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Special Report: HIV/AIDS Service Needs Assessment

Shamara M Baidoobonso
Roxanne Longman Marcellin
Leah Meidinger
Rob Haile
Harina Mokanan, et al.

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The Black, African and Caribbean Canadian Health (BLACCH) Study is a community-based research project designed with the goal of improving access to health care and the health status of Black people from Canada, Africa, the Caribbean, and other parts of the world who reside in London and Middlesex County, Ontario, Canada.

The Black, African and Caribbean Canadian Health (BLACCH) Study Special Report #1, October 23, 2012

Background

The burden of HIV infection is disproportionately high among Black people from countries where HIV is endemic (Public Health Agency of Canada 2009). It is estimated that the HIV infection rate among African, Caribbean and other Black (ACB) people is 12.6 times higher than among other Canadians (Public Health Agency of Canada 2009). Research suggests that many ACB people become infected after immigration (Quorum Communications 2006), and the disproportionate burdens of social, economic, and behavioral factors may increase this population's vulnerability to HIV infection and act as barriers to accessing prevention and care services (Public Health Agency of Canada 2009). Since the ACB population represents the largest visible minority group in Middlesex County, and since London has the third highest infection rate in Ontario (Remis, Swantee, Schiedel, Liu 2008), an inquiry into the factors impacting HIV prevention and care is imperative. This HIV needs assessment focuses on factors that impact the uptake and delivery of HIV services for ACB people. Learning about HIV-related needs, attitudes and priorities of ACB communities will aid the development of more responsive interventions. The goal of this needs assessment is to compile simple, understandable, practical information that can be used by stakeholders.

Our Approach

In Phase I of the Black, African and Caribbean Canadian Health (BLACCH) Study, a purposive sample of 22 local ACB community members and eight service providers were interviewed about ACB people's HIV service needs and HIV-related risks. In Phase II of the research project, 188 self-identified ACB people residing in London and area completed a paper-based survey on their own. All survey participants were aged 18 and older. They were asked questions about the social determinants of health, HIV testing, condom use, HIV service needs, HIV service preferences, HIV-related stigma and knowledge about HIV transmission. Below, we present a summary of responses from Phases I and II that pertain to HIV service needs and structural and behavioural factors related to HIV vulnerability. Interview results were analyzed using qualitative content analysis, and survey results were analyzed using chi-square tests. Fisher's exact test, with and without the Monte Carlo approximation, was used in lieu of chi-square tests when appropriate.

Key Findings

Perceptions about HIV/AIDS and HIV Risk: In the interviews, male and female community members identified HIV as a problem in ACB communities, but men seemed to have a greater tendency to recognize HIV as a problem than women. Some women said that they did not know if HIV was a problem in the Canadian context but mentioned HIV as a problem in ACB communities abroad. A few respondents said that HIV was not a problem in ACB communities at all.

> *Yeah, I think it is. And as I said earlier we are not immune from anything. (Male)*

> *Oh yes, yeah it is a big problem in our community. It's just a taboo, we don't talk about it, it's as if it's not there but, even like it affected me a lot back home like so many of my cousins, my relatives died of you know HIV and we know, and here our people are like our you know friends who have you, who have you… they go back home and then they get in touch with other people and… it's so easy to get contracted with HIV but they don't talk about it. It's just you know a taboo so of course I worry about that. (Female)*

Community members also talked about stigma having a negative impact on HIV awareness.

> *I think community based kind of thing is much better, because HIV become a taboo in our community; nobody wants it. HIV, having HIV positive means a death penalty and nobody knows…nobody wants to know his or her*

status at all and they don't want to talk about it, they don't want to hear about this kind of thing. (Male)

When asked about their perceived personal risk of contracting HIV, both male and female community members said that it was difficult to be certain of one's level of risk. However, married women reported that they believed their risk of contracting HIV was low because of marriage. In fact, among female respondents, marriage and abstinence were cited as reasons for no risk of HIV infection. Whereas several men said that their risk of contracting HIV was low, none said that they had absolutely no risk of contracting it, and men did not cite either marriage or abstinence as protective factors.

[A]t this moment in my life I would say it's quite low because I'm practicing abstinence right now, but had I not been, I think it would be quite high because obviously the only potential mates that actually approach me, I don't approach them, are of the Black community, [Laughs] but I will add that it's unwelcomed [Laugh]. But if they do it's of the Black community and I just know at the back of my head that we have a high HIV prevalence rate [Laughs] yeah, so – but for now it's quite low my risk of contracting HIV/AIDS. (Female)

I think I'm pretty at low risk. I am not promiscuous. I'm already married. I have no intentions of having any kind of affairs. (Female)

In terms of the risk behaviors associated with HIV transmission, women identified alcohol use and intravenous drug use as factors that increased risk. Moreover, men and women commonly linked HIV risk to sex by citing sexual activities as factors that increased HIV risk.

