports and AIDS cases in the HIV-endemic exposure subcategory were reported in people aged 39 years and younger, initiatives targeting the young Black population are an integral part of a comprehensive response.

Of the 57 projects reviewed, 14 (24.6%) projects identified youth as a target audience. Organizations such as the African in Partnership Against AIDS [E13], the Toronto People with AIDS Foundation [E42], the Black Coalition for AIDS Prevention [E22], the Centre des Jeunes Francophones de Toronto [E24], the Ethiopian Association in the Greater Toronto Area and the Surrounding Regions [E30] as well as other youth-specific organizations [E31, E33, E57] and community health centres, [E28, E39, E41, E45, E46, E50] have developed projects, which either targeted youth or included a youth component. These projects, located in the greater Toronto area, focused on ethno cultural community outreach, mentoring youth leaders, recruit-

ing youth volunteers to facilitate peer-to-peer culturally sensitive outreach sessions, and the cultural adaptation and dissemination of HIV/AIDS prevention material through outreach sessions or cultural events.

In particular, the Warden Woods Community Centre Bell Estate [E45] has developed a prevention project with a focus on youth from African and Caribbean communities in Scarborough, Ontario. This project seeks to increase knowledge about gender vulnerability and to develop skills to negotiate safer sex practices for male and female youth and young adults.

The Ottawa Somerset West Community Health Centre [E39] has adapted an intergenerational approach to increase the ability of Sub-Saharan African and Caribbean communities to provide HIV/AIDS prevention education to their own communities. The project provides an opportunity for community representatives of all ages to communicate on difficult subjects despite the fact that discussions on sexuality and HIV prevention remained, for the most part, an uncomfortable topic.

6.5.3 Immigration

The immigration waves of the mid-70s and 90s, the fact that 55% of Canada's Black population was born outside of Canada, the impact of the CIC 2002 HIV testing policy, and the immigration process itself all contribute to making immigration a relevant influence on the HIV/AIDS response in this population.

Of the 57 projects reviewed, 21.1% (12) identified immigrant, migrant or refugee populations as their target audience. Many of these projects addressed issues pertinent to Black people from countries where HIV is endemic without specifically targeting them. Of these, four were located in Alberta [E5-8], three in Ontario [E30, E37, E46] two in British Columbia [E2, E4], two in Quebec [E51, E56], and one in Manitoba [E9]. This status report did not review projects of a more general nature related to immigrant or refugee populations or those funded outside of health-related programs.

xix For this and subsequent alphanumeric references, you will find a brief description of the organization and the project title in Appendix D.

A number of projects focus on linking health care and community services by emphasizing the development of support networks, social integration and addressing systemic factors to improve services. These projects often result in the development of policy papers, networks and service-provider training.

For example, the Centre for AIDS Services of Montreal (Women) [E51], in collaboration with the Royal Victoria Hospital, offers support services to help HIV-positive refugee women or those awaiting a decision on their refugee claim to access the health care and social services they require. Meanwhile, Toronto's Regent Park Community Health Centre [E37] and Winnipeg's Sexuality Education Resource Centre Manitoba, Inc. [E9] are addressing systemic barriers to improve the quality of service-provider responses for HIV-positive immigrant and refugee populations. In particular, the latter works on increasing knowledge and awareness of the barriers to access resources faced by immigrants and refugees living with, or affected by, HIV/AIDS and identifying service gaps. This project also addresses stigma and fear related to HIV within regional health organizations. The Vancouver Refugee Services Alliance [E4], through its S.O.S. health promotion program, provides orientation services to the Canadian health system and offers HIV/AIDS education and support.

Other projects focus on education, outreach and HIV-prevention for recent immigrants, including the translation of existing materials and the production, dissemination and development of culturally sensitive HIV/AIDS information, prevention materials and workshops. Efforts are being made to ensure leadership development on HIV/AIDS issues within these communities.

For example, the Ethiopian Association in the Greater Toronto Area and the Surrounding Regions [E30] provides one-on-one HIV/AIDS prevention education to newcomers. In particular, religious leaders in the Ethiopian community are provided with prevention messages for those members of the community who frequently travel between Toronto and Ethiopia. The

association also hosts education workshops; encourages HIV testing through Ethiopian print medias; and promotes HIV awareness during events, such as the Ethiopian Canadian Day and AIDS Awareness Week. The association works in collaboration with other community organizations, such as the Africans in Partnership Against AIDS and the Black Community for AIDS Prevention.

6.5.4 Socio-economic conditions

Despite the link between HIV/AIDS and the socio-economic conditions experienced by certain segments of Canada's Black population, such as higher rates of unemployment, current HIV/AIDS projects do not appear to address these conditions in a comprehensive and integrated manner. However, the community's role in these projects and the organizations' involvement with Black people of lower socio-economic status, lead us to presume that socio-economic factors are taken into consideration in service planning and delivery. For example, in Ontario, Scarborough's Warden Woods Community Centre [E45] addresses poverty through its information session on HIV/AIDS.

6.5.5 Stigma, discrimination, cultural practices and norms influencing access to services^{xx}

The stigma, discrimination and racism experienced by Black communities, the availability of culturally appropriate services, as well as cultural practices and norms, greatly influence an individual's ability to access prevention, care, treatment, support and diagnosis services.

