Who Feels It Knows:
The Challenges of HIV Prevention for Young Black Women in Toronto

BLACK C•A•P

BLACK COALITION FOR AIDS PREVENTION

Who Feels It Knows:
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This report is dedicated to the diverse groups of young Black women in Toronto whose strength and resilience is inspiring.

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BACKGROUND

Who Feels It Knows: The Challenges of HIV Prevention for Young Black Women in Toronto highlights the issues and challenges that place Toronto's young Black women, aged 15 to 29, at increased risk for HIV and sexually transmitted infections (STIs). As HIV infection rates in Toronto's Black communities[1] continue to increase at alarming rates, community-wide responses are required to reduce new infections. At this time, Black communities have not sufficiently mobilized around this issue, due, in part, to having other significant survival issues to deal with, such as poverty, housing, healthcare, sexual violence, racism, stigma, patriarchy, and homophobia. This report highlights some of the challenges that organizations, such as the Black Coalition for AIDS Prevention (Black CAP), face in their attempts to reduce HIV infection rates. It also identifies recommendations to be considered as new HIV prevention programming is developed.

In response to the increasing rates of HIV infection among Black communities in Ontario, the Ministry of Health and Long Term Care - AIDS Bureau provided additional funding to Black CAP to support the development of new HIV prevention programming. Black CAP plans on expanding its HIV programming to recognize the local service context, emerging services, and recent initiatives by other groups. These initiatives include the development of community-specific provincial strategies such as the African Caribbean Council on HIV/AIDS in Ontario (ACCHO), the Gay Men's Strategy and the Women's Strategy, as well as developments in relation to local planning, such as the Community Planning Initiative.

ACCHO has also identified key principles inherent to effective HIV/AIDS prevention in the *Strategy to Address Issues Related to HIV Faced by People in Ontario from Countries where HIV is Endemic*, also known as the African and Caribbean Strategy on HIV/AIDS. It acknowledges the barriers faced by Black women in relation to HIV/AIDS. These barriers were considered during the production of this report. Where possible, attempts were made to align this report with the ACCHO Strategy, and to clearly define the community's role in developing a response to HIV/AIDS within African and Caribbean communities. Future programming will demonstrate, where possible, alignment to the ACCHO Strategy.

Black CAP hopes to enhance its HIV prevention strategies in Toronto's Black communities by ensuring that these strategies are informed by best practices and research, as well as targeted in relation to gender, sexual orientation, religion, culture, class, age, and geographic location of the populations that it serves. Black CAP is also focused on developing new service models that recognize the dynamic nature of HIV in Toronto's Black communities. In order to achieve these goals, Black CAP initiated a process to identify the nature of new prevention programming; this process includes community and stakeholder consultations, an analysis, and production of this report.

[1]For the purposes of this report, given the common discrimination among the Black Canadian, Black African and African-Caribbean communities, the terms 'Black population' & 'Black communities' will be used throughout the report to refer to the afore-mentioned groups

Review process

The process to design Black CAP's new HIV prevention program included three stages. Stage One was comprised of a community consultation and review process with community stakeholders, followed by data analysis and production of this report. Stage Two of the process will include a review of the report by a community advisory committee. Stage Three will include the development of a new HIV prevention program.

Community Consultation

In October 2006, Black CAP determined that an external consultation process was required for the development of a new HIV prevention program due to changes in HIV-related funding trends, service responses, and community mobilization. Black CAP felt that the dynamic nature of the sector required an analysis and review of existing programming, trends, and epidemiological data. To achieve this, Black CAP undertook three primary activities:

- Stakeholders interviews
- Literature and best practices review
- Epidemiological analysis

Stakeholder interviews (see Appendix I for a list of interviewees) were held with individuals involved in HIV/AIDS research, service providers in Toronto's Black communities, and funding organizations. Black CAP completed 25 semi-structured interviews (see Appendix II for the interview guide) that focused on some of the following questions:

- What kind of service response should Black CAP provide?
- What existing HIV/AIDS prevention strategies are/were implemented in Toronto that specifically focused on Black communities?
- What research/documentation should be considered?
- Through your work with members of the Black communities, what issues are being voiced as major challenges to HIV prevention?
- Do you have any over-arching values that you use to guide your work?

An analysis of the interviews was completed to identify common themes, emerging issues, and trends. A simultaneous literature review was also completed to achieve a deeper understanding of best practices in HIV/AIDS prevention programming and emerging research. The scope of this analysis ranged from local research, such as "Sisters, Mothers, Daughters & Aunties: Protecting Black Women from HIV" (Newman, Williams, Massaquoi, & Sakamoto, 2006) to international research by the Pan American Health Organization.

Finally, Black CAP completed an analysis of epidemiological and complementary socio-demographic data that was useful in the selection of priorities. Sources of data included the Ontario HIV/AIDS Epidemiological Monitoring Unit (OHEMU), the University of Toronto, and the United Way of Greater Toronto Research Unit.

Community Advisory Committee

The Community Advisory Committee will provide community oversight and incorporate the knowledge of others working in the HIV/AIDS and community sectors. Black CAP recruited six committee members who represented a broad spectrum of issues in relation to HIV prevention in Toronto's Black communities including sexual health, sexual assault, research, and youth-specific issues. The Committee will:

- Provide feedback on the findings included in this report
- Identify gaps in the key findings and analysis included in this report
- Ensure a focus on community development in the design and delivery of the new HIV prevention program
- Provide recommendations on the design process for Black CAP's new HIV prevention program
- Make recommendations to Black CAP about potential target communities to be reached through this project
- Ensure that the proposed programming avoids duplication and is innovative
- Ensure that the proposed program fits anti-racism and anti-oppression frameworks

The committee will meet two to three times and will help Black CAP staff to clarify priorities and affirm the direction of our response.

Program design and Implementation

Upon the selection of an appropriate target community, service area, etc., Black CAP will undertake a process to design a new program focused on HIV prevention in a sub-set of Toronto's Black communities. Some of the following principles will guide the design of the program:

- Design and evaluation of the program will be participatory. The target population will have a level of ownership over the development of the program and will comprise a substantial portion of the advisory committee.
- Where there are similar services, ensure that there are partnerships with existing strategies.
- Incorporate the social determinants of health into the program design.