I would say a lot of factors; the first one would be unprotected sex, another one would be not knowing the sexual background of your partner. And the last one just really general – I'd just say rushing into a situation that is not knowing a lot of information about it as well so I guess that kind of encapsulates the first two points though. (Male)

The results from Tables 1 and 2 suggest that ACB men and women did not have different opinions about how concerned ACB people should be about HIV or HIV being an issue in the ACB community, which seems to counter the findings from the interviews. Majorities in both groups said that ACB people in Canada should be "concerned" or "very concerned" about HIV and that HIV is an important issue in the ACB community. These findings about HIV risk perception show that there is an opportunity to work with the community on matters pertaining to HIV.

The mixing of drugs or alcohol with sex was mentioned specifically by female community members who participated in the interviews, and the survey results showed that men and women differed when asked about whether they had ever used drugs or alcohol before or during sex. Men were more likely to report ever using drugs or alcohol before sex (Table 3). The results from the survey lend credence to community members' perceptions about the sexual nature of HIV risk, and these results are explored in more detail later.

Table 1: Amount of Concern ACB People in Canada Should Have About HIV

Degree of Concern	% Males (n=68)	% Females (n=108)
Should not be concerned at all	0%	2%
Should not be very concerned	3%	1%
Should be somewhat concerned	7%	13%
Should be concerned	28%	29%
Should be very concerned	56%	49%
Don't know	6%	6%
Fisher's exact test (MC): p=0.6374		

Table 2: Agreement with the Statement that HIV is Not an Important Issue in the ACB Community

Level of Agreement	% Males (n=67)	% Females (n=109)
Strongly disagree	52%	55%
Disagree	28%	31%
Neutral	10%	6%
Agree	4%	3%
Strongly agree	4%	5%
Fisher's exact test (MC): p=0.8270		

Table 3: Ever Using Alcohol or Drugs Before or During Sex

Response	% Males (n=63)	% Females (n=90)
No	49%	63%
Yes, before sex	46%	30%
Yes, during sex	3%	0%
Yes, before and during sex	2%	7%
**= statistically significant at p=0.05		
Fisher's exact test (MC): p=0.0254**		

Barriers to Accessing HIV-related Services: Not all community members were able to cite barriers to accessing HIV/AIDS services, and some said that they did not know of any barriers. However, both male and female community

members were able to identify discrimination or insensitivity of service providers, generalized stigma within ACB communities and lack of awareness and education about HIV/AIDS as barriers to accessing HIV services. The most frequently identified barrier was HIV-related stigma within ACB communities—people avoided accessing services out of fear that other members of their community would find out about their HIV infection or assume them infected with HIV, even if they were only seeking information about how to prevent infection.

Barriers mentioned by female community members but not males included language difficulties, illiteracy and homophobia. Men were the only ones to mention embarrassment, mental health issues, culture, beliefs about HIV, people thinking that they are not at risk and individuals not trying to access services as barriers.

> *I'm not sure if I'm right or not, but I think where HIV is concerned social stigma attached to things like homosexuality, for one thing, and that in some ways may impact on people in terms of them feeling comfortable seeking services you know. (Female)*

> *Ah stigmatization. Like nobody wants to come in and talk about those things because people might think well you know maybe you have it or whatever so embarrassment, fear, fear that you might already have it. (Male)*

HIV service providers reported that ACB community members did not request services until they became sick. When they did ask for help, they requested housing, food and transportation services most frequently. These were followed by requests for multicultural services and referrals. ACB clients also requested complex medical services, access to testing, general support, tuberculosis testing and HIV testing for their children.

> *They request housing. They request [a local AIDS service organization], food, nutrition, support, TB testing. That type of thing. Testing for the children. Housing, I think I said that. Social determinants of life all you know my job is more as a broker to find out what their needs are and then to try and connect them with the persons that can help them access those goals. (Female)*

Service providers also identified lack of trust as a barrier to accessing HIV services. One service provider revealed that there was a shroud of secrecy around HIV. An ACB service provider pointed to the fear and stigma around HIV within ACB communities, homophobic attitudes and conservatism in ACB communities as potential barriers to service access. Since HIV is often seen as a homosexual disease, some ACB men were less likely to seek HIV services out of fear of being considered homosexual or discomfort in accessing services related to the doubly stigmatized infection.

According to data from the survey, gender was not related to HIV stigma or knowledge about HIV transmission (Table 4). Men and women had the same stigma and knowledge scores, and the results showed that both groups had low stigma scores and high HIV knowledge scores (Table 4). Hence, lack of knowledge about HIV might not be a barrier to service access for this population. Also, based on the level of concern about HIV (Tables 1 and 2), lack of awareness may not be a barrier to service access either.

Table 4: Median HIV Stigma and Knowledge Scores

Scale	Median Score Males	Median Score Females	P-value
Inappropriate Fear of Contagion	6 (range: 0 to 12) (n=62)	6 (range: 4 to 12) (n=102)	0.8355
Enacted Stigma	0 (range: 0 to 7) (n=60)	0 (range: 0 to 7) (n=97)	0.7308
HIV Knowledge	17 (range: 8 to 20) (n=64)	17 (range: 6 to 20) (n=104)	0.2530

Gender also had no impact on community members hearing about the Regional HIV/AIDS Connection [RHAC; $\chi^2(1)=1.47$, p=0.2248], visiting RHAC [$\chi^2(1)=0.16$, p=0.6925], or using RHAC's services [$\chi^2(1)=0.53$ p=0.4678]. Despite knowing about RHAC, both men and women were less likely to visit it and far less likely to have accessed services provided by the organization (Tables 5 and 6). It must be noted that RHAC regularly does outreach to ACB communities and provides HIV testing, information, education services and volunteering opportunities. Hence, even though stigma scores were low, the reluctance to access HIV services shows that stigma persisted in the community, which is in line with what community members said in the interviews.