Projects were reviewed to identify interventions that focus on reducing barriers to access to services by addressing the community's specific cultural practices and norms. Such projects often focus on building community leaders' capacity through peer prevention education sessions and outreach activities in the community. In many instances, such projects are implemented by Black

^{xx} This includes the full spectrum of HIV/AIDS prevention, care, treatment, support, and diagnosis services.

HIV/AIDS community-based organizations in partnership with HIV/AIDS community-based organizations.

The HIV/AIDS prevention, education and information project led by Toronto's Africans in Partnership Against AIDS [E13] provides a good example of how community-driven projects work to reduce barriers to service access by shifting the community's perception of HIV/AIDS. The group offers prevention education workshops to a range of organizations, which provide services to diverse African communities. Awareness sessions are organized with religious leaders; outreach activities are provided in African social venues, such as barbershops, hair salons, restaurants and bars; articles are published in African print media; and messages are delivered through radio stations.

In Toronto, 22 organizations operate HIV/AIDS projects targeting the Black population [E11-13, E19-38, E41-48, E50]. They all share the common objective of shifting the community's perception of practices and norms that have limited access to HIV/AIDS services. This level of involvement is unparalleled in the country and confirms the importance of coordination, collaboration and communication in efforts to tackle HIV/AIDS. The Black Coalition for AIDS Prevention [E20] works with African Community Health Services^{xxi} and Africans in Partnership Against AIDS to coordinate service delivery. This partnership has improved program integration, planning and coordination.

Evidence also highlights the influence of stigma, discrimination and racism on access to programs and services. A comprehensive response needs to address the linguistic and communication needs of the Black population, recognize its diversity; be culturally competent; provide appropriate information; and engage caring and culturally competent health care providers. Certain projects aim to increase the capacity of service providers to deliver more effective services to African and Caribbean communities. For example, the development of cul-

turally appropriate services in community-based AIDS organizations is being encouraged. The Ontario Ministry of Health and Long-Term Care AIDS Bureau has taken an innovative approach providing support to eight agencies across Ontario for prevention workers positions to develop and implement culturally appropriate and effective education and prevention strategies. The AIDS Bureau supports ACCHO [E10] in the implementation of its strategy and in its role regarding the coordination of the prevention workers' activities. Among other things, this has enabled community-based organizations located in smaller urban centres, such as AIDS Niagara, AIDS Committee of London and the AIDS Network of Hamilton, to enhance their outreach capacity and provide relevant services to this population. This is in addition to the ethno-specific organizations that receive funding from the AIDS Bureau – the Black Coalition for AIDS Prevention and Africans in Partnership Against AIDS.

ACCHO also developed *HIV Prevention Guidelines and Manual: A Tool for Service Providers Serving African and African Caribbean Communities Living in Canada* [6]. This comprehensive resource helps service providers and community organizations develop their capacity to work with African and Caribbean communities and addresses issues, such as stigma, discrimination and racism.

In Toronto and Ottawa, many HIV/AIDS projects led by local community health centres serving the Black community are conducted in partnership with community-based HIV/AIDS organizations. This suggests a positive impact on the capacity of the HIV/AIDS organizations to provide a culturally appropriate response in efforts to meet the needs of the Black population requesting their services.

It is worth noting that HIV/AIDS community-based organizations, such as the AIDS Committee of Toronto and Séro-Zéro in Montreal, have developed specific ethno-cultural components to their community services and activities. This is likely the case for other large community-based HIV/AIDS organizations across the country.

xxi The African Community Health Services no longer exists.

Other projects are addressing this issue from a policy perspective by highlighting systemic barriers to inform policy makers and community workers. For example, the Regent Park Community Health Centre [E37] is identifying barriers to improve access to services for immigrants and refugees living with HIV/AIDS through policy and program changes.

Further research and evaluation is required to determine the extent to which the response addresses the stigma, discrimination and racism faced by the Black Community and positively affects their ability to access services.

6.5.6 Populations within the Black population^{xxii}

Women:

In 2006, women accounted for 2/3 of AIDS cases in the HIV-endemic exposure category. It is, therefore, encouraging to see that women were the focus of at least 19 (33.3%) projects reviewed [E3, E5, E6, E9, E22, E24, E29, E41, E44-E49, E51-53, E56, E57]. The projects link health care with community outreach to women, focus on mentoring, and the recruitment of volunteers to facilitate outreach sessions, and the production and dissemination of information for women through outreach sessions or cultural events. For example, Toronto's Women's Health in Women's Hands Community Health Centre [E47] helps African and Caribbean women obtain accurate information on HIV transmission patterns and on ways to reduce HIV infection risks. Similarly, the East York East Toronto Family Resources [E29] recruits and trains women to become sexual health peer workers charged with providing outreach sessions for women.

