HIV risk in African, Caribbean and Black youth: perceptions of community leaders in the Windsor-Sussex Region

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Abstract

Disproportionately high rates of HIV in African, Caribbean and Black (ACB) communities are well documented; this is particularly true in youth. A quarter of new HIV cases between 2012 and 2017 occurred in those with Black ethnicity and several factors have been identified, including poor education, stigma leading to misconceptions, risky sexual behaviours, etc. These risk factors can be grouped into individual level factors and community level factors. Research has not been conducted on community leaders' and elders' perceptions of risk. Thus, this study aimed to assess community leaders' perceptions of HIV risk in ACB youth in Windsor, Ontario. Twelve individual interviews and two focus groups were conducted with individuals who had deep connections to the Windsor ACB community and its youth. Interviews were transcribed, coded, and thematically analyzed using NVIVO by multiple raters to ensure inter-rater reliability. Ultimately, community leaders' answers were organized into two groups of risk factors: direct and distal factors. Direct factors were regarded as increasing HIV risk and included beliefs and conventions, poor sexual health education and knowledge, and lack of community services. Distal causes were contextual factors that increased HIV risk; these included racism, poverty, family breakdown, and immigration challenges. Finally, interviewees identified three main solutions that were in line with previous literature. These included increasing community services, providing role models and peer connections, and increasing sexual health education.

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Introduction

HIV rates are disproportionately high among African, Caribbean and Black Canadians (ACB). In Canada in 2009, while ACB Canadians made up less than 3% of the population, they accounted for 14% of individuals living with HIV.[1] In 2009 in the United States, African Americans represented 44% of new HIV cases, while representing only 14% of the population.[2,3]

Of people living with HIV and AIDS (PLWHA), an important sub-population are youth. In Canada, individuals between the age of 10-29 make up more than 20% of new HIV cases annually.[4] However, it is unclear what proportion of this represents ACB youth. As of 2010, African American adolescents (13-19 years old) accounted for 69% of HIV and AIDS diagnoses in U.S. adolescents, though they only represented 15% of this age group.[3] Several risk factors for contracting HIV in adolescence have been identified, such as early sexual debut, regular alcohol use, poor education, and absent parents.[5] Adolescents also face barriers to accessing HIV prevention and treatment services. These services are insufficient in number, and where they do exist, they lack in quality and are often inaccessible.[6] Stigma, which is perpetuated by a lack of knowledge about HIV, also deters adolescents from accessing prevention and treatment services.[7]

ACB communities are a priority population for HIV programming in Ontario. Between 2012 and 2017, roughly a quarter of new HIV diagnoses occurred among ACB individuals. In 2016/17, over half of women diagnosed with HIV were ACB.[8] Most past research has studied HIV/AIDS in very large metropolitan areas like Toronto, or areas of low-income countries. Typical findings suggest a need for provision-based prevention programs, including condom availability and sex education for impoverished areas.[3,5] However, recent studies have proposed a more holistic approach that addresses contextual factors. Community-based strategies, including HIV-education programs through formal education and community centres have shown promise in recent literature.[6]

HIV vulnerability can be analyzed distinctly at an individual level, and at a social/contextual/community level. The latter includes socioeconomic factors such as income, poor employment prospects, substance abuse, stigma surrounding sexual orientation and disease contraction, and general knowledge/misconceptions regarding safe sex practices.[5,6] These factors may promote HIV-related sexual risk behaviours, which include having multiple partners, refraining from condom use, and not getting tested.[9] Individual factors contributing to HIV vulnerability include vertical transmission, forced sex, and unexpected circumstances like infection from a blood transfusion.[5,10]

Although past research has examined HIV/AIDS vulnerability in ACB, youth, and ACB youth, studies have yet to explore community leaders' perceptions of HIV susceptibility in their youth.[3,5,8,10]

This study aims to understand community leaders' perceptions of factors that make their youth vulnerable to HIV, the broader contexts in which these risk factors occur, and the role of HIV-prevention programs in ameliorating risk.