Table 5: Using Services at the Local AIDS Service Organization (ASO), Males			
Response	**% Heard about ASO (n=70)**	**% Visited ASO (n=70)**	**% Used ASO's Services (n=71)**
No	47%	77%	87%
Yes	53%	22%	13%

Table 6: Using Services at the Local AIDS Service Organization (ASO), Females			
Response	**% Heard about ASO (n=108)**	**% Visited ASO (n=108)**	**% Used ASO's Services (n=108)**
No	38%	80%	91%
Yes	62%	20%	9%

Men and women also did not differ in their level of literacy, but there may be differences between both groups at the highest levels of education (Table 7). The high level of education among community members who participated in the survey suggests that lack of literacy may not be barrier for men or women, which contradicts what was said in the interviews.

Table 7: Highest Level of Education Attained		
Highest Level of Education	**% Males (n=75)**	**% Females (n=113)**
Less than high school	4%	8%
Completed high school	16%	11%
Some community college to completed community college	19%	21%
Some university to Bachelor's	32%	42%
Above Bachelor's	29%	19%
Fisher's exact test (MC): p=0.2381		

Men were more likely to deny the existence of homophobia in the ACB community than women, but both groups appeared to be equally likely to say homophobia was "common" or "very common" in the ACB community (Table 8). This seems to confirm what service providers said about homophobia's impact on HIV service access for ACB men.

Table 8: Commonness of Homophobia in the ACB Community		
Response	**% Males (n=65)**	**% Females (n=98)**
Not common at all	9%	7%
Not very common	17%	3%
Somewhat common	17%	28%
Common	20%	21%
Very common	37%	41%
= statistically significant at p=0.05 Fisher's exact test (MC): p=0.0293		

Facilitators for Accessing HIV Services: Interview participants said making HIV-related information and education about HIV prevention available facilitated access to HIV services. Men were more likely to call for these than women. Other facilitators mentioned by service providers included building trust between ACB people and service organizations and bringing services into ACB communities rather than waiting for ACB people to visit service organizations. As one female service provider put it:

> *If Mohammed won't go to the mountain, take the mountain to Mohammed. So in other words, certain demographics won't access us for a number of reasons. Bisexual men are not going to come to see us, they're going to wonder what if someone recognizes them … they're not going to test at their doctors because chances are their doctor knows they're married, right? So that's a demographic that will be totally missed. Another one is street youth, I mean they have more pressing issues than 'am I HIV positive'… because of their difficult life they may be exchanging sex for a place to sleep, sex for food, so high risk. Another one is needle users… their biggest concern is 'where am I going to get my next fix' not 'where am I going to get an HIV test', yet we know these are three high risk groups, so one of the things we do is to go where they are.*

Female service providers also pointed to word of mouth, producing results, referrals and bridging cultural norms as possible facilitators for accessing HIV-related services.

Factors Identified as Important for HIV Prevention: Some participants reported that they did not know what services were required for meeting ACB people's HIV-related needs, and women had a greater tendency to say this than men. Women asked for more statistics about HIV in Canada, more condoms, greater access to health care, and more community supports and involvement. Men asked for more culturally-based services, family testing and HIV education at non HIV-related events.

One male service provider also called for a participatory framework that involved engaging community members in service planning:

So you know in general my approach working with any minority community is based on participatory framework… And participatory framework means that you really need to engage key people within that community to be part of the solution.

Condom use is an important part of HIV prevention, and as such, it is important to understand the circumstances surrounding it. The survey results show that levels of condom use and reasons for using condoms did not differ between men and women who had sexual intercourse in the past year. More than half of individuals in both groups reported that did not use condoms in the past year (Table 9). The two most common reasons for using condoms, regardless of gender, were avoiding pregnancy and protection from sexually transmitted infections (STIs) or HIV. STI and HIV prevention was the most common reason for condom use with casual partners, and contraception was the most common reason for condom use with regular partners (Tables 10 and 11).

Table 9: Condom Use in the Past Year

Response	% Males (n=50)	% Females (n=66)
No	58%	55%
Yes	42%	42%
Rather not say	0%	3%
Fisher's exact test (MC): p=0.6714		

Table 10: Reasons for Using Condoms in the Past Year, Males

Reason	Regular Partners (n=46)	Casual Partners (n=44)
Avoid pregnancy	37%	23%
Protect against sexually transmitted infections or HIV	20%	34%
Partner asked/ insisted	9%	14%
Didn't trust partner/ thought partner had other partners	2%	9%
Partner is HIV-positive	0%	0%
I am HIV-positive	0%	0%
Don't know	0%	0%
Rather not say	4%	0%