Gay Men and other Men Who Have Sex with Men (MSM):

Black gay men and other MSM were found to be the target audience of four (7.1%) [E21-23, E31] of the 57

projects reviewed and were all located in Toronto. These projects identified Black MSM as their target population for outreach activities in social and recreational venues, such as Gay Pride events, bars, bathhouses. The Black Coalition for AIDS Prevention's project *Gay, Bisexual, MSM Outreach* integrates outreach activities in gay settings and publishes HIV prevention messages for Black MSM in Caribbean community print media. This project benefits from the collaboration with various gay men networks in identifying Black MSM issues.

The information-gathering process excluded programs and projects focused on the broader gay men and MSM community, which may or may not include Black MSM as part of their audience. For instance, Montreal's Séro-Zéro offers ethno cultural programming for gay men and MSM that is not specific to Black MSM.

Prison inmates and people who inject drugs:

Save for a few projects that include elements of harm reduction or deal with street-involved individuals (e.g. youth), incarceration, addictions and injection drug use are not being addressed in the response for people from countries where HIV is endemic.

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- (2) A National Portrait - A Report on Governments' Responses to the HIV/AIDS Epidemic in Canada. Ottawa: Federal/Provincial/Territorial Advisory Committee on AIDS (F/P/T AIDS), Public Health Agency of Canada (PHAC); 2004 Nov.

xxii Please note that "Youth" as a sub-population has already been covered in section 6.5.2 (age) of this chapter.

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CHAPTER 7 - Conclusions

7

People from countries where HIV is endemic make up a unique segment of the concentrated HIV/AIDS epidemic in Canada. This is the first time PHAC has attempted to present evidence from a variety of sources in one document to better understand the impact of HIV and AIDS on this population. The report also highlights a number of gaps and identifies opportunities for future policy and program development and research priorities.

Collecting and presenting relevant information regarding ethnicity in the surveillance data reported to PHAC presented several challenges. First, the categories for reporting ethnicity are quite broad and some individuals may not clearly fit into any particular category, creating the potential for misclassification. Second, there still remains a number of large gaps in the completeness of ethnicity data reported nationally for HIV cases. Although the heterosexual exposure sub-category entitled “origin from an HIV-endemic country” provides some information in P/T jurisdictions where ethnicity is not reported, it does limit assessment of the number of people from countries where HIV is endemic in other exposure categories, such as MSM and IDU. In addition, the definition of an “HIV-endemic country” inevitably changes over time as HIV and AIDS cases continue to affect a growing number of people from other regions in the world outside of Africa and the Caribbean and these changes will complicate the interpretation of trends.

The report has confirmed that communities play a critical role in addressing the HIV/AIDS diagnosis, prevention, care, treatment and support needs of the population. However, the success of community-based organizations, public health officials and other groups in lowering the number of new HIV infections in this population and in improving the quality of life of Black people living with HIV/AIDS is influenced by how well Canada as a country “addresses the factors that influence health, physical and social environments, which could facilitate decisions to achieve and maintain the highest state of health possible” [1].

The evolution of the HIV situation in this population is linked to a variety of broad factors and determinants of health, which influence the population’s vulnerability to HIV/AIDS. Additional research and evidence will be required to analyze and understand some of these, including the incidence and prevalence of HIV in their countries of origin and in Canada, the population’s demographic evolution, its interaction with the immigration system, its biological or genetic endowment and its experience with racism, as well as sexual violence, and the complex interplay of these factors in relation to HIV/AIDS in this population. Comprehensive, coordinated efforts will be required to address the broader health inequities that influence the vulnerability of people from countries where HIV is endemic.

While the relationship between immigration and HIV/AIDS has been the focus of some research, projects and community-based initiatives, the ability of HIV-positive immigrants to connect with, and benefit from, health and HIV/AIDS services upon their arrival in Canada needs to be further examined. Areas in need of further attention also include the access to prevention, diagnosis, care, treatment and support services for migrant workers from countries where HIV is endemic and for individuals from this population moving to regions experiencing rapid economic growth, such as Alberta.

The experiences of Black people in Canada differ significantly from those of African Americans in the USA or Black immigrants in European countries. Therefore, results from research conducted outside of Canada may not always be applicable to the Canadian context, and yet transnational issues affecting this population, such as the impact of frequent travel between countries where HIV is endemic and Canada on our domestic epidemic, have not received much attention from the Canadian research community. Genetic studies demonstrate that the predominant HIV virus strains found among people from countries where HIV is endemic living in Canada are similar to strains found in Africa and the Caribbean and are quite different to the strains commonly found among other populations affected by

HIV/AIDS in Canada. The potential implications of this finding for HIV epidemiology in Canada and for prevention and care programs have not been well studied.

Barriers to accessing appropriate culturally sensitive health services and information still remain a problem for this population. The impact of racism, stigma and discrimination within the health system continue to affect the quality of life and health outcomes of Black people living with HIV/AIDS. The ongoing stigma and discrimination against AIDS and people living with HIV/AIDS exercised by the Black community itself continues to hamper prevention efforts directed at this population.

Organizations involved in the delivery of the HIV/AIDS response to the Black community have built solid networks, which have encouraged knowledge exchange and culturally relevant approaches to HIV/AIDS. Strengthening their evaluation capacity will be important to determine whether current programs, interventions and activities adequately meet the prevention, care, treatment, and support needs of this population. Best practices for this population could assist the pan-Canadian response. As such, cross-sectoral and cross-jurisdictional activities to share best practices, to increase partnerships among a wider range of stakeholders and to better use evidence in the development of strategies and interventions should be fostered and encouraged.