Following this process, Black CAP will launch a new prevention program sometime prior to August 2007.

KEY INFORMANT FINDINGS AND LITERATURE REVIEW

Black CAP has been present in Toronto's Black communities for 20 years, and, as such, has developed an awareness of the range of issues and risks factors that are faced by these communities in relation to HIV/AIDS. The community consultation process acknowledged the accuracy of this awareness and also identified new information, ways of thinking, and opportunities for Black CAP to consider when responding to emerging issues.

The majority of the information contained in this report is based on findings from 25 Key Informant interviews completed between October 2006 and January 2007. Interviews and analysis of the literature helped Black CAP identify common themes that should be considered in the development of future prevention programming. Themes included:

- The need for AIDS service organizations (ASOs) to adopt new approaches to HIV prevention
- Recognition of the low levels of HIV knowledge in Toronto's Black communities
- The limited knowledge transfer of sexual health information
- Sexual violence
- Earlier participation in sexual activity by youth
- Impact of young men's health on their female partners' sexual health
- Poverty as a predictor of HIV risk
- Sexual inequality in relationships
- The persistence of homophobia as a significant barrier to HIV prevention education
- Access to HIV and STI testing

The need for ASOs to adopt new approaches to HIV prevention

Most Key Informants stressed the need for a custom-built HIV/AIDS prevention strategy for Black communities in Toronto. This is due, in part, to the significant socio-economic challenges that these communities face. Furthermore, like other ethnic communities, Black communities have their own unique set of cultural norms which they live by; hence, most broad, mainstream HIV/AIDS prevention strategies are less effective for these communities since they do not account for these differences in norms. For example, a researcher from the AIDS Committee of Toronto (ACT) commented on the importance of accurate and appropriate representation of the Black communities in HIV/AIDS prevention strategies, suggesting that, otherwise, the prevention messages could potentially go un-noticed.

Differences within Toronto's Black Communities

Due to the broad spectrum of religions and cultures that make up Toronto's Black communities, there also needs to be a shift away from the thought that "all Black people are the same."

Within Black communities, there is a strong distinction by community members as to who is from continental Africa, from the Caribbean, and whose heritage is historically Canadian. Furthermore, there are distinctions between people from the different countries/islands of the Caribbean and continental Africa. This is further broken down by religion, e.g. Christian or Muslim, and even further by ethnicities. Responses should recognize the stratification and non-homogenous nature of Toronto's Black communities.

Sex and sexuality are also discussed in varying degrees among families within Black communities (Warren-Jeanpiere, 2006). In some African-Caribbean and African cultures, sexuality is woven into music and dance. For example, numerous reggae, dancehall, and soca songs have strong sexual innuendos. Also, many communities tolerate and sometimes encourage multiple sex partners for both single and partnered males. In contrast, social mores related to women are often the opposite; for instance, there is a general expectation that women should remain celibate until marriage and should not engage in extra-martial affairs after marriage.

Accessibility of Messages: Language, Literacy, and Cultural barriers

There is a vast span of languages and dialects spoken by people from the Caribbean and the African continent. While many do speak English or French, their level of fluency varies which, at times, limits their capability to fully access and understand HIV prevention programs and initiatives available in Toronto. As a result, some people cope by interpreting workshops by whatever limited means is possible, including the use of visual cues and body language, or by copying the demonstration with their partner, action for action. This can be problematic, especially if the tools used during the demonstration are not interpreted or understood as models for the human body parts being discussed. For example, a demonstration, delivered in English, that uses a banana to model effective condom use can be misinterpreted by someone who has never seen or used a condom and whose English is poor; the misinterpretation may be that condoms placed on bananas will prevent HIV transmission.

Positive Prevention

As voiced by the Black CAP Support Coordinator and a Key Informant from Voices of Positive Women, the impact of HIV/AIDS prevention campaigns on persons living with HIV/AIDS (PHAs) should also be considered when these campaigns are developed. In the past, scare tactics were a common strategy used in HIV prevention campaigns, in attempts to help people realize the serious nature of HIV/AIDS. This produced a negative effect, whereby PHAs would be demonized and seen only through a lens of infection and sickness. Such messages also served as dreadful reminders to PHAs of their illness and the possibility of early death. Furthermore, some campaigns also stigmatized PHAs through messages that implied and/or stated that, "It's your choice/responsibility to prevent HIV/AIDS." When viewed from another perspective, these messages can also be interpreted as "If you contract HIV, it's your fault." It was noted by four Key Informants that there is little messaging that addresses 'Positive Prevention', i.e., messaging geared at PHAs that encourages them to take measures that would prevent them from becoming re-infected with another strain of HIV or from transmitting the virus to an HIV-negative person.

Recognition of the low levels of knowledge of HIV in Toronto's Black communities

"You can't think higher than your understanding."- PASAN Key Informant

A Key Informant from ACT noted that, in general, people are misinformed about sex and HIV or lack the confidence to talk about safer sex. In some cases, there are misconceptions about HIV/AIDS and sexuality. This lack of accurate knowledge about HIV in Black communities may stem from:

- The common belief that HIV/AIDS originated in Africa and was/is brought to western developed countries by African newcomers (Lawson et al, 2006). Given the historical affiliation of HIV and Haiti, one could expect that this 'myth' could also include Black people from the Caribbean.
- The strong affiliation of Black communities with the Church and the Mosque and the religious laws regarding drug use and sexuality (e.g., homosexuality is wrong). The belief is that any behaviour that goes against such laws could be viewed as disobeying God/Allah and that HIV infection is punitive.
- In some Caribbean cultures, HIV/AIDS is still viewed as a gay disease, thus if you are a man with HIV, you are assumed to be gay. The notion of HIV/AIDS being a gay disease arose from the Western World where it was primarily gay men that were affected at the start of the pandemic. In most African countries that are severely affected by HIV/AIDS, the virus was/is spread primarily through heterosexual sex. Thus, in most African communities, HIV is not considered a gay disease.
- Recent media stories are linking men on the 'down-low' (i.e. men who are having sex with other men in secrecy) to higher HIV infection rates in Black communities. This coupled with the high levels of homophobia in Black communities has further perpetuated this belief.