Table 11: Reasons for Using Condoms in the Past Year, Females

Reason	Regular Partners (n=62)	P-value+	Casual Partners (n=49)	P-value^
Avoid pregnancy	31%	0.4914[a]	16%	0.4354[a]
Protect against sexually transmitted infections (STIs) or HIV	21%	0.8580[a]	24%	0.3085[a]
Partner asked/ insisted	8%	1.0000[b]	6%	0.2991[b]
Didn't trust partner/ thought partner had other partners	11%	0.1344[b]	14%	0.5301[b]
Partner is HIV-positive	2%	1.0000[b]	0%	----
I am HIV-positive	0%	----	0%	----
Don't know	0%	----	0%	----
Rather not say	5%	1.0000[b]	0%	----

+=Comparing male and female response for regular partners
^= Comparing male and female response for casual partners
[a] Chi-square test
[b] Fisher's exact test

Among men and women, being with a regular sex partner was the main reason for not using a condom in the past year. This was followed by thinking that a sexual partner did not have HIV or an STI, the participant not having an STI or HIV, not having condoms handy and dislike for condoms. The only reason for non-condom use on which men and women differed was the belief that the sex partner was free of HIV and STIs—women were more likely to say that they did not think their partner had HIV or an STI (Table 12). These results suggest that HIV prevention interventions should focus on making condom use normative by creating a culture that promotes condom use in ACB communities. It might also be beneficial to highlight condoms as contraceptives and promote them on the basis of safety, cost effectiveness and the different types of condoms that are available to satisfy a variety of preferences.

Table 12: Reasons for Not Using Condoms in the Past Year			
Reason	**% Males (n=43)**	**% Females (n=60)**	**P-value**
I was with regular partner	86%	87%	0.9278[a]
I didn't think partner had HIV or an STI	16%	37%	0.0233[a]**
I don't have HIV or an STI	19%	22%	0.7037[a]
I don't like condoms	12%	13%	0.7972[a]
Partner didn't want to use one	9%	13%	0.7569[b]
I didn't have a condom at the time	14%	8%	0.3624[a]
I didn't think of using a condom	2%	8%	0.3967[b]
The sex was too exciting	5%	7%	1.0000[b]
I (or my partner) wanted to get pregnant	5%	5%	1.0000[b]
I couldn't talk about using a condom with my partner	2%	3%	1.0000[b]
I was pressured into having sex	0%	2%	1.0000[b]
I was using alcohol or drugs	2%	0%	0.4175[b]
I was afraid my partner would accuse me of having sex with other people	2%	0%	0.4175[b]
I was too embarrassed to buy condoms	0%	0%	----
I could not afford condoms	0%	0%	----
I did not know where to get one	0%	0%	----
Other	7%	12%	0.5127[b]

**= statistically significant at p=0.05
[b] Fisher's exact test
[a] Chi-square test

Like condom use, HIV testing is important for HIV prevention. Level of HIV testing did not appear to differ by gender. Men and women reported high levels of ever testing for HIV (Table 13), but lower levels of HIV testing in the past year (Table 14).

Table 13: Ever Tested for HIV		
Response	**% Males (n=73)**	**% Females (n=110)**
No	33%	37%
Yes	64%	58%
Don't know	3%	5%
Fisher's exact test (MC): p=0.7076		

Table 14: Tested for HIV in the Past Year		
Response	**% Males (n=74)**	**% Females (n=109)**
No	78%	76%
Yes	22%	22%
Don't know	0%	2%
Fisher's exact test (MC): p=0.6923		

Men appeared to be more likely to have been tested for HIV for immigration purposes, and this difference approached statistical significance (Table 15). However, men were significantly more likely to report that their main partner had not been tested for HIV, and women were more likely to report that their main partner had had an HIV test or that they did not know if their main partner had been tested (Table 16). These results show that many couples are unaware of each other's HIV status. Couples testing should be available and promoted, as suggested in the interviews.

Table 15: Tested for HIV for Immigration Purposes		
Response	**% Males (n=74)**	**% Females (n=108)**
No	59%	68%
Yes	38%	25%
Don't know	3%	7%
*= approaches statistical significance at p=0.15		
Fisher's exact test (MC): p=0.1015*		

Table 16: Main Partner Tested for HIV		
Response	**% Males (n=58)**	**% Females (n=67)**
No	34%	19%
Yes	36%	43%
Don't know	24%	37%
Rather not say	5%	0%
**= statistically significant at p=0.05		
Fisher's exact test (MC): p=0.0399**		

Since HIV testing was seen as important for HIV prevention and participants indicated that family testing and more involvement of health care providers was needed (Table 27), survey participants were asked about their access to primary care. About 70% of men and women indicated that they had primary care providers, and 14% of men and 27% of women said they were "uncomfortable" or "very uncomfortable" with primary care providers in London. Although not statistically significant, the results suggest that men may be more comfortable with primary care providers in London than women (Tables 17 and 18). These findings seem to confirm women's concerns about low health care access for ACB people. If people are not comfortable with their primary care providers, they are less likely to share sensitive or stigmatizing information and may not discuss HIV with their doctors at all. This might lead to missed

opportunities for prevention counselling.