Canadian stakeholders involved in addressing HIV/AIDS among Black people of African and Caribbean descent from countries where HIV is endemic have demonstrated strong collective will and leadership. Their unwavering dedication to increase HIV/AIDS awareness and to reduce stigma and discrimination has contributed to a growing recognition among this population that the epidemic cannot be ignored and that they must continue to lead this response. This report acknowledges their important role, their successes and their ongoing quest to get ahead of, and reverse the spread of, HIV/AIDS in this population.

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Appendix A

A

List of HIV-Endemic Countries

Caribbean, Bermuda and Central/South America

Anguilla	French Guiana	Netherlands Antilles
Antigua and Barbuda	Grenada	St. Lucia
Bahamas	Guadeloupe	St. Kitts and Nevis
Barbados	Guyana*	St. Vincent and the Grenadines
Bermuda	Haiti	Surinam*
British Virgin Islands	Honduras*	Trinidad and Tobago
Cayman Islands	Jamaica	Turks and Caicos Islands
Dominica	Martinique	U.S. Virgin Islands
Dominican Republic	Montserrat	

Asia

Cambodia*	Myanmar (Burma)*	Thailand*
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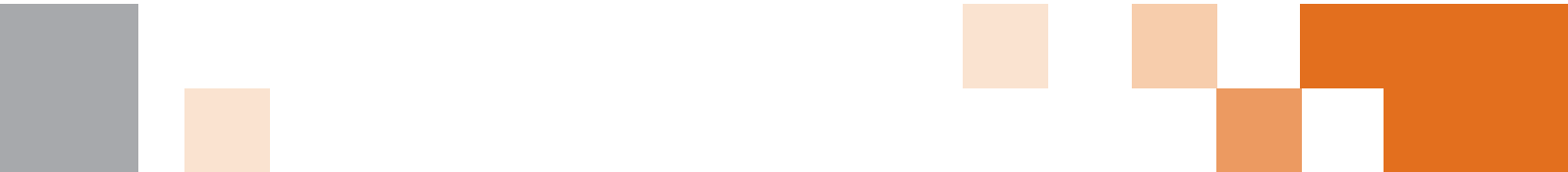
Africa

Angola	Gabon	Nigeria
Benin	Gambia	Rwanda
Botswana	Ghana	Senegal
Burkina Faso	Guinea	Sierra Leone
Burundi	Guinea-Bissau	Somalia
Cameroon	Ivory Coast	South Africa
Cape Verde	Kenya	Sudan
Central African Republic	Lesotho	Swaziland
Chad	Liberia	Tanzania
Congo	Malawi	Togo
Djibouti	Mali	Uganda
Equatorial Guinea	Mozambique	Zaire
Eritrea	Namibia	Zambia
Ethiopia	Niger	Zimbabwe

* This report only focuses on people from countries where HIV is endemic of African and Caribbean descent. Countries with an asterisk were not part of this Status Report.

POPULATION-SPECIFIC HIV/AIDS STATUS REPORT

People from Countries where HIV is Endemic – Black people of African and Caribbean descent living in Canada



Appendix B

1) Search terms

English

	Countries of the Caribbean:	Countries of Sub-Saharan Africa:
Black African Caribbean Immigrant Refugee Endemic Ethno cultural Ethno racial Afro-Canadian Afro-Caribbean West Indian People of Colour Visible minorities Racialized Minoritized Undocumented immigrants Illegal immigrants	Anguilla Antigua and Barbuda Aruba Bahamas Barbados Belize Bermuda British Virgin Islands Cayman Islands Cuba Dominica Dominican Republic Grenada Guadeloupe Guyana Haiti Jamaica Martinique Montserrat Netherland Antilles – Saba, St. Eustatius, Saint Maarten St. Barts St. Kitts and Nevis St. Lucia St. Martin St. Vincent and the Grenadines Trinidad and Tobago Turks and Caicos	Angola Benin Botswana Burkina Faso Burundi Cameroon Cape Verde Central African Republic Chad Côte d'Ivoire Comoros Congo Democratic Republic of Congo Djibouti Equatorial Guinea Eritrea Ethiopia Gabon Gambia Ghana Guinea Guinea Bissau Kenya Lesotho Liberia Madagascar Malawi Mali Mauritius Mozambique Namibia Niger Nigeria Rwanda São Tomé and Príncipe Senegal Seychelles Sierra Leone Somalia, including Somaliland South Africa Sudan Swaziland Tanzania Togo Uganda Zambia Zimbabwe