These factors are a few of the plausible reasons that Black people distance themselves from the issue of HIV/AIDS. Having any knowledge about HIV/AIDS could imply that one is infected or engages in taboo/deviant behaviour. Social perceptions of men and women also impact a person's openness to the topic of HIV/AIDS prevention. For example, in some Black communities, a woman who carries condoms is perceived as a slut, instead of as a woman who loves herself by being sexually responsible.

As observed by a Key Informant at PASAN, a common misconception is that most people are expected to have a certain level of knowledge and maturity by a certain age. This isn't always the case: a 29 year old from one community and background may not have the sexual vocabulary, information, or knowledge that a 14 year old of a different background may have. For example, children who immigrate to Canada in their mid-teens and are inserted into the education system will sometimes have missed the sexual health education that their peers participated in at a younger age. However, they may still engage in the sexual activities that their peers are engaging in, without having had the benefit of sexual health and STI prevention information.
The study "Sisters, Mothers, Daughters & Aunties: Protecting Black Women from HIV"

(Newman et al, 2006), found that major barriers to accessing HIV related resources or information include:

- HIV stigma
- Discrimination such as racism, sexism, poverty, homophobia
- Poverty
- Lack of safety from disclosure of HIV status
- Lack of transportation
- Lack of knowledge of where to access resources.

Six Key Informants also cited a need for updated and simplified sexual health and HIV pamphlets for young Black women. Effective interventions require that service providers know these young women's level of HIV awareness prior to starting HIV education. Informants also indicated that service providers should consider the following about their target group prior to delivering HIV education:

- Do they need to start with the basics of HIV?
- Are they comfortable with their bodies?
- Are they comfortable talking about sex?

Limited Knowledge Transfer of Sexual Health Information

As people age, their source for sexual health information changes. These sources vary from family, parents, and peers, to schools, their cultural community, and mainstream society. The credibility of the information also varies according to who the messenger is and where/how the message is delivered. HIV prevention programming must recognize this and ensure that the medium selected for conveying the message will be considered to be credible.

Familial Knowledge Transfer

Researcher Warren-Jeanpiere (2006) suggests that sexual socialization occurs at two levels: familial and societal[i]. Most young Black women typically learned how to view their bodies and their sexuality from their mothers first, followed by learning through social environments, i.e. with peers, school system, and media. Often, there was little communication between Black mothers and daughters about sex. When there was discussion, it included the message that young women should not present themselves in a sexual manner. The closeness of the mother and daughter also impacted on their ability to talk about sexuality. For those who had a close relationship, it was found that speaking about sexuality made a greater positive impact than for those whose mother-daughter relationship was not as close. The lack of communication was, in part, due to the mother's history of how sex and sexual health had been addressed by her own family when she was growing up, as well as the mother's experiences with healthcare professionals in relation to the quality of care received during visits. Most mothers involved in the study emphasized their desire to maintain their

daughter's sexual health, but most often only in medical/gynaecological references. One mother commented: "I wish we could have been more open…especially given the number of diseases that exist today."

For parents who are uncomfortable about discussing sexual health issues with their daughters, there are youth-specific sexual health programs available in Toronto. However, an issue that arises from having co-ed sexual health groups is that many mothers are concerned that, as a result of these programs, their daughters may feel more pressured to have sex and/or may become pregnant. This is evident by the comment made by a Key Informant from Women's Health in Women's Hands (WHIWH) who has noted from her work that "…a lot of the mothers don't want their daughters attending the programs being held at the community centre, as there are too many guys". As identified through a study of Black youth living in the Toronto neighbourhood of Malvern (Mensah, 2005), Black female youth often took the initiative to seek sexual health information, even when it was considered a taboo subject in their family. The study also found that most Black female youth received information from television programming and books, though some cited that such information did not reflect their lifestyle[ii]. A key informant from WHIWH also noted that when examining points of knowledge transfer, it was important not to ignore the value of extended family members, such as aunts, grandmothers, and older cousins. These family members were sometimes considered to be more likely to give non-judgemental advice to their younger relatives. This may be especially true for youth whose parents left them in the care of extended family members when they immigrated to Canada, and whom they may have formed a close bond with.

School-based sexual health education

A Key Informant of Planned Parenthood of Toronto (PPT) discussed findings from the Toronto Teen Survey (TTS), which was developed with the help of a youth advisory committee. The findings indicated that youth are more receptive to information that is delivered outside of school. Some youth are cynical about workshops run in schools since they see the facilitator as another school-affiliated official who is not really there to help. The Youth Advisory Committee of the TTS also noted that if the teacher is presenting the material in a boring manner, youth will tune out the information being given. The Black CAP Outreach Coordinator has also found that when teachers are responsible for teaching sexual health education, they may not cover topics with which they are uncomfortable (e.g. anal sex).

Peer-based education

Several Key Informants also cited the effectiveness of a peer-based education model where individuals receive HIV-related training and skills development, then use that knowledge to be peer leaders and educators. A Key Informant from Toronto Public Health noted that the persons who appeared to gain the most from the peer-based model were the peer leaders. Youth, in general, were also found to show more willingness to take leadership and be more involved in sexual health education roles when these opportunities occurred outside of school. The Key Informant from Planned Parenthood of Toronto also noted that youth preferred to work with agencies they were familiar with as it increased their confidence and

made them feel like experts. However, youth often did not want to do outreach in their own communities due to worries of backlash, rejection, or religious implications for discussing sex openly in their communities.

It should be noted however, that a peer is not just defined by race and age. Class, socio-economic status, level of education, sexual orientation, physical environment etc., all contribute to the definition of a peer. While an upper-middle class, young Black woman may seem to be suitable to educate other young Black women, this is not always the case. In this case, the peer educator may not share the multiple realities of the target community and thus cannot truly relate.