Methods

This paper uses data from interviews and focus groups with adult leaders in the African, Caribbean and Black (ACB) communities in Windsor, Ontario. The purpose of the interviews and focus groups was to identify factors increasing HIV vulnerability among ACB youth and were conducted between March 2013 and July 2014. Interviews with youth were done separately to ensure openness dialogue among and between youth. Results related to youth can be found in other papers.[11] Research methods, interview and focus group questions, and interpretation of results were developed in consultation with a youth advisory committee following the model developed in the Toronto Teen Survey.[12]

Two criteria were used in selecting participants for this portion of the research: representation of a broad spectrum of leadership positions and community leaders who had contact with and were knowledgeable about ACB youth. A preliminary list of interviewees was created with input from the youth advisory committee based on their knowledge of the community. Four research team members conducted one-on-one interviews with 12 community leaders (1 each: pharmacist, social service provider, mental health counsellor, police officer, African man, African woman, Caribbean man, Caribbean woman, Black man and 4 religious leaders from different religious organizations). Two team members conducted a focus group with 10 educators who regularly met to discuss issues related to education in their community (secondary school teachers, counsellors, human rights officers, university professors, and school principal) and 6 leaders of ethno-cultural organizations who also regularly met to discuss issues and plan events in their communities. Interviews were held at a location chosen by each participant or, in the case of focus groups, at the regular group meeting place. Procedures to ensure the ethical conduct of the research were reviewed and consent forms signed after which interviews and focus group discussions of approximately one hour were conducted and audio-recorded. Audio-recordings were transcribed with all personal, identifying information removed from transcripts. Transcripts were then coded and thematically-analyzed in NVIVO using grounded theory to highlight and analyze emergent themes.[13] Multiple raters were used, and concordance was established to assess inter-rater reliability.

All research procedures were reviewed and cleared by the Research Ethics Boards at the University of Windsor and Wilfrid Laurier University.

Results

Data analysis revealed a number of themes related to HIV vulnerability, which were subsequently categorized into direct and distal factors. It is worth noting that these factors are a reflection of ACB community leaders' perspectives on HIV vulnerability among their youth.

Direct factors

In their discussion of HIV vulnerability in ACB communities, community leaders identified three broad, but direct factors that they believe promote sexual risk behaviour in youth. Direct factors, as opposed to distal factors, are identified as immediate and intuitive reasons for elevated HIV rates. Distal factors have their effects through a multi-step process.

Beliefs systems

Many participants attributed HIV vulnerability in youth to various belief systems held in ACB communities. First, certain moral values were cited as possibly increasing sexual risk behaviours. For example, participants felt that maintaining virginity until marriage was considered an essential virtue in many of their communities, and as such, youth were engaging in anal sex with the perception that it would conserve their virginity:

> *A lot of females are having anal sex with boys because they want to protect their virginity so they're having sex with boys anally and I think they need to be educated…you know, whether it be vaginal, anal, or whatever you have to practice it safely.*

Another factor felt to promote HIV vulnerability was discomfort with homosexuality in some ACB communities: "In our community, our kids might be involved in same-sex relationship and you might never know. And if you know, you are in denial. You don't want to accept that he or she is gay but you see all the signs." Participants felt that an unwillingness on the part of parents and community leaders to accept or even discuss homosexuality was preventing youth from being fully informed and leading them towards risky sexual behaviours: "Gay and lesbian relationships. In the Black community, we don't talk about it. We don't talk about the sex issue. We don't talk about different types of sex. And so our kids are getting into all sorts of activity."

Furthermore, an avoidance of discussing "taboo topics" related to youth, namely sex and sexual health, was thought to increase sexual risk behaviours among youth: "I think [HIV rates] are higher because not enough people talk about it. Like I said, parents don't talk to their children enough about AIDS and other STDs." Participants frequently described how this mentality was resulting in youth being ill-informed about sexual risk factors, making them more vulnerable to HIV: "sometimes your parents don't want to talk to you about sex and all that stuff so the information, the knowledge is not there."

The last convention cited as contributing to sexual risk was the tight-knit nature of the communities leading to privacy concerns. Participants explained that people were reluctant to seek out sexual health services or discuss matters relating to sexual health for fear of having confidential information spread in the community, thus becoming the subject of rumors:

> *The stigma, the fear, if someone hears I'm talking to you about AIDS, what would they think about? We're close-knit people, that's the way we are, I think Black people in the world, and we are. So it's like, as a victim by association, I don't want to know or talk about it.*

Community leaders explained how this may possible increase sexual risk behaviours: "I don't want people to identify me with ACW (local HIV organization). Going there, they might think I'm HIV positive. So, if I don't have access to condoms, then I will not use them consistently."

Lack of sexual health education and knowledge

Another theme that emerged in the data was a lack of sexual health education and knowledge: "By the time they hit high school a lot of the kids are sexually active if they didn't get any of this education from grade school now they're in high school, you probably miss a lot of them. A lot of them are already falling in the cracks." When asked about the cause of HIV vulnerability in ACB youth, one participant responded, "lack of knowledge is what I think it is. If people are not educated about protection, about the diseases that are out there, they're just going to do whatever so, that's my opinion that's what I think is lack of knowledge."