French

	Pays des Caraïbes :	Pays de l’Afrique subsaharienne :
Noir	Anguilla	Afrique du Sud
Africain	Antigua-et-Barbuda	Angola
Caraïbe	Antilles néerlandaises (Saba, Saint-Eustache, Saint-Martin)	Bénin
Immigrant	Aruba	Botswana
Réfugié	Bahamas	Burkina Faso
Endémique	Barbade	Burundi
Ethnoculturel	Belize	Cameroun
Ethnoracial	Bermudes	Cap-Vert
Afro-canadien	Cuba	Comores
Afro-antillais	Dominique	Congo
Antillais	Grenade	Côte d’Ivoire
Personnes de couleur	Guadeloupe	Djibouti
Minorités visibles	Guyana	Érythrée
Victimes de racisme	Haiti	Éthiopie
Minorités	îles Caïmans	Gabon
Immigrants sans papier	îles Vierges britanniques	Gambie
Immigrants illégaux	îles Turks et Caicos	Ghana
	Jamaïque	Guinée
	Martinique	Guinée Bissau
	Montserrat	Guinée équatoriale
	République dominicaine	Kenya
	Saint Barthélemy	Lesotho
	Saint Kitts et Nevis	Libéria
	Saint Vincent et les Grenadines	Madagascar
	Saint-Martin	Malawi
	Sainte Lucie	Mali
	Trinité et Tobago	Maurice
		Mozambique
		Namibie
		Niger
		Nigéria
		Ouganda
		République centrafricaine
		République démocratique du Congo
		Rwanda
		Sao Tomé et Príncipe
		Sénégal
		Seychelles
		Sierra Leone
		Somalie (y compris le Somaliland)
		Soudan
		Swaziland
		Tanzanie
		Tchad
		Togo
		Zambie
		Zimbabwe

2) Databases searched

- CINAHL 2000 – 2007/08
- Current Contents 2001 – September 2007
- Global Health 1998-2008
- MEDLINE 2001 – September 2007
- PreMEDLINE – September 2007
- SCOPUS – September 2007

3) Key websites

- AIDS Education Global information System - <http://www.aegis.org/>
- Alberta Heritage Foundation for Medical Research - <http://www.ahfmr.ab.ca/>
- British Columbia Centre for Excellence in HIV/AIDS - <http://www.cfenet.ubc.ca/>
- Canadian Association for HIV Research - <http://www.cahr-acrv.ca/english/home/>
- Canadian Association for HIV Research Ontario - <http://www.cahro.ca/>
- Canadian Council on Social Development - <http://www.ccsd.ca/home.htm>
- Canadian Foundation for AIDS Research - <http://www.canfar.ca>
- Canadian Health Network - <http://www.canadian-health-network.ca/>
(no longer exists)
- Canadian HIV Research Inventory - <http://www.hivresearch.ca/index.asp?navid=2>
- Canadian Institutes of Health Research - <http://www.cihr-irsc.gc.ca/e/193.html>
- Canadian Women's Health Network - <http://www.cwhn.ca/>
- Google Canada - <http://www.google.ca>
- Google Scholar - <http://scholar.google.com>
- Health Association of African Canadians - <http://www.haac.ca/>
- International AIDS Society - <http://www.iasociety.org/>
- Metropolis - http://canada.metropolis.net/index_e.html
- Michael Smith Foundation for Health Research - <http://www.msfr.org/>
- Nova Scotia Health Research Foundation - <http://www.nshrf.ca/>
- Ontario HIV Treatment Network - <http://www.ohtn.on.ca/>
- Sex Information and Education Council of Canada - <http://www.sieccan.org/>

POPULATION-SPECIFIC HIV/AIDS STATUS REPORT

People from Countries where HIV is Endemic – Black people of African and Caribbean descent living in Canada



Appendix C

Information-gathering template

The HIV/AIDS Policy, Coordination and Programs Division at the Public Health Agency of Canada is currently in the process of preparing a series of population-specific status reports whose ultimate goal is to positively affect the health and well-being of individuals in Canada with HIV/AIDS and individuals at risk of infection. The first status report to be produced will focus on people from countries where HIV/AIDS is endemic: Black Canadian, African and Caribbean communities and it will contain a comprehensive collection of existing data on the communities. The status report will specifically include information on the characteristics and demographics of the Black

Canadian, African and Caribbean communities as well as statistical information of the impact of HIV/AIDS on the communities. It will also identify currently funded research, recent publications, current responses and information on the lived experience of the communities.

This data gathering sheet is being circulated to solicit information specific to HIV/AIDS and Black Canadian, African and Caribbean communities. Please complete the tables below with any relevant you have and share the sheet with others who may be able to provide assistance. Note that information identifying “immigrants,” “refugees,” “visible minorities,” “people of colour,” “ethnocultural communities” or “ethnoracial communities” is also welcomed.

1.0 Funded Research from 2000 – 2007

Title & Researcher(s)	Funder	Source/ Reference/ Website	Comments/ Other Information

2.0 Articles and Reports Published 2003 – 2007

Title & Author(s)	Funder/ Publisher	Source/ Reference/ Website	Comments/ Other Information

3.0 Presentations Made at Conferences from 2000 – 2007

Title & Author(s)	Conference & Year	Source/ Reference/ Website	Comments/ Other Information

4.0 Upcoming Publications (within 2007)

Title & Author(s)	Funder/ Publisher	Source/ Reference/ Website	Comments/ Other Information

5.0 Currently Funded Projects and Programs

Organization & Name of Project/ Program	Funder	Contact for Information	Comments/ Other Information

6.0 Current Networks or Coalitions

Name of Network or Coalition	City and/or Province/ Territory	Contact for Information	Comments/ Other Information