Comfort discussing sexuality

A Key Informant from PASAN also noted that, in some information sessions, participants sometimes pretend to be HIV/AIDS ignorant because they feel uncomfortable about the session's location and the form of engagement being used. Participants also often comment on the exclusion of information on various topics that might normally be culturally taboo for discussion:

"Sex & HIV need to be addressed in a candid way; "Unprotected anal and vaginal transmission are methods of transmission for the HIV virus…" People need to hear about it, as not only men who have sex with men (MSM) have anal sex; women do as well. Anal sex is commonly practiced by some heterosexual couples who wish to preserve a woman's virginity. We shouldn't be presumptuous about what people do. We have a message and we need to be consistent. You can talk about abstinence in reference to sexual activity, but what else are you abstaining from? Abstinence is a wide variety of things, and its definition varies between people. Some may see not having vaginal sex as abstaining, but they will continue to engage in oral sex."

Sexual Violence

Sexual violence against women is a persistent global problem. It is estimated that, around the world, at least one in every three women has been beaten, coerced into sex, or otherwise abused during her lifetime (Heise, Ellsberg, & Gottemoeller, 1999). In Canada, it is estimated that, among adult Canadians, 53 percent of women and 31 percent of men were sexually abused when they were children (Hay and Allen, 1997).

Childhood Sexual Abuse (CSA)

Recently, Fulco et al. (2006) examined childhood sexual abuse (CSA) as a predictor of adolescent risky sexual behaviour among female and male youth in the Canadian child welfare system. Their research concluded that CSA was associated with risky sexual behaviour, especially with female youth. Female victims of CSA were more likely to have had sex with an unknown partner in the last 6 months. Furthermore, females whose CSA experiences included forced sex were also more likely to have began engaging in consensual sex at an earlier age.

Findings from a Los Angeles study (Wyatt, Carmona, Loed, & Williams, 2005) conducted with HIV-positive Black women were similar to those from the Canadian study; however, it was also found that women who experienced CSA had lower condom self-efficacy, less frequent and consistent use of condoms, as well as higher rates of sexually transmitted infections[iii]. Both studies (Fulco, 2006 & Wyatt et al., 2005) also found a strong link between substance abuse and CSA. Drugs might have been used by these women to help them cope with the intrusive images, trauma, and emotional effects of childhood sex abuse. Drugs also reduced these women's abilities to learn effective and healthier coping strategies. Wyatt et al. (2005) also found that female victims of chronic CSA were seven times more likely to engage in HIV-risk behaviours, citing intravenous drug use, STIs and unprotected anal sex as specific markers of risk. In Canada, the major issue with CSA is that it usually goes unreported. In those cases that are reported, only 45% are actually substantiated (Trocme & Wolfe, 2001). As a result, women who have experienced CSA are at risk of contracting HIV/AIDS, not from only the sexual violence experienced, but from the consequential behaviours that follow.

Intimate Partner Violence (IPV)

Many HIV prevention campaigns make assumptions about sexual interactions including:

- All sexual interactions that women engage in are consensual; thus
- All women can take action to reduce their risk of contracting HIV/AIDS, as
- All women have power in their sexual relationships.

A Key Informant at the Toronto Rape Crisis Centre (TRCC) noted that there is a common myth that sexual assault impacts mainly women of colour or women of a certain socio-economic status. The informant dispelled this myth, noting that women of all backgrounds, ethnicities, ages and social statuses access the TRCC's counselling resources.

Several Key Informants also found that there is a harmful myth that, in order for an act to be classified as sexual assault, penetration must occur. A Canadian study conducted in Toronto (Coghlan et al, 2006) found that even though most young women were able to define the broad spectrum of actions that constituted intimate partner violence (IPV), their perceptions were influenced by contextual factors such as the type and nature of abuse, how frequently it occurred, and whether or not it was intentional. For example, some women may not consider a lone occurrence of abuse to be IPV. Participants in the study were influenced by social and cultural norms about what they considered acceptable behaviour with regards to displays of power, force, and mutual aggression in relationships. For example, a woman may be involved in a relationship that would be considered abusive to other women, but normal to her, because she was raised in a social context where those alleged abusive actions were acceptable. Also, women who are financially dependent on their partner may find it harder to leave an abusive relationship if they feel that their options for financial survival are severely limited.

A Boston study (Raj et al., 2006), whose participants were primarily members of Black and Hispanic communities, found a positive correlation between males who committed violence against their partner (i.e., IPV) and engaged in risky sexual behaviours. On average, these

males were also found to have fathered three or more children. This implies that abused women lack reproductive control, i.e., the ability to choose when they will conceive, and are at risk of contracting HIV and other STIs, due to interference by their partners. Of note, the study was conducted in a community health centre and the authors cited this as a key venue in reaching males who were at risk for committing IPV and/or contracting STIs and/or HIV. Also, it was noted that insisting, but not forcing, a partner to perform a sexual act (e.g., oral, anal, or sexual intercourse), was considered an IPV perpetration and was cited as the most common type of IPV. Approximately 80% of men reported inconsistent or no condom use when engaging in vaginal or anal intercourse with their main female partner.

Speaking with the Black CAP Support Coordinator and a client, sexual violence was deemed to be a major issue for women who are HIV-positive. They often feel less worthy because of their HIV status and this impacts on whom they choose as their partner. The issue of abandonment after disclosing one's status is a fear for some female PHAs. Consequently, some female PHAs stay with partners who know their HIV status, even when these partners abuse them physically and/or emotionally and/or mentally and/or sexually.

Earlier onset of sexual activity by youth and teen pregnancy

Many of the Key Informants agreed that young women of colour are sexually initiated at increasingly younger ages. This is due, in part, to various influences, including friends/peers, media, the Internet, and their male peers. Several Key Informants also noted that a major issue that young women currently face is how women are viewed sexually and how to develop healthy relationships and self-esteem in light of an absence of knowledge. These issues fit into the context of larger issues like poverty and education. A Key Informant from WHIWH commented that very young women spoke mostly about the fear of pregnancy and not much else: "They still don't think that HIV is affecting them. They think they are invincible".