This lack of knowledge was also described as manifesting in the subscription to HIV misconceptions, for example, the sentiment that HIV solely affects gay men: "There could be the assumption that HIV/AIDS is gay men. And if someone views themselves being heterosexual male or female then it's not applicable to them. So it's not really any worry." Participants felt that this resulted in youth dismissing the risk of HIV and therefore avoiding preventative measures.

Lack of community services

Participants widely believed that insufficient community programming was driving youth towards unsafe sexual activities, resulting in elevated HIV rates:

> *They can't find jobs and with them not finding jobs they have a lot of free time on their hands, then there isn't a lot of regulated programs like in the community centre where they can go and like get tutoring for their homework or homework clubs or youth programs where they can go camping, and just really get to know each other, socialize in a safe way. There isn't enough of that in the city for them so I think a lot of times they get sidetracked by doing things that they shouldn't be doing because they don't have anything better to do.*

This sentiment was echoed by many participants. Another community leader similarly described this phenomenon:

> *Getting into trouble with drugs and plus teenage pregnancies because they are living here in Windsor has one of the highest teenage pregnancy rates right and they think it's because they don't have a lot of social activities to do so they have sex and they get into trouble with the police and drugs and stuff like that because there isn't enough recreational activities for them.*

Distal factors

While community leaders offered many direct explanations for HIV vulnerability in ACB youth, they also spoke about contextual factors that indirectly lead to HIV vulnerability. They describe conditions that disadvantage, disenfranchise and marginalize ACB youth, making them more vulnerable to HIV risk behaviours.

Racism

Participants engaged extensively in conversations detailing the racism and discrimination facing their youth: "But when it comes to Black, our young people, I think I should just mention, they are not included. They seem to be marginalized. They are getting more marginalized every day."

Others reported instances of racism from the police:

> *The Windsor police is biased against the young kids. Especially the boys. They are totally, totally biased. They always think that a young black person walking on the street is always up to no good, walking on the street, driving, they think that they are up to no good.*

Discrimination in the job market was also cited by participants: "you should focus about that. Marginalization of young Africans. Even when they finish their universities you won't see any financial institution hiring them;"

> *With respect to African Canadians or Caribbean Canadians, there is no doubt that they have less opportunities in the job market. And when they do get a job that they qualify for is less than what the other person will qualify for due to certain barriers that are not only self-inflicted but the stigma society places on them.*

Overall, community leaders expressed that deep-seeded discrimination on the part of governmental and policy workers leads to a decrease in effort or resolve when supporting ACB youth.

> *... when there is discrimination attached to the way you see people you tend not to help them the way you would help other people that are in the mainstream culture, so definitely I see that a lot the racialized minority youth, they are discriminated against.*

Poverty

A common topic of discussion among community leaders was poverty in ACB communities.

> *If they don't have good income, the parents for example, their children will go through things like drugs and alcohol because of poverty and then we get lost so when they go through those things like alcohol drugs and many other you know society community, you know, bad things, so they will go get those HIV easily.*

Issues of low income and low levels of educational attainment were viewed as detrimental in multiple ways. One participant viewed educational attainment as a sort of buffer against HIV risk:

> *Kids who normally go on and to higher education or getting into a trade they don't tend to live that kind of loose life you know that makes them reckless or at least because they are more educated they tend to know more about AIDS and HIV and how to even, if they are involved in sexual activity.*

Another participant described the effects of poverty: "poverty is related, what poverty does it brings about lack of guidance, so if the parents are poor they have to go out and work 2 or 3 jobs and leave the kids at home, the kids are free and so there is less supervision."