7.0 Current Strategies or Plans

Name of Strategy or Plan & Author(s)	City and/or Province/ Territory	Contact for Information	Comments/ Other Information

8.0 Current policy initiatives

Name of Initiative	City and/or Province/ Territory	Contact for Information	Comments/ Other Information

Appendix D

D

Organizations involved in the response to HIV/AIDS among people from countries where HIV is Endemic – Black people of African and Caribbean descent living in Canada

National

Interagency Coalition on AIDS and Development

The Interagency Coalition on AIDS and Development is a network of 176 Canadian international development non-governmental organizations (NGOs), AIDS service organizations and individuals concerned about global HIV/AIDS issues. [<http://www.icad-cisd.com/>]

- **Project, E1:** *National HIV/AIDS Strategy for Black Canadian, African and Caribbean Communities* (national scope).

British Columbia

AIDS Vancouver

AIDS Vancouver provides free and confidential services for people affected by or living with, HIV/AIDS or people concerned about becoming infected with HIV. [www.aidsvancouver.org]

- **Project, E2:** *Program Targeting Immigrants from Endemic Areas* (local scope).

National Congress of Black Women Foundation

The National Congress of Black Women Foundation facilitates, develops, implements and promotes activities, such as fundraising, research and educational programs that foster the advancement and education of Black women.

- **Project, E3:** *Peer-based outreach, prevention material distribution to Black Women and support group for Black women affected by HIV/AIDS* (local scope)

S.O.S. (formerly Storefront Orientation Service)

S.O.S. focuses on services for refugee claimants to orientate them to all stages of the complex immigration process and to help them deal with the realities of adjusting to their new life. [www.vrsa.ca]

- **Project, E4:** *Latin American Health, AIDS Education Program* (local scope).

Alberta

Calgary Immigrant Women's Association

The Calgary Immigrant Women's Association is a non-profit organization that addresses the needs and concerns of immigrant and refugee women, youth, children and families. [<http://ciwa-online.com/>]

- **Project, E5:** *I CARE – Immigrant Community AIDS Resources and Education* (local scope).

Central Alberta Immigrant Women's Association

The Central Alberta Immigrant Women's Association aims to empower and raise the level of immigrants' awareness of the different aspects of Canadian society. [www.cirsonline.ca/caiwa]

- **Project, E6:** *Programs for Immigrant and Refugee in Red Deer* (local scope).

Multicultural Health Brokers Cooperative

The Multicultural Health Brokers Cooperative supports immigrant and refugee families who are most often isolated because of cultural and linguistic barriers. [www.mchb.org]

- **Project, E7:** *Prevention Messages for Immigrant and Refugee—Edmonton* (local scope).

Options Sexual Health Association (formerly Planned Parenthood Edmonton)

The Options Sexual Health Association equips new Canadians with the skills and knowledge to make informed choices around issues of sexuality, within the context of their values, beliefs, culture and experiences. [<http://www.optionssexualhealth.ca/>]

- **Project, E8:** *Prevention for Immigrant and Refugee Communities* (local scope)

Manitoba

Sexuality Education Resource Centre Manitoba

The Sexuality Education Resource Centre Manitoba's mission is to promote sexual health through education.

[www.serc.mb.ca]

- **Project, E9:** *Improving Access to Services by Immigrant and Refugee Communities in Winnipeg and Brandon* (local scope).

Ontario

African and Caribbean Council on HIV/AIDS in Ontario

The African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) is made up of organizations and individuals committed to HIV prevention, education, advocacy, research, treatment, care and support for African and Caribbean communities in Ontario. [www.accho.ca]

- **Project, E10:** *Community-Based AIDS Education and Support Program* (coordination role provincial scope).

African Community Health Services^{xxiii}

The African Community Health Services was a non-profit community-based organization providing holistic services for Africans and diverse communities living with, and affected by, HIV/AIDS.

- **Project, E11:** *Ontario's ACCHO Strategy Outreach Workers* (local scope).

Africans in Partnership Against AIDS

Africans in Partnership Against HIV/AIDS is a community-based, Canadian non-profit charitable organization serving the Greater Toronto Area. It was established by members of the African community in response to the increased need for services intended to assist Africans living with HIV/AIDS. [www.apaa.ca]

- **Project, E12:** *Ontario's ACCHO Strategy Outreach Workers* (local scope).
- **Project, E13:** *HIV/AIDS Prevention, Education and Information* (local scope).

AIDS Committee of Cambridge, Kitchener, Waterloo & Area

The AIDS Committee of Cambridge, Kitchener, Waterloo & Area responds to the changing needs of community and individuals infected with, affected by, and at risk for, HIV/AIDS through the provision of prevention, education, advocacy and support programs and services.

[www.acckwa.com]

- **Project, E14:** *Community Education Program* (local scope).

AIDS Committee of London

The AIDS Committee of London brings people together in partnership to provide leadership in education, support and advocacy to meet the challenge of HIV/AIDS.

[www.aidslondon.com]

- **Project, E15:** *Ontario's ACCHO Strategy Outreach Workers* (local scope).