Table 17: Have Primary Care Provider in London		
Response	**% Males (n=73)**	**% Females (n=111)**
No	34%	27%
Yes	66%	73%
$\chi^2(1)=1.10$ p=0.2953		

Table 18: Level of Comfort with Primary Care Providers in London		
Response	**% Males (n=68)**	**% Females (n=110)**
Very uncomfortable	12%	22%
Uncomfortable	2%	5%
Comfortable	41%	37%
Very comfortable	29%	24%
Don't have a primary care provider locally	16%	13%
Fisher's exact test (MC): p=0.3496		

Gender Dynamics and HIV: Service providers observed differences in service access and use by gender, and the gender dynamics observed in ACB communities differed by the gender of the service provider. According to female service providers, women did not feel empowered enough to access services. Hence, ACB men were more likely to elect to be tested than ACB women.

> *…[S]o we'll get a number of… Black men who will step forward to be tested because it really takes a lot of courage, but it also takes someone who feels empowered to say you know what? I'm not going to have this test done at my family doctor; I'm going to have this test done at this anonymous clinic so that's really an empowering thing. Whereas the women may not be as empowered.*

Female service providers also reported that ACB women were getting more involved in the community and getting educated, which were seen as important first steps to women becoming more empowered within their own relationships and thus being better able to negotiate safer sex with their partners. Female service providers also outlined the pressures men faced in society that could impact their health, e.g. cultural beliefs preventing ACB men from disclosing information. It was also reported that there was a belief in the community that men should not wear condoms. These beliefs may keep men from seeking health services, from being forthcoming when they are ill and from protecting themselves against HIV infection. Male service providers claimed that gender dynamics were culture-specific and tended to change once individuals were in Canada. They reported that women had more opportunities in Canada, and this was often at the expense of the family, so women may feel guilty for taking the opportunities that arise, which may therefore impact their health negatively.

Barriers that Stop Women from Protecting Themselves against HIV: Both male and female service providers cited lack of empowerment as a barrier to women protecting themselves against HIV infection; it was the most frequently mentioned barrier. A male service provider said that ignorance about the impact of HIV in their communities is a barrier to women protecting themselves against HIV infection. However, as mentioned previously (see Tables 1, 2 and 4) men and women were equally concerned and knowledgeable about HIV.

> *...[M]aybe ignorance if they don't know you know that is really a problem. (Male)*

Barriers cited by female service providers included marital infidelity, lack of finances, condom use not being allowed within some cultures and religions, the need to feel accepted and loved, discomfort when talking about sex, single motherhood, trust for their partners, lack education about how to protect themselves, gender-based violence and partners not wanting to use condoms.

Table 12 shows that women and men did not differ in the majority of barriers or reasons for not using condoms. Furthermore, few reported disliking condoms or partners refusing to use condoms. No women said they did not use condoms because of embarrassment, cost or lack of knowledge about how to use them.

Men and women did not appear to differ in their tendency to report that their main sex partner had concurrent sex partners (i.e. more than one sex partner during the same time period). Men seemed more likely to say that they did not know if their main partner had concurrent partners, but their "no" and "yes" responses were comparable to those of women (Table 19). Survey results suggest that both groups were equally likely to report having concurrent partnerships (Table 20). Hence, partner concurrency was not unique to men, as some service providers seemed to suggest. Additionally, men may be more uncertain about their partners' sexual behaviours than women, as evidenced by the "don't know" responses.

Table 19: Regular Partner Having Concurrent Partners in the Past Year		
Response	**% Males (n=53)**	**% Females (n=67)**
No	49%	52%
Yes	2%	4%
Don't know	42%	25%
Not applicable	8%	15%
Rather not say	0%	3%
Fisher's exact test (MC): p=0.2278		

Table 20: Participants Having Concurrent Partners in the Past Year		
Response	**% Males (n=52)**	**% Females (n=68)**
No	75%	82%
Yes	19%	13%
Don't know	4%	1%
Rather not say	2%	3%
Fisher's exact test (MC): p=0.6715		

Poverty status and religiosity were seen as barriers that stop women from protecting themselves against HIV infection, but results from the survey suggest that these factors did not disproportionately affect women. Men and women were equally likely to live below the low-income cut-off (LICO; Table 21) and displayed similar levels of religiosity (Table 22). However, a higher proportion of men reported being non-religious than women, but this difference was not statistically significant. Overall, the results show that religious leaders must be engaged in HIV interventions, and practical issues related to poverty that impact access to HIV prevention and care services will have a great impact on the success of interventions for ACB people. These issues must be considered when designing HIV services.

Table 21: Poverty Status		
Response	**% Males (n=75)**	**% Females (n=113)**
Below LICO	33%	26%
At or above LICO	67%	74%
LICO= low-income cut-off $\chi^2(1)=1.30$ p=0.2551		

Table 22: Religiosity		
Level of Religiosity	**% Males (n=73)**	**% Females (n=109)**
Not religious at all	16%	6%
Not very religious	19%	23%
Religious	42%	51%
Very religious	22%	19%
= approaches statistical significance at p=0.15 $\chi^2(3)=5.37$ p=0.1468		

Barriers that Stop Men from Protecting Themselves against HIV: Male and female service providers said that condom use is not something that is engrained in men. One male service provider said lack of self-control is the main barrier preventing men from protecting themselves against HIV infection. Barriers cited by female service providers included: sharing injection drug use equipment; hierarchy of needs; fatalism among some gay men; myths about how HIV is transmitted; hierarchy of beauty in gay culture; young gay men lacking education about HIV; men thinking that they know everything and do not need education; men not accessing services; and lack of Black, male counsellors that ACB men would prefer to access.