Finally, poverty was associated with an inability to prioritize health:

> *I think when we talk about 16-25, for someone that age experiencing poverty or homelessness, health issues really go to the bottom of their priority list. It's not something in the front of their mind on a daily basis. They are not thinking of how this will affect their health or their partner's health.*

Family breakdown

Family breakdown was brought up by many community leaders as a negative contextual factor affecting ACB youth:

> *Our brothers who are from the Caribbean and those who are of North American, more of North American, many of them don't have stable families, most of them are being raised by single mothers and I consider that as a major factor in the sexual behaviour of the young people. Many of them don't have the fathers at home, but if you look at it closely, you will see that homes where the parents are not living together, especially there's no father, the children tend to be less restrained in their sexual encounters so there are a lot more teenage pregnancies and all those things. So I believe that is a major factor.*

The idea of the absent father, which leads to a void in male role models, contributing to increased sexual activity among youth was echoed by other community leaders:

> *There is a lack of father representations in the families. As such some of the children let loose to do what they want, at an adolescent age. The mother can't do it at some point. But it reaches a point where we need the father figure or a male figure especially with the young men. To be able to be a role model for them. But I think that's a lack in the ACB community.*

Participants also spoke about youth who leave home at young ages:

> *There are families where kids have left home really young. They are exposed to just the opportunity be having unprotected sex whenever they feel like it too. They don't have parental controls where people are watching and educating them and making sure they have medical care.*

The importance of the family in the lives of ACB youth, and with respect to their risk-taking behaviour was emphasized consistently by community leaders:

> *What is big for me is the family structure, family situation. I believe that if we are able to find a way to help families to stay together to help take care of the children, a big part of the problem will be solved, I see that as the main issue.*

Immigration challenges

Participants explained that many community members were newcomers to Canada and that this posed various unique challenges for youth. One example was the feeling of false security associated with immigrating to Canada:

> *The other reason is that at times we come in here, we get the feeling that this is Windsor, this is Western country, so I'm safe, there is no HIV here. They don't talk about HIV in Canada, so I might tend to engage in unprotected sex. Before I know it, I could get infected by a partner that is already HIV positive in Canada.*

Youth who have recently immigrated may have experienced significant trauma or stressors that prevent them from participating fully in society:

> *The immigrant kids, a lot of times they experienced a lot of tragedy and a lot of loss leading up to them being here. It almost seems like we are saying, "Oh go to this program, you can learn about a job interview. The kid is looking at you like, "Are you kidding me right now? Do you even know the life I lived?" And they may live with an aunt or uncle or just one parent, or they experienced a lot of death and trauma and things like that. A lot of kids come here alone to live with a family member. They don't know the culture. They don't even know the family member that they are coming to live with. So, I think there are so many factors in their personal lives that they are really not motivated to reach out to programs and agencies.*

Additionally, once these youth arrive in Canada, they are unaccustomed to the norms of sex because "when they come here they want to explore. They want to explore. Sex in Africa is not as common as it is here."

The final factor related to immigration is different norms related to discipline. Community leaders felt that increased leniency in Canada was allowing youth to engage in risky behaviours:

> *They just, you know, have all these, all these, different organizations, oh, child protection agency, if your parent threatens you, you can pick up the phone and call and kids are like that, kids minds are you know…oh you can't touch me, you know, I can make this phone call, and you'll go to jail, imagine telling your parents that. So ...our society has given these kids, they're here, their children, but they put them way up here like parents, they even miss the adult age, they go from children and they're already the parents so, you have a problem there, they've created a problem in society of kids.*

Solutions

Three general solutions to high HIV prevalence in ACB youth in Windsor were proposed by community leaders: Increasing community services, increasing sexual health education, and providing youth with mentors and role models.

Increasing community services

Community leaders unanimously agreed that more community services were needed to provide youth with safe and engaging recreation, and that this would reduce behaviours that make them vulnerable to HIV:

> *Our youth need a place to call, a place like home, this is not a big place… if we help youth connect to a bigger place and have more activities and supervise, it will make a difference, where Saturday and Sunday they can go out and see a movie, play basketball. we don't have that…*

One participant further specified that there should be community-based services dedicated specifically to these youth: "we need an African hall, community hall, African community place where we can have… like where those African and Black people… can just use a computer, play games, we don't have that."

Providing role models and peer connection

A common sentiment among community leaders was that providing youth with positive role models and constructive peer interaction is a key step in improving the lives of these individuals and alleviating the HIV epidemic: "if we get people who truly care to deal with the kids, like we said the kids don't want to talk to their parents so if there are mentors doing different things…they'll open up to those people." One participant described how implementing mentorship would impact the youth: "I really think that if they have the right guidance these kids could do amazing things. They can

reach amazing levels, heights whatever success you want you could reach and it comes from guidance."