AIDS Network of Hamilton

The AIDS Network of Hamilton has operated as a non-profit organization committed to improving quality of life for all those affected by HIV/AIDS in the communities of Hamilton, Halton, Haldimand, Norfolk and Brant.

[www.aidsnetwork.ca]

- **Project, E16:** *Ontario's ACCHO Strategy Outreach Workers* (local scope).
- **Project, E17:** *Community Outreach: People from Endemic Countries* (local scope).

AIDS Niagara

AIDS Niagara is a community-based organization made up of dedicated and caring staff and volunteers committed to providing support, education and advocacy in a safe and confidential environment to all who are infected with, or affected by, HIV and AIDS.

[www.aidsniagara.com]

- **Project, E18:** *Ontario's ACCHO Strategy Outreach Workers* (local scope).

Black Coalition for AIDS Prevention

The Black Coalition for AIDS Prevention is a volunteer-driven, charitable, not-for-profit, community-based

xxiii The African Community Health Services no longer exists.

organization whose mission is to reduce the spread of HIV infection in Black communities and to enhance the quality of life of Black people living with, or affected by, HIV/AIDS. [<http://black-cap.com/>]

- **Project, E19:** *Ontario's ACCHO Strategy Outreach Workers* (local scope).
- **Project, E20:** *Muungano, African and Caribbean ASOs working to Coordinate HIV/AIDS* (local scope).
- **Project, E21:** *Gay, Bisexual, MSM Outreach* (local scope).
- **Project, E22:** *AIDS Prevention* (local scope).
- **Project, E23:** *Black PHA Prevention Project* (local scope).

Centre des Jeunes Francophones de Toronto

The Centre des Jeunes Francophones de Toronto uses appropriate cultural approaches in the delivery of its services and programs by offering youth a unique opportunity to develop skills, ability, attitudes and competency grounded in the Canadian experience. [www.centredesjeunes.org]

- **Project, E24:** *Sexe c'est ta vie tu décides – Sex It's Your Life, You Decide* (local scope).

Centre Francophone de Toronto

The Centre Francophone de Toronto supports the development and betterment of the diverse French-speaking community in the Toronto area. [www.centrefranco.org]

- **Project, E25:** *entraide communautaire – Community peer-support* (local scope).
- **Project, E26:** *Quand la communauté se prend en main – Community empowerment* (local scope).
- **Project, E27:** *Ubuntu, Komipesa, Angajmant Kominoté, Engagement communautaire – Community Involvement* (local scope).

Dixon Hall - Toronto

The Dixon Hall organization targets residents of local public housing (Regent Park - Canada's largest public housing complex) and transient homeless men and women in the delivery of stable housing, meaningful employment, and activities that challenge and empower growth.

- **Project, E28:** *Youth Supporting Leaders Achieving New Growth* (local scope).

East York East Toronto Family Resources

The East York East Toronto Family Resources provides formal and informal family support services for families. [www.eyetfrp.ca]

- **Project, E29:** *Women AIDS Education* (local scope).

Ethiopian Association in the Greater Toronto Area and the Surrounding Regions

The Ethiopian Association in the Greater Toronto Area and Surrounding Regions provides community and social service programs to people of Ethiopian origin and others. [www.ethiocommun.org]

- **Project, E30:** *HIV/AIDS Prevention Project* (local scope).

JD Griffin Adolescent Centre

The JD Griffin Adolescent Centre provides services to youth and their families and adults (16 years and older), who have a dual diagnosis of mental health concerns and developmental delay. [<http://griffin-centre.org/>]

- **Project, E31:** *HIV/AIDS Outreach Project* (local scope).

Lakeshore Area Multi-service Project

Lakeshore Area Multi-service Project provides a variety of programs and services to meet the health needs of the South Etobicoke community. [www.lampchc.org]

- **Project, E32:** *Street HIV/AIDS Prevention Project* (local scope).

PAPE Adolescent Resource Centre

PAPE Adolescent Resource Centre is a joint project of the Children's Aid Society of Toronto, the Catholic Children's Aid Society and Jewish Family and Child Services. Its mandate is to assist youth who are currently or have been in the care of any of these agencies. [www.parcyouth.com]

- **Project, E33:** *"Awear" of Choices 2007* (local scope).

Parkdale Community Health Centre

The Parkdale Community Health Centre is a community-based health organization serving the residents of the Parkdale and surrounding areas. [www.parkdalehealth.ca]

- **Project, E34:** *HIV/AIDS Outreach and Info for Vulnerable Populations* (local scope).

Peel HIV/AIDS Network

The Peel HIV/AIDS Network is committed to serving people living with, and affected by, HIV/AIDS and limiting the spread of the virus through support, education, advocacy and volunteerism. [www.phan.ca]

- **Project, E35:** *Ontario's ACCHO Strategy Outreach Workers* (local scope).
- **Project, E36:** *Health Promotion for People Living with and Affected by HIV/AIDS* (local scope).

Regent Park Community Health Centre

The Regent Park Community Health Centre is a community-based health organization serving the residents of Regent Park and surrounding areas.

[www.regentparkchc.org]

- **Project, E37:** *Improving Services for Immigrant and Refugee Persons with HIV/AIDS* (local scope).