> *Certainly I have, I'm thinking of one, one Black client in particular who accesses very regularly the needle exchange program at [a local organization], but again you know in terms of what prevented, what, what were the factors that prevented him from becoming positive in the first place it was that imprinting of the importance of condom use or the imprinting of you don't share needles you know. It's just, it's like the emotions take over and people make emotional decisions and they, it's like that, that hierarchy of needs again. You meet the basic need first and then you do the uh-oh afterwards. (Female)*

Table 12 shows that the main barriers to men using condoms were: having sex with a regular partner, thinking their partner was free of HIV and STIs and the men themselves being free of HIV or STIs. None of the men surveyed said that pressure to have sex, embarrassment, cost or not knowing where to buy condoms were reasons for not using condoms.

Tailoring HIV Services to ACB People: Men and women generally thought that HIV education services should be tailored to ACB people, but the results were more split when asked about whether or not ACB people's images should be included in HIV-related media. In fact, 12% of men and 15% of women said pictures of ACB people should not be included in HIV-related media. There were no statistically significant differences between men's and women's responses (Tables 23 and 24). These results therefore confirm the importance of providing culturally-specific, tailored services to ACB communities.

Table 23: Tailoring HIV Services and Images to ACB People, Males		
Response	**Tailoring HIV Education And Services (n=65)**	**Including ACB Images in HIV-Related Media (n=68)**
Not important at all	2%	7%
Not very important	0%	10%
Neither important nor unimportant	5%	26%
Important	14%	28%
Very important	77%	16%
Tailored services should not be provided	3%	----
Pictures of ACB people should not be used	----	12%

Table 24: Tailoring HIV Services and Images to ACB People, Females		
Response	**Tailoring HIV Education And Services (n=104)**	**Including ACB Images in HIV-Related Media (n=105)**
Not important at all	0%	7%
Not very important	5%	8%
Neither important nor unimportant	6%	22%
Important	24%	25%
Very important	61%	24%
Tailored services should not be provided	5%	----
Pictures of ACB people should not be used	----	15%
*= approaches statistical significance at p=0.15		
Comparing male and female responses for tailoring services: Fisher's exact test (MC): p=0.1007 *		
Comparing male and female response for including images of ACB people: Fisher's exact test (MC): p=0.7904		

HIV Service Provider Preferences: The majority of men and women said that the gender of the HIV education provider did not matter, but when there was a gender preference, men preferred male HIV education providers and women preferred females (Table 25). Survey participants were also asked if they had a racial or ethnic preference for HIV education providers, and their responses did not differ by gender. Both men and women overwhelmingly said the race or ethnicity of the HIV education provider did not matter, but 10% of men and 13% of women preferred an HIV education provider from their own ethnic group (Table 26). These results suggest that male and female HIV education providers are needed.

Table 25: Preferred Sex of HIV Education Provider		
Preferred Sex	**% Males (n=62)**	**% Females (n=105)**
Male	15%	0%
Female	6%	20%
Sex doesn't matter	79%	80%
**= statistically significant at p=0.05		
Fisher's exact test (MC): p<0.0001**		

Table 26: Preferred Race or Ethnicity of HIV Education Provider		
Response	**% Males (n=68)**	**% Females (n=105)**
A Black health care professional of the same ethnicity as my own	10%	13%
A Black health care professional from a different ethnic group than me	4%	6%
A White health care professional	2%	1%
A non-Black, non-White health care professional	3%	0%
The race/ethnicity does not matter	81%	80%
Fisher's exact test (MC): p=0.5079		

Men and women did not differ in the types of HIV educators they preferred. However, they preferred to have HIV services delivered by health care providers, such as doctors and health workers. People knowledgeable about HIV and people living with HIV were the second and third most preferred types of HIV educators. Few participants said they wanted to learn more about HIV from their peers—friends and partners—and even fewer said they wanted to learn about HIV from settlement workers (Table 27). These results illustrate the importance of engaging health care workers in HIV prevention and care.

Table 27: Preferred Type of HIV Education Provider			
Type of HIV Educator	**% Males (n=70)**	**% Females (n=108)**	**P-value**
Family doctor/general practitioner	66%	59%	0.3866[a]
Health worker	54%	57%	0.6818[a]
Anybody knowledgeable	44%	53%	0.2683[a]
Person living with HIV	49%	45%	0.6758[a]
Nurse	40%	37%	0.6911[a]
Other health professional	34%	35%	0.9021[a]
Counsellor	33%	32%	0.9501[a]
Friend(s)	16%	19%	0.6299[a]
Spouse, boyfriend, girlfriend, partner	19%	16%	0.6222[a]
Family member(s)	13%	18%	0.3966[a]
Settlement worker	17%	10%	0.1764[a]
Other	4%	1%	0.3014[b]
Don't know	1%	2%	1.0000[b]
None of the above	3%	1%	0.5624[b]

[a] Chi-square test
[b] Fisher's exact test

When asked about sources from which they would like to receive education about HIV, the vast majority of men and women preferred websites, and this was followed by brief printed materials (i.e. booklets, brochures and postcards). Health workers were the next most preferred sources of HIV education. The least preferred sources were settlement workers, advertisements and health workers in chat rooms and on health lines. However, men were more likely to prefer to receive HIV education from settlement workers than women (Table 28).