A particular suggestion was to have community professionals mentor youth:

> *They can be great mentors because if you set up the kids now to go meet those people they're going to tell you their story, I did this, I did that, maybe there is a kid, I want to be a lawyer but now I see a Black lawyer who, and then he's going to, belief level goes up.*

Community leaders built on the idea of guidance by emphasizing the importance of peer relationships in influencing youth behaviour:

> *I think a big part of the problem with the youth that we support as well, is amongst their own peer groups, it's not always acceptable to seek out help in the community. The peer groups that we service are so important to them. If they feel included if they feel they are part of a group among their peers.*

It was recommended that services be designed to facilitate positive social interactions among peer groups: "I have read a few things about after school programs that people need to be involved in to just take their minds off stress of school and be able to develop very good peer, with their peers in a positive way so that also needs to be developed."

Sexual health education

The last proposed solution was to increase sexual health education provided to ACB youth and other ACB community members: "I think basically it will be about education. Educating the youth about the dangers of this HIV." In particular, participants expressed the need to educate youth about the consequences of sexual behaviours and about preventative measures:

> *I would think education is huge, education is very, very, very, important in terms of translating the knowledge of what needs to happen, preventative measures to be put in place, education right from the time these kids are in school, you know, so they will tell them about the negative effects of sexual encounters.*

Furthermore, regarding education, community leaders emphasized the importance of educating parents so that they are able to prepare their children effectively: "So we need to educate the parents as well. We can educate the youth yes, but we also have to educate the parents, actually maybe we need to start educating the parents when they get here."

Discussion

In this study, community leaders in the Windsor ACB community were interviewed regarding their views on contributing factors to HIV vulnerability among ACB youth. While this paper presents their perspectives, it is important to recognize that it does not suggest that ACB communities are more susceptible than others to the factors discussed.

In the present study, community leaders identified maintaining virginity until marriage, disapproval of homosexuality, cultural silence, and privacy concerns, as being related to sexual risk behaviour and HIV vulnerability were among ACB youth. These have been highlighted in past studies. For example, in Gardezi et al.'s examination of HIV in ACB communities in Toronto, a major theme was the simultaneous perception that HIV is a "gay disease" and the unwillingness to accept homosexuality among members of ACB communities. As described in this paper, informants felt that individuals who contract HIV are to be "blamed," and that this issue should not be discussed in the mainstream.[14] This was raised by community leaders in this study as well; since HIV was largely considered a "gay disease", youth were not taking adequate precautions to protect themselves because of a false sense of security. This was also seen in a UK study, in which HIV positive status was seen as a moral failing, indicating sexual promiscuity and homosexuality. This study also cited religious beliefs as a key promoter of HIV stigma and misconceptions, a sentiment that emerged in the present study, as well.[15]

When discussing homophobia, particularly in ACB communities, it is important to historically contextualize it. Homophobia is rooted in the extensive religious historical colonization experienced by ACB peoples. The subsequent structural racism that has ensued over the years, has created such deep-seeded beliefs in ACB communities.[16]

HIV-positive individuals have previously described a lack of conversations about sex, sexuality, physical health issues, and a reluctance to seek out sexual health care.[14] Some believe the discomfort in talking about sex is heightened when speaking to parents, minimized with siblings/peers of similar age, and young Christians have noted the effects of religion in limiting such discussions, especially due to the condemnation of pre-marital sex.[17] The absence of such candid conversation was noted in another paper about African immigrants, where the community was averse to discussing "taboo" topics, such as sex.[18] The importance of public conversations about STIs was shown in one study conducted in Nyanza, Kenya. In areas with high numbers of HIV-related deaths, youth reported medium or high risk perception, indicating that knowledge about such tragedies is vital to developing one's risk perception and taking precautionary actions. Yet, in most schools and communities such deaths were not acknowledged and failed to increase risk perception.[19]

Privacy concerns due to the closeness of ACB communities is also present in the literature. In Amibor and Ogunrotifa's study, participants shared the sentiments of community leaders in this study, explaining that being identified by other members of the community was a primary deterrent to accessing HIV prevention services.6 One study of ACB communities in Toronto noted that the community gossip was prominent in HIV-positive people's accounts of their experiences. They explained that because information spreads so quickly, many individuals were discouraged from speaking at all.[14]

Lack of sexual health knowledge was regarded by community leaders as one of the most significant factors in youth HIV vulnerability. This theme is reflected in the literature, where high risk sexual behaviour, and early sexual debut, particularly, were found to be associated with poor knowledge of STIs.[20] Additionally, one study of African-American adolescents exploring predictors of condom use and HIV risk behaviour found that consistent condom users had higher AIDS knowledge scores than non-users, demonstrating the conversion of poor knowledge to risky behaviour.[21] This lack of knowledge was also highlighted in a 2015 study, in which 50% of female participants believed that HIV transmission may occur via mosquitoes and supernatural forces.[5] One paper found that although youth had low levels of knowledge overall, those with medium or high risk perception had greater levels of knowledge, rejected HIV myths, and had greater condom-use efficacy.[19]