A Key Informant at the Massey Centre for Women in Toronto was also interviewed about the issues that young women in Toronto are facing and factors that place them at risk for contracting HIV, STIs and unplanned/unwanted pregnancies. The Informant noted that most girls that went through an intake interview at the Massey Centre were found to have a history of some form of abuse. Another common factor among the girls was that they had come from homes where they were at risk for physical, mental or emotional abuse. The Key Informant cited these as major factors that led to the girls' low self-esteem which, in turn, made them more susceptible to negative influences. An intake worker at the Massey Centre also commented that there a large number of girls were infected with chlamydia and/or genital warts (HPV) at the time of their intake interview. This coupled with the unplanned/unwanted pregnancies suggests that these girls were unable to negotiate or consider safer sex.

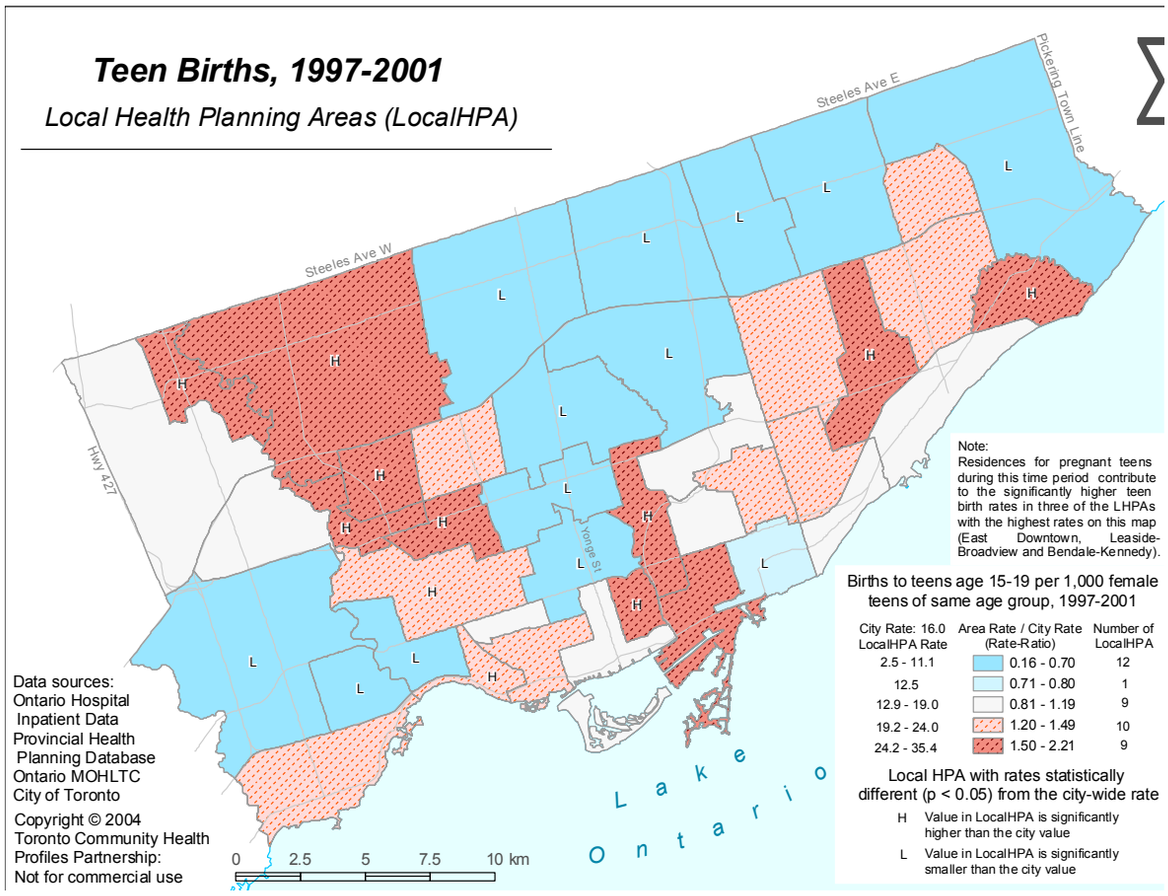


Figure1: Map of Teen Births in the City of Toronto, 1997-2001 [iv]

When comparing the map of teen births (Figure 1 above) with the map of the Black population in Toronto (see page 31), we noted that 11 of the 15 neighbourhoods that had more than 3000 Black persons were also included in 9 of the local health planning areas (LHPAs) that had the city's highest teen birth rates (i.e. 19.2-24.0 and 24.2-35.4 births per 1000 female teens between ages 15-19).

A Key Informant at WHIWH conducts outreach in the Jane & Trethewey area in North York. She noted that the level of sexual health knowledge among most young Black women is low and that many girls are seen with repeat cases of STIs. Additionally, those girls who had previously been taught about safer sex methods continued to practice unprotected sex. Sixteen (16) Key Informants commented on the ineffectiveness of the sexual educational programming that youth receive in high schools. This is also evident to Black CAP, which receives several requests annually to run HIV/AIDS workshops in high schools that already have a sexual health programming curriculum.

"A one day session about sexual health cannot combat a lifetime of negative messaging. The information needs to be reinforced" - Key Informant

In a study conducted in Los Angeles (Chang, Bendel, Koopman, McGarvey, & Canterbury, 2003) with delinquent youth, it was found that, compared to their White counterparts, Black

youth were more likely to have had their first sexual experience at a younger age and/or were more likely to have had more sexual partners. However, Black youth were also found to use condoms more frequently than their White counterparts. The study also found a positive association between HIV/AIDS knowledge and safe sex attitudes, suggesting that increased HIV/AIDS knowledge reinforced a positive attitude about safer sex. Black youth often came from urban, low-income communities.