Table 28: Preferred Type of HIV Education			
Source of Information	**% Males (n=68)**	**% Females (n=106)**	**P-value**
Websites	82%	86%	0.5343[a]
Booklets, brochures, or postcards	65%	62%	0.7445[a]
Health worker or health professional at a doctor's office	56%	50%	0.4484[a]
Health worker or health professional at a sexual health clinic or HIV clinic	54%	48%	0.4175[a]
Health worker or health professionals at a voluntary organization or charity	54%	44%	0.1945[a]
Information group or workshop	49%	42%	0.4316[a]
Articles in newspapers, magazines, or newsletters	44%	44%	0.9771[a]
Health worker or health professional in community settings	38%	37%	0.8478[a]
Health worker or health professional on a telephone via a help line	31%	28%	0.7152[a]
Advertisements	28%	24%	0.5189[a]
Health worker or health professional in an Internet chat room	22%	22%	0.9552[a]
Settlement worker	22%	10%	0.0350[a]**
Other	1%	1%	1.0000[b]
None of the above	3%	0%	0.1514[b]

**= statistically significant at p=0.05
[a] Chi-square test
[b] Fisher's exact test

HIV Program Preferences: Over 70% of men and women thought that HIV/AIDS education seminars, risk behaviour counselling, HIV testing and stigma reduction programs should be provided to the ACB community. They were also very concerned about the quality of life of those living with HIV, and thus asked for assistance with basic needs for people living with HIV, support for friends and relatives of those living with HIV and friendly visitors for people living with HIV (Table 29). There were no significant differences by gender.

Table 29: HIV Services or Programs That Should be Provided			
Service or Program	**% Males (n=60)**	**% Females (n=107)**	**P-value**
Education and counselling			
HIV/AIDS education seminars	82%	79%	0.7287[a]
Risk behaviour counselling	75%	71%	0.5815[a]
HIV/AIDS counselling for those with HIV	65%	67%	0.7636[a]
Pre-test counselling	60%	69%	0.2310[a]
HIV/AIDS pamphlets/brochures	67%	64%	0.6861[a]
Peer-to-peer counselling	63%	63%	0.9776[a]
Testing and risk reduction services			
HIV/AIDS testing	77%	84%	0.2351[a]
Addiction services and counselling	67%	69%	0.7399[a]
Needle exchange program	42%	53%	0.1501[a]
Basic services and financial assistance			
Assistance with basic needs for those with HIV	75%	72%	0.6712[a]
Friendly visitors for people infected with HIV	63%	69%	0.4422[a]
Social assistance	53%	64%	0.1962[a]
Housing assistance	65%	56%	0.2600[a]
Food bank	52%	59%	0.3673[a]
Emergency financial assistance	43%	54%	0.1776[a]
Transportation	45%	50%	0.5737[a]
Advocacy and social support			
Support groups for those with HIV	80%	81%	0.8367[a]
Stigma reduction programs	77%	71%	0.4307[a]
Support groups for friends and families of those with HIV	73%	69%	0.5697[a]
Advocacy services	55%	56%	0.8933[a]
Other			
Referrals to other services	48%	58%	0.2315[a]
Role models	50%	42%	0.3221[a]
Other	10%	9%	0.8904[a]
None of the above	5%	1%	0.1327[b*]
*= approaches statistical significance at p=0.15	[a] Chi-square test [b] Fisher's exact test		

HIV-Related Topics of Interest: Participants wanted to learn more about a variety of HIV-related topics. The three most popular topics were preventing discrimination against people living with HIV, stigma reduction and safer sex. Men were more likely to ask for information about treatments for HIV infection and circumcision and HIV (Table 30).

Table 30: Topics About Which Participants Would Like to Know More			
Topics of Interest	**% Males (n=64)**	**% Females (n=105)**	**P-value**
Preventing discrimination against people with HIV	36%	34%	0.8270[a]
How to reduce HIV stigma	31%	31%	0.9806[a]
Safer sex and how to prevent HIV	34%	27%	0.2869[a]
The law and HIV transmission	31%	24%	0.2885[a]
Treatments for HIV infection	34%	21%	0.0538[a]*
Managing relationships	25%	23%	0.7506[a]
HIV testing	25%	23%	0.7506[a]
Testing and treatment for other sexually transmitted diseases	27%	19%	0.2518[a]
Post-exposure prophylaxis (PEP)	22%	21%	0.8807[a]
Living well with HIV	25%	17%	0.2165[a]
How to be more confident in sexual situations	16%	23%	0.2553[a]
Who is able to get free HIV treatment	22%	19%	0.6565[a]
How to stop condoms breaking or coming off	23%	16%	0.2434[a]
How to find HIV-sensitive doctors	16%	17%	0.7968[a]
Female condoms	14%	18%	0.4940[a]
Circumcision and HIV	22%	11%	0.0687[a]*
Breastfeeding and HIV	13%	17%	0.4171[a]
What different kinds of condoms are available	19%	13%	0.3438[a]
Where to find a boyfriend/girlfriend	9%	8%	0.6879[a]
Peer to peer counselling/support groups	10%	5%	0.2428[a]
None of the above	14%	20%	0.3272[a]
*= approaches statistical significance at p=0.15	[a] Chi-square test		