Many studies have also demonstrated the importance of extracurricular and community-based services in promoting positive socialization. In one study exploring HIV vulnerability from the perspective of ACB youth, participants felt that providing youth with more opportunities would be beneficial in limiting risky sexual behaviour.[3] In a paper exploring the relationship between social status and HIV risk in ACB populations, researchers stated that community programs should be tailored towards particular sub-groups and should address proximal and contextual factors that promote HIV vulnerability.[22]

Community leaders discussed poverty as a contextual factor that promotes sexual risk behaviours. One study indicated that low SES increased probability of exposure to, and engaging in risky behaviours, such as unprotected sex; the authors also identified education as a protective factor due to its association with better health, jobs, income, and, on average, a later age to start a family in youth.[5] Another study noted that such individuals become negatively affected by the social determinants of health on a daily basis, and these economic disadvantages increase risk of contracting infections.[14] Other researchers have shown that economic disadvantage, especially generational poverty, indirectly influences one's vulnerability to infectious diseases, because with no hope for a prosperous future, people are less encouraged to act safely, particularly in their sexual behaviour.[3] These circumstances are especially likely for immigrants, who often describe under-employment in Canada and its tie to HIV risk behaviours.[18] These factors also act as barriers to accessing HIV-prevention services and treatment programs, perpetuating the existing trend.[6]

Similarly, community leaders' view of immigration problems and their links to HIV is also reflected in the literature. The notion of immigration status as a social determinant of health that contributes to HIV vulnerability was explored in one Toronto study, where participants believed that being a newcomer reduced one's agency regarding health-seeking behaviour, thus decreasing access to HIV prevention services.[6] In our study, participants described a false sense of security, with ACB newcomers believing that HIV is distant from the Western world; a sentiment further explored in another Toronto study.[14]

The impact of fractured family structures on HIV vulnerability among ACB youth has also been documented elsewhere. For example, in a study exploring HIV/AIDS service needs from the perspective of African immigrants to Canada, "family breakdown" was recognized as an overarching theme that promotes HIV vulnerability on various levels. Researchers recommended family-centred interventions, including workshops and family counselling.[18] Another paper looking at the impact of parent involvement found it to be a protective factor in reducing sexual risk in adolescents, through various mechanisms including parental monitoring and parent-adolescent communication regarding sexual health. They noted that a parent-adolescent communication intervention promoted increased communication on sex-related topics, parental monitoring, condom-use skills and self-efficacy in the youth.[24]

It is critical to root these discussions within a context of systemic racism, a significant and overarching challenge in the lives of ACB individuals. Firstly, instances of racism, particularly within healthcare systems, have been shown to perpetuate HIV vulnerability in many past studies. In one study exploring elevated rates of HIV in Black Canadian women, racism and discrimination were identified as barriers to HIV prevention. Specifically, the stereotyping of Black Canadians as inherently more vulnerable to HIV and the historic mistrust of Black people were highlighted by participants.[23] Another study noted that discriminatory treatment from healthcare professionals acted as a deterrent to accessing healthcare and other services. Participants in that study were fearful of being characterized as inherently more disease prone due to their race or ethnicity.[14] Moreover, many of the other contributing factors discussed in this paper – poverty, family breakdown, and lack of sexual health knowledge are attributable to the pervasiveness of anti-black racism within society and societal structures.[25,26] For example, racist practices such as separating black children from parents more readily than white children, employment discrimination, and increased police scrutiny cultivate disproportionate tension within black families and promote poverty.[27-29] It is the intersection of the various racial inequities present in Canadian society that creates fertile ground for HIV vulnerability to increase.

The solutions presented in this study are supported by previous research. Increasing community programs and services was suggested in many similar studies and included programs related both to youth engagement and to HIV prevention services.[3,22,30] Efforts to improve sexual health education was also proposed in past literature.[19,23] Notably, however, some studies specifically stated that education alone is not sufficient in reducing HIV risk.[3,15] While the concept of role models and mentors was not prevalent in the literature as a potential solution to HIV vulnerability in youth, some papers did acknowledge the role of peers and social groups.[3] Other proposed solutions from similar research include increased cultural sensitivity in service providers, more service providers from ACB backgrounds, and addressing issues associated with recent immigration, such as housing.[6,15,18] Finally, it is relevant to mention that, although community leaders discussed racism as a contributing factor to HIV vulnerability, their proposed solutions did not deal with potential ways to reduce it. Some ideas brought forth in other articles include anti-discrimination training for healthcare providers,[31,32] as well as mass media campaigns aimed at reducing stigma towards HIV positive black individuals.[33] While the issues of anti-black racism and discrimination are complex and require broad, high-level solutions, it is critical to address them at individual and community levels in any way possible.