Outside of school, such as in home or social settings, there is often either the lone message of abstinence or no messaging geared towards youth. There is a fear held by many parents that if they talk about sex with their children or give them condoms, then they are promoting sexual activity to their children. The ill-informed idea is that if a youth knows nothing about sex, then this would mean there would be no desire for sexual activity. Several Key Informants also noted that most adolescent youth don't raise the topic of sex with their parents. Youth tend to feel that their independence and autonomy would be threatened if their parents thought they were sexually active. Another reason for youth not seeking sexual health information from their parents is that they receive some sexual health information in school (Beard, 2005).
We recognize, however, that it is nearly impossible for any youth to grow up in Toronto without being bombarded daily with some form of sexual imagery. This imagery is coupled with a lack of accurate information available to them and the low self-esteem that many youth may struggle with, hence, it is easy to see how external influences can shape a youth's decision-making process about sex.

An issue that has not been previously considered by some HIV prevention programs is that a number of children are growing up HIV-positive and their needs, especially in relation to their sexuality and sexual activities, are not being addressed (Toronto HIV/AIDS Community Planning Initiative, 2007). Effective solutions to address this population subset could include the creation of support and advocacy groups for HIV-positive youth; the development of relevant educational materials regarding health sexuality for HIV-positive youth; the development of tools/strategies to help youth cope with the responsibility of caring for their HIV-positive parents and vice versa; and support for HIV-positive parents who place their child's health needs above their own.

Biological implications that place women at risk

In general, the female body is at greater risk for contracting HIV due to a combination of biological and social factors.
The vagina's delicate environment is dynamic and reacts to hormonal cycles and any environmental changes, including irritation through penetration, infection, etc. When an infection develops in the vagina, white blood cells emerge and attack the infection (Kaushic, 2007). These cells are also the targets of HIV, which, if present, will attach itself and enters the cells, thereby infecting the woman. This also partially explains why the presence of an existing STI increases a woman's chance of contracting HIV.

The vaginal environment contains various healthy bacteria, including lactobacilli, whose role

is to maintain the acidity of the vagina. Recent studies have suggested that the presence of lactobacilli may also play a protective role against transmission of HIV-1 and other STIs (Kaushic, 2007). While the evidence is not conclusive, these studies also found that African women produced very low amounts of vaginal lactobacilli, thereby possibly making them more vulnerable to HIV and other STIs. White and Hispanic women were found to produce more of the bacteria, thereby benefiting from the protection.

In some African, Caribbean, and other cultures, there is a notion that a woman's vagina is unclean (James, 2006). A walk through a drugstore's section for feminine hygiene products reveals countless products that claim to clean and freshen the vagina. Some of these cleansers are too harsh for a woman's vagina and can cause irritation and inflammation of the vaginal lining, thus physically altering the vaginal environment to one that is more favourable to HIV transmission. If a woman uses this vaginal cleanser prior to having unprotected sex with an HIV-infected partner, her risk of contracting HIV is greatly increased.

A Key Informant indicated that some Black men may be intimidated by women who are sexually knowledgeable, since it challenges the patriarchal ideas and norms that many African and Caribbean societies follow. One central point of patriarchy is the control of women's lives and women's bodies. This could be the underlying reason as to why female genital mutilation (FGM) is justified in some African cultures as a way of controlling female sexual desire. Unfortunately, women who have experienced FGM are at greater risk of contracting HIV/AIDS because their vaginas are more susceptible to tearing during sexual intercourse.

Impact of Men's health on their female partners' sexual health

In 2004, Planned Parenthood of Toronto (PPT) conducted a community consultation with young men to examine how they access health services in Toronto. It was found that there was a huge gap in information and resources available regarding young men's health. It was also found that youth have less access to information and resources related to their health. In addition, strategies to address heterosexism, homophobia, self-esteem, double standards around sexuality, and young men's mental, emotional, and sexual health were found to be inadequate. As a result, PPT developed the "Bust the Myth" program as a strategy aimed at increasing young men's awareness of their physical, mental, emotional, and sexual health. Mental and emotional issues were found to have stemmed from most men's definition of a 'real man' as someone who was supposed to be tough and not need help from anyone in any form because needing help could indicate weakness. As recounted by a PPT Key Informant, '…Most young men don't go to the doctor unless they are bleeding to death OR their penis is falling off...'

Young men attending the "Bust the Myth" workshops cited that their cultural definition of a man heavily influenced certain choices they made. As a result, they were found to struggle around issues of masculinity and homophobia. All the participants appeared to be homophobic, as though they feared that their peers would think they were gay if they

sided even slightly with the notion that homosexuality was okay. They did not make a link between homophobia and the way they related to female partners: e.g., being sensitive to their partner's needs was seen as being weak and considered to be a gay behaviour and, therefore, unacceptable. The workshops also revealed that male participants wanted to learn how to have healthier relationships, healthier sexuality, conflict resolution, as well as negotiation around sex.

Many African and Caribbean cultures strongly defend their definitions of masculinity and anything that threatens it is met with great opposition. Men who do not fit the standard definition often experience discrimination. As a result, some homosexual men may feel pressured to enter heterosexual relationships, have multiple female partners, or even father several children, out of fear of isolation and ostracism. If young men are engaging in unprotected sex and are not monitoring their sexual health, their female partners are at risk for contracting HIV or other STIs.

There is an issue of power for some African and African-Caribbean men, as explained by Winston Husbands (2006). A number of African and Caribbean men are socialized in a place where they may have had more control over their lives, family, employment, and relationships. These are key areas that define their manhood. However, when they migrate to Canada, they are presented with barriers to success and control, such as racism, discrimination, poverty and stigma, which impact on how they can provide for themselves and their family. This may result in a loss of control and influence on key areas of their lives. As a result, the only remaining opportunity to exercise control and influence is often within their relationships and family lives. This creates an opportunity for further power imbalances, especially sexual inequality in their relationships. It was also noted that some men might experience the opposite and experience relationships where their female partners were the abusers, both physically and emotionally. This may have led to further emasculation by their partner. There are also few places to talk about this issue, as their friends would judge them as being weak.