Opinions about Reasons for the Spread of HIV: Lastly, participants were asked about what they thought were the reasons for HIV spreading. Again, there were few differences in men's and women's responses. The top reasons given by both groups were lack of education, sex between untested partners, promiscuity and unfaithful partners. Using a p=0.10 significance level, women were significantly more likely to cite sex between untested partners and violence against women as reasons for the spread of HIV (Table 31). These results further highlight the importance of education, awareness, testing and condom use for HIV prevention.

Table 31: Reasons for the Spread of HIV

Reason	% Males (n=65)	% Females (n=107)	P-value
Lack of education	54%	57%	0.6854[a]
Sex between partners who haven't been tested	34%	49%	0.0581[a]*
Promiscuity	43%	38%	0.5369[a]
Unfaithful husbands, wives, or partners	34%	36%	0.8239[a]
Poverty	26%	22%	0.5784[a]
Injection drug use	18%	20%	0.8508[a]
Violence against women (i.e. forced sex)	9%	20%	0.0931[a]*
Lack of condoms	12%	16%	0.5183[a]
Sex before marriage	20%	11%	0.1130[a*]
Male homosexuality	12%	8%	0.4064[a]
Other	8%	6%	0.5879[a]

*= approaches statistical significance at p=0.15 [a] Chi-square test

Recommendations to Impact Policy and Practice

The results from this needs assessment show that there is a need for action at the policy and behavioural, or public health, levels. Here are our primary recommendations:

1) It is important to meaningfully engage the local ACB community in all HIV-related efforts—prevention, detection, treatment, support and care. This will increase the community's motivation and ability to collaborate with AIDS service organizations (ASOs) and respond to HIV. Additionally, ACB people can be engaged through volunteer activities focused on HIV in ACB communities, especially activities that focus on improving quality of life for people living with HIV. In addition to building relationships and trust between ACB communities and ASOs, meaningful community engagement can also serve to reduce HIV-related stigma in ACB communities. Groups that should be involved in HIV-related efforts include faith leaders, community leaders, community members at-large and respected and prominent people in the community.

2) ACB community members prefer to access HIV-related information through websites and media that are used to provide short, straightforward bits of information. As such, these types of media should be used to provide key messages to the community. Since HIV knowledge is high in this community, these media can be used to provide messages about local HIV services, promote HIV-related campaigns and efforts and provide educational information. Topics of focus may include: couples testing, stigma reduction, safer sex, the law and HIV transmission, HIV treatment and other topics community members are interested in learning about (see Table 30). Additionally, when possible, HIV information websites tailored to ACB people should be linked to non-HIV-related websites that ACB people commonly visit.

3) Stigma is a huge barrier to HIV service access and prevention, so it must be addressed whenever an opportunity arises to do so. Hence, stigma reduction should be consciously incorporated into all HIV-related efforts. In addition to the recommendations mentioned above, additional strategies to reduce stigma can include awareness campaigns covering various aspects of HIV, such as the level of concern people in the community have about HIV. At minimum, this message can be a conversation starter.

Here are our secondary recommendations:

1) Community engagement can lead to services that are more relevant and specific to the community's needs. Additionally, HIV services should be brought to the community through outreach and private home visits, where appropriate. These services can also be provided when ACB community members are accessing other services, which can help make access to HIV services discreet. For example, HIV counselling can be provided when immunizations or birth control are being sought. This provides an opportunity to circumvent stigma while still connecting ACB people with needed HIV services.

2) There should be at least two dedicated HIV educators for ACB communities—one male and one female. To reduce costs, at least one educator should be hired full-time and the other can be hired part-time. Additionally, whenever possible, straight male HIV education providers or volunteers should be available, and these men should be trained in strategies that help combat homophobia.

3) Health care providers should be part of HIV-related efforts and should provide HIV services, such as prevention-focused counselling. To meaningfully and fully bring health care providers into the fold, it is important to provide them with training to increase their competency to provide HIV services. For instance, health care providers should receive diversity, cultural competence and stigma reduction training.

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Contributing Authors

Shamara Baidoobonso, Roxanne Longman Marcellin, Leah Meidinger, Rob Haile, Harina Mokanan, Julius Ehiemua

If you want more information about the project or our work, please e-mail blacchstudy@gmail.com to be added to our e-mail list, visit our Facebook page (The Black, African and Caribbean Canadian Health Study), join our Facebook group (The BLACCH Study), or follow us on Twitter (@BLACCH).