Somali Immigrant AID Organization

The Somali Immigrant AID Organization addresses immigration, education, health, social services, cultural, and economic development needs of Somali-Canadians and other immigrants in Canada, through programs, services, and advocacy. [www.webhome.idirect.com/~siao]

- **Project, E38:** *AIDS Prevention – Community Voice* (local scope).

Somerset West Community Health Centre (Ottawa)

The Somerset West Community Health Centre is a non-profit, community-governed organization that provides primary health care, health promotion and community development services, using interdisciplinary teams of health providers. [www.swchc.on.ca]

- **Project, E39:** *Ethnocultural peer training for HIV/AIDS prevention* (local scope).

- **Project, E40:** *Operation Hairspray Phase 2: HIV/AIDS Prevention in Ottawa's African and Caribbean* (local scope).

Rexdale Community Health Centre

The Rexdale Community Health Centre supports and advocates for the physical, economic, social and mental well-being of its diverse community.

- **Project, E41:** *LIFE – Live it to the Fullest Everyday* (local scope).

Toronto People with AIDS Foundation

The Toronto People with AIDS Foundation is the largest direct support service agency for people living with HIV/AIDS in Canada. [www.pwatoronto.org]

- **Project, E42:** *Speaker's Bureau* (local scope).

VIVER – Portuguese-Speaking HIV/AIDS Coalition

VIVER works with the Portuguese-speaking community of Toronto to promote culturally competent and language-specific awareness, prevention and advocacy programs and to eliminate barriers for Portuguese-speaking people living with, affected by, and at risk for, HIV/AIDS.

- **Project, E43:** *Portuguese Speaking Men's Outreach* (local scope).

Voices of Positive Women

The Voices of Positive Women is a community-based, member-driven agency that provides free and confidential support and advocacy to HIV-positive women throughout Ontario. [www.vopw.org]

- **Project, E44:** *Voices of Positive Women Community Connections Projects* (local scope).

Warden Woods Community Centre - Bell Estate

The Warden Woods Community Centre exists to build caring, compassionate, interdependent and just communities in southwest Scarborough.

[www.wardenwoods.com]

- **Project, E45:** *Scarborough HIV/AIDS Prevention Project - Young People Rethinking* (local scope).

- **Project, E46:** *HIV/AIDS Education and Prevention* (local scope).

Women's Health in Women's Hands Community Health Centre

Women's Health in Women's Hands Community Health Centre is a participatory health centre for Black women and women of colour in Toronto and surrounding municipalities. [www.whiwh.com]

- **Project, E47:** *HIV Education, Prevention for African and Caribbean Women* (local scope).
- **Project, E48:** *Education Program: Sharing our Model of Care* (local scope).
- **Project, E49:** *African and Caribbean HIV Community Capacity Building Project* (national scope).

York Community Services

York Community Services provides integrated health, legal, counselling and community services to residents of the former City of York in Central West Toronto.

[www.ycservices.com]

- **Project, E50:** *HIV/AIDS Prevention Program* (local scope).

Québec

Centre for AIDS Services Montreal (Women)

The mission of the Centre for AIDS Services of Montreal (Women) is to provide support, education and referrals for women living with HIV/AIDS, their families, and for women who believe themselves to be at risk.

[www.netrover.com/~casm]

- **Project E51:** *Soutien réfugiés + : projet d'accompagnement de soutien des personnes réfugiées (Refugee Support + : Buddy Support Project for Refugee People)* (local scope).
- **Project E52:** *Support Services for HIV-Positive Women*^{xxiv} (local scope).

Groupe d'Action pour la Prévention de la Transmission du VIH et l'Éradication du Sida

The Groupe d'Action pour la Prévention de la transmission du VIH et l'Éradication du Sida is an umbrella organization of community-based organizations, professionals, and independent experts all engaged in the fight against the AIDS epidemic in the general population but more specifically among the Haitian community.

[www.aihc.ca/CCRI/gapvies.html]

- **Project E53:** *Pour elles, par elles, pour la vie - For Her, by Her, for Life* (local scope).
- **Project E54:** *Éducation et prévention – Education and Prevention* (local scope).

Pacte de Rue

Through its team of street workers, the Pacte de Rue provides anonymous and confidential support and reference services for its street-involved clientele.

- **Project, E55:** *Travail de proximité, agir en émergence des problèmes – Outreach Work, Intervention Ahead of the Problems* (local scope).

Refuge Juan Moreno

The Refuge Juan Moreno provides emergency shelter and protects the rights of women and children who are refugee claimants.

[www.refugejuanmoreno.ca/whoweare.htm]

- **Project E56:** *Femmes en santé – Healthy Women* (local scope).

Unité d'intervention mobile l'Anonyme (Mobile Intervention Unit – Anonyme)

The mission of the Mobile Intervention Unit, *Anonyme* is to offer help to youth in difficulty aged 14 to 30, by meeting them in their own environment.

[www.anonyme.ca]

- **Project E57:** *Hey fille! Mets tes culottes – Hey Girl! Pull up your underpants* (local scope).

xxiv This project was formally led by the Centre de ressource et d'intervention en santé et sexualité - this organization no longer exists.