Several limitations did exist in this study, including the definition of "community leader", which is dynamic depending on the community. Additionally, the results were limited in that they characterized opinions, rather than objectively observed phenomenon. Moreover, Windsor is such a unique setting and the generalizability of these findings may be thus limited.

Conclusion

Community leaders identified several major factors that influence HIV vulnerability among ACB youth. The solutions proposed in this study will enable community leaders, policy-makers, and parents to limit the risk factors that lead to elevated HIV rates in ACB youth and promote positive and safe sexual behaviour.

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References

1. Public Health Agency of Canada. Population-Specific HIV/AIDS Status Report: People from Countries where HIV is Endemic – Black people of African and Caribbean de-scent living in Canada. [place unknown]: Public Health Agency of Canada; 2009
2. Centre for Disease Control and Prevention. Today's HIV/AIDS Epidemic [Internet]. [place unknown: publisher unknown]; 2016 Aug [cited 2020 July 6]. Available from https://www.cdc.gov/nchhstp/newsroom/docs/factsheets/todaysepidemic-508.pdf
3. Woods-Jaeger BA, Sparks A, Turner K., et al. Exploring the social and community context of African American adolescents' HIV vulnerability. Qual Health Res. 2013;23(11):1541–1550. doi: 10.1177/1049732313507143
4. Public Health Agency of Canada. Surveillance and Risk Assessment Division, Centre for Communicable Diseases and Infection Control: HIV and AIDS in Canada surveillance report to December 31, 2007 [Internet]. [Place unknown: publisher unknown]; [updated 2014 Nov 28; cited 2020 July 6]. Available from: http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/2007/pdf/HIV_AIDS_Surveillance_2007_VIH_sida.pdf
5. Dévieux JG, Rosenberg R, Saint-Jean G, et al. The continuing challenge of reducing HIV risk among Haitian youth: The need for intervention. J Int Assoc Provid AIDS Care. 2015:217–223. https://doi.org/10.1177/2325957411418119
6. Amibor P, Ogunrotifa, AB. Unravelling barriers to accessing HIV prevention services experienced by African and Caribbean communities in Canada: lessons from Toronto. Glob J Health Sci. 2012;4(3):1–12. doi: 10.5539/gjhs.v4n3p1
7. Mihan R, Kerr J, Maticka-Tyndale E, et al. HIV-related stigma among African, Caribbean, and Black youth in Windsor, Ontario. AIDS Care. 2016;28(6):758–763. https://doi.org/10.1080/09540121.2016.1158397
8. Ontario HIV Epidemiology and Surveillance Initiative. New HIV diagnoses in Ontario, 2017. Toronto, Ontario: OHESI; July 30, 2019. 60 p
9. Yao Y, Wang N, Chu J, et al. Sexual behavior and risks for HIV infection and transmission among male injecting drug users in Yunnan, China. Int J Infect Dis. 2009;13(2),154–161. doi: 10.1016/j.ijid.2008.05.1228
10. Ayres JR, Paiva V, França I, et al. Vulnerability, human rights, and comprehensive health care needs of young people living with HIV/AIDS. Am J Public Health. 2006;96(6):1001–1006. doi: 10.2105/AJPH.2004.060905
11. Fante-Coleman T, Wilson CL, Marcotte AA, et al. Influences of sexual behaviors and vulnerability to HIV/AIDS among heterosexual ACB youth living in Windsor, Ontario. Journal of Social and Personal Relationships. 2019;36(11-12):3515-3536. doi:10.1177/0265407519826350
12. Flicker S, Flynn S, Larkin J, et al. Sexpress: The Toronto Teen Survey Report. Toronto (ON): Planned Parenthood Toronto; 2009
13. Birks M, Mills J. Grounded theory: a practical guide. 2nd ed. London: SAGE; 2015
14. Gardezi F, Calzavara L, Husbands W, et al. Experiences of and responses to HIV among African and Caribbean communities in Toronto, Canada. AIDS Care. 2008;20(6), 718-725. https://doi.org/10.1080/09540120701693966