In a report that investigated how Black youth from the Malvern community of Toronto accessed the health care system, it was found that several male Black youth considered violence as their primary health risk, so much so that it over-shadowed other health risks such as HIV/AIDS (Mensah & Lovell, 2005). Another issue that arises from gun violence is the lack of space for young Black men to openly grieve since it would be considered unmanly, i.e., "real men don't cry; they're tough!" Little research has been conducted on how this grief is expressed alternatively. A Key Informant from the Jane and Finch Community Centre also discussed the issue of defining and protecting territory (aka turf) among rivalling neighbourhoods within Toronto. As a result, the Informant stressed the importance of implementing programming in neutral areas, so that it is accessible to all youth, regardless of gang or territorial affiliation.

On March 28th 2007, the World Health Organization officially recommended that countries adopt circumcision as a part of their HIV/AIDS prevention programming (WHO and UNAIDS announce, 2007), though they clearly stressed that, "…Male circumcision does not provide complete protection against HIV…" Another point issued by a UNAIDS recommendations report discussed the reduced transmission of HIV from women to men and not the reverse (WHO/UNAIDS Technical Consultation, 2007). The report also cautioned that great care must be taken in promoting circumcision as a preventative measure, as there is the risk of creating

a "…false sense of security in men, who may then engage in high-risk behaviours that could undermine the partial protection provided by male circumcision… "[v] (HIV Prevention: Male circumcision, 2007, page 4, par. 2). The report continues to advise that men who chose circumcision as a preventative measure "…must continue to use other forms of protection such as male and female condoms, reducing the number of partners…" (HIV Prevention: Male circumcision, 2007, page 4 par.3).

Poverty as a predictor of HIV risk

When the only choice you have is the chance you might catch AIDS and die in a few years time, or the certainty of starving to death in a few weeks, there is no choice
-Tom Miller, Plan International

We consider poverty to be one of the major factors driving the HIV/AIDS pandemic. Even though the virus is spread through specific behaviours, poverty can increase the likelihood of a person engaging in those behaviours. In a study (2005) by the Canadian Association of Social Workers (CASW), Black women were found to be among the poorest in the country. It was found that Black women are at a double disadvantage as Black people make less money than other Canadians, and women make less than men. In 2000, the average income of a Black woman in Canada was $20,029, while the average income of all other Canadians was $29,769. This meant that 34.5% of Black women in families and 52.7% of single Black women fell below the poverty line. The unemployment rate for Black women was 63% higher than all other women, which indicates race is a factor in relation to employment.

The geographic concentration of poverty in Toronto neighbourhoods is somewhat correlated with Black communities. This suggests that prevention responses must target specific geographic communities where members of Toronto's Black communities live. In 2001, the regions of Scarborough, North York, Etobicoke, York, and East York had 92 of their combined neighbourhoods classified as 'poverty neighbourhoods.' This was a six-fold increase from 15 neighbourhoods in 1981 (Housing and Homelessness Report Card, 2003).[vi] It was also found that non-European families in Toronto make up 36.9% of all families, but account for 58.9% of all poor families (Ornstein, 2000).[vii]

For women who immigrate to Canada from other countries, finding adequate employment is a significant issue. A major challenge that most newcomers face is that the education and technical skills acquired in their countries of origin are not accepted or recognized in Canada as legitimate, thus disqualifying them from attaining an income level that is equal to their qualifications (Reitz, 2005). As a result, they may find themselves unemployed or in entry-level jobs that pay very poorly. According to Statistics Canada (2003), Canadian landed newcomers have a 37% unemployment rate.[viii] This places many newcomers in a financially compromising situation that also affects their health at a time when they are trying to establish themselves in a new country. Coupled with language and cultural barriers, this increases the risk of HIV/AIDS within these communities. HIV-positive persons who are living in poverty risk a faster progression from HIV to AIDS when they are faced with a lack of affordable housing, inadequate health insurance, and insufficient income to adequately

manage their condition.

In a Florida study (Whyte IV, 2006), it was found that some women engaged in survival sex as a way to provide for themselves and their families. Survival sex was defined as providing sex in exchange for money, food, and/or shelter. This practice was seen among homeless adolescents (i.e., street youth) and older women with low income. Young women were more likely to engage in survival sex and less likely to use safer sex practices than older women (ibid). Young Black women often have limited mobility in relation to income; hence, their risk for HIV would increase if they engaged in risky sexual behaviour for financially profitability.

When a youth is evicted, a shelter may be their only housing option. Unfortunately, shelter life is unstable. Also, the youth receive little money and need to find other means to make more. This opens them up to the practice of unsafe behaviours such as survival sex, placing their health and/or freedom at risk.

It becomes easier to see why HIV/AIDS is not an immediate concern for some members of Toronto's Black communities when the lingering thought is that, 'until you survive tomorrow, next year's plans are irrelevant.'

Sexual inequality in relationships

Social and religious norms in African and African Caribbean communities sometimes support the notion that Black women should be subordinate to their male counterparts. There are also set expectations about the circumstances surrounding women's sexual behaviour. The common belief is that women should only learn about sex from their marital partner. Thus, women who are knowledgeable about their sexuality and express their desire to engage in safer sex practices are often labelled as being promiscuous.

In the Caribbean, there is a longstanding practice of relationships between younger girls and older men (CARICOM & PAHO, 2006). A Key Informant at WHIWH attests to this also being true in African-Caribbean communities in Toronto. In her outreach work with young Black women, the Informant found that most girls cited their desire for a male partner who was financially affluent, hence why they chose to date older men. However, older women (i.e., 30 years old and up) are also looking for the same type of man. This high demand for a particular type of man, particularly in a culture that lauds male promiscuity, can grant such men power over the women that want them. Young women also want a male partner who is perceived as a thug, e.g., he has a "tattoo on his neck, money in his pocket" as re-stated by the Key Informant at WHIWH. He must also have street credibility, i.e., he is respected and/or feared in his neighbourhood. For these young women, this gives them a sense of physical safety and financial security. Such a relationship can result in disempowerment of the female partner.

In the 'HIV Prevention Guidelines' developed by ACCHO (2006) the major challenges that create sexual inequality in African and African-Caribbean heterosexual relationships were identified as follows:

- The male partner maybe the sole income earner
- The female partner's immigration status limits her ability to access social services such as welfare
- The male may withhold his partner's legal/travel documents to ensure she does not leave him
- Language barriers: only one partner can speak English or French
- The male partner may interpret the desire for condom use as an accusation of infidelity and may threaten to end the relationship.