15. Anderson M, Elam G, Gerver S, et al. HIV/AIDS-related stigma and discrimination: Accounts of HIV-positive Caribbean people in the United Kingdom. Soc Sci Med. 2008;67(5):790–798. doi: 10.1016/j.socscimed.2008.05.003
16. Bertolt B. The invention of Homophobia in Africa. J adv Humanit. 2019;5(3), 651–659. doi: 10.15520/jassh53418
17. Omorodion F, Gbadebo K, Ishak P. HIV vulnerability and sexual risk among African youth in Windsor, Canada. Cult Health Sex. 2007;9(4):429–437. https://doi.org/10.1080/13691050701256721
18. Worthington C, Este D, Strain K, et al. African immigrant views of HIV service needs: Gendered perspectives. AIDS Care. 2012;25(1):103-108. doi: 10.1080/09540121.2012.687807
19. Tenkorang EY, Maticka-Tyndale E. Assessing young people's perceptions of HIV risks in Nyanza, Kenya: Are school and community level factors relevant? Soc Sci Med 2014;116:93–101. doi: 10.1016/j.socscimed.2014.06.041
20. Maharaj RG, Nunes P, Renwick S. Health risk behaviours among adolescents in the English-speaking Caribbean: a review. Child Adolesc Psychiatry Ment. Health. 2009;3(1):10. doi: 10.1186/1753-2000-3-10
21. Reitman D, St. Lawrence JS, Jefferson KW, et al. Predictors of African American adolescents' condom use and HIV risk behavior. AIDS Educ. Prev.1996;8(6):499-515
22. Baidoobonso S, Bauer GR, Speechley KN, et al. HIV risk perception and distribution of HIV risk among African, Caribbean and other Black people in a Canadian city: mixed methods results from the BLACCH study. BMC public health. 2013;13:184. doi: 10.1186/1471-2458-13-184
23. Newman PA, Williams CC, Massaquoi N, et al. HIV prevention for Black Women: Structural barriers and opportunities. J Health Care Poor Underserved. 2008;19(3):829-841. doi: 10.1353/hpu.0.0043
24. Wang B, Stanton B, Deveaux L, et al. The impact of parent involvement in an effective adolescent risk reduction intervention on sexual risk communication and adolescent outcomes. AIDS Educ Prev. 2014;26(6):500–520. doi: 10.1521/aeap.2014.26.6.500
25. Mullings DV, Morgan A, Quelleng HK. Canada the great white north where anti-black racism thrives: Kicking down the doors and exposing the realities. Phylon. 2016 Jun 1;53(1):20-41
26. Syed I, Wilson C, McKie R, et al. More Threatened Than Safe: What African, Caribbean, and Black Youth Living In Southern Ontario Say About Their Interactions with Law Enforcement. Community Psychology in Global Perspective. 2018:101-118
27. Contenta S, Monsebraaten L, Rankin J. Taking Steps to Help Black Youth in CAS [Internet]. Toronto: The Toronto Star. 2014 December 11 [cited 2020 June 18] . Web. 20 July, 2015
28. Mullings DV. Racism in Canadian social policy. Canadian Social Policy Issues and Perspectives. 2012 May 25:95-114
29. Lawson, E. Disenfranchised grief and social inequality: bereaved African Canadians and oppositional narratives about the violent deaths of friends and family members. Ethnic and Racial Studies. 2014;37(11):2092-2109
30. Logie CH, Okumu M, Ryan S, et al. Pathways from resilient coping to safer sex communication among African, Caribbean, and Black women in Toronto, Canada: Results from a cross-sectional survey. Int J Behav. Med. 2018;25:479. doi: 10.1007/s12529-018-9728-x
31. Mahajan AP, Sayles JN, Patel VA, et al. Stigma in the HIV/AIDS epidemic: a review of the literature and recommendations for the way forward. AIDS. 2008;22 Suppl 2(Suppl 2):S67-S79. doi:10.1097/01.aids.0000327438.13291.62
32. Brondolo E, Brady Ver Halen N, Pencille M, et al. Coping with racism: a selective review of the literature and a theoretical and methodological critique. J Behav Med. 2009;32(1):64-88. doi:10.1007/s10865-008-9193-0
33. Brown L, Macintyre K, Trujillo L. Interventions to reduce HIV/AIDS stigma: what have we learned?. AIDS Educ Prev. 2003;15(1):49-69. doi:10.1521/aeap.15.1.49.23844