In the study by James Whyte IV (2006), one-third of the women surveyed had engaged in sex to avoid being left by their partner. Additionally, women who had previously been physically forced to have sex were more likely to engage in sex to avoid being abandoned, physically abused or evicted from the home by their partner. As expected, women who engage in this type of survival sex are unable to negotiate safer sex; thus, increasing their risk of contracting HIV and other STIs, as well as unwanted pregnancies.

At a 2007 presentation held at WHIWH, a Toronto Public Health nurse asked why some young women stayed with partners who continuously re-infected them with STIs. A Key Informant from WHIWH replied, "You need to consider protective risk factors. She may be in this relationship for a number of reasons such as physical protection from abusers, financial support, and emotional support. It is for these reasons that she may find it hard to leave, especially if she has a child with this partner." Most research that examines sexual inequality in relationships looks at heterosexual relationships. It is not widely acknowledged that women in same-sex relationships can also experience abuse and sexual inequality that places them at risk of STIs and even HIV/AIDS. Therefore, the issue of sexual inequality should consider all types of relationships.

The persistence of homophobia as a significant barrier to HIV prevention education

Homophobia in Black communities is pervasive, highly misunderstood, and rarely discussed. Homophobia was identified throughout the Key Informant interviews as an exceptionally significant issue to be considered in developing effective HIV prevention programming. In a report on HIV and African and Caribbean Women by WHIWH (Tharao, Massaqoui, & Teclom, 2006), homophobic views among Black communities appeared to be predominantly based on religious beliefs that regarded homosexuality as a moral aberration.

Women who identify as lesbians are often considered to be at low risk for contracting HIV from their female partners. It was noted when reviewing the literature, and also commented on by Key Informants, that the discussion about women's risk of contracting HIV is typically focused on heterosexual women. Also, there is a misconception that lesbians do not engage in authentic sexual relations because there is no penile penetration involved in the sexual act. Currently, there is very limited mainstream information that speaks to the risks of transmission for female-female sexual relations. In a study conducted by WHIWH (Williams & Massaquoi,

2007), out of a sample of 226 Black women and women of colour, 10% identified as lesbian, bisexual or queer, and 9.5% of that sub-population identified as HIV-positive.

Due to systemic barriers in Canadian society, all Black women have particular vulnerabilities to the issues of sexism, poverty, and sexual violence, lack of education around HIV transmission, cultural barriers, stigma, immigration, housing, and racism. Hence, a woman facing deportation may marry a man to remain in the country. Likewise, a lesbian who is of a lower economic status or homeless may engage in heterosexual sex for money. Some Black women who identify as lesbians or bisexuals must also deal with isolation and discrimination from their communities As a result, they may deny or hide their sexuality by engaging in heterosexual relationships. This is important to consider since there is often a misconception that women who identify as lesbians do not have sexual relationships with men.

In addition to the direct impact of homophobia on lesbian, bisexual, and queer Black women, the impact is similarly detrimental on heterosexual Black women. Peter Newman found in his Toronto study (2006) that homophobia impacted on African and African-Caribbean heterosexual relationships by encouraging Black men who had sex with other men to maintain a code of silence about their behaviour. This has resulted in the popular phrase, 'being on the down-low', which refers to men who maintain relationships with women but secretly also engage in sexual activity with men. In part because of homophobia, many of these men on the 'down low' do not identify themselves as gay or bisexual -either because they do not feel that is their identity or because they fear the repercussions of openly declaring their true sexuality. Some men do not use condoms with their male partner as a way of self-convincing that it is not really sex, since they are not comfortable or ready to acknowledge their own sexual orientation. Some men who engage in homosexual activity may also enter heterosexual relationships only as a cover. This places all of their partners at risk for HIV and other STIs. Interestingly, there was general consensus among the women in the study that they did not wish to know if their male partner was engaging in any homosexual or heterosexual relationships outside of their own.

Prisoners

"No crime exists in isolation outside the Social Determinants of Health"
- PASAN Key Informant

Like HIV/AIDS and poverty, Black communities are vastly over-represented in the prisoner populations of provincial and federal correctional institutions across Canada. "The majority of women in prisons are members of social groups marginalized not only on the basis of gender, but also on the basis of race, class, sexual orientation, disability, substance use, and/or occupation as sex workers" (Canadian HIV/AIDS Legal Network, 2005). Female prisoners often have more health problems than male prisoners. Many suffer from chronic health conditions due to lives of poverty, drug use, family violence, sexual assault, adolescent pregnancy, malnutrition, and poor preventive health care. HIV seroprevalence among female prisoners generally exceeds that of male prisoners. In a recent study in provincial prisons in Québec (ibid), the HIV seroprevalence rate among women was 8.8%, while it was 2.3% among male prisoners. Similarly, in 2002, 3.71% of prisoners in federal women's institutions,

compared to 1.96% of male prisoners in the Canadian federal prison system were known to be HIV-positive (ibid).
A Key Informant from PASAN indicated that a major challenge for women who were incarcerated is employment. After release, employment options are limited since most people are hesitant to hire a person who has a criminal record. This limits a female ex-prisoner's ability to obtain gainful employment and gain financial autonomy. As a result, the only immediate employment options that may appear to be available are risky behaviours such as survival sex or illegal business. These options can put these women at increased risk of HIV infection and re-incarceration. The topic of female prisoners is rarely discussed among Black communities. There is a lot of negative stereotyping that surrounds women who have been incarcerated, therefore women who come out of the prison system have been very selective about whom they disclose their past to, much like their HIV status. These women need to see that their needs are included in HIV prevention programming otherwise they do not feel validated, nor do they see how the current options fit into their reality.

In a research paper conducted in Los Angeles (Chang et al, 2003), it was found that there was a greater prevalence of risky sex practices among incarcerated youth than non-incarcerated high school students. The former group often came from urban, low-income communities and also returned to these communities without education on HIV/AIDS. The authors cite the period of incarceration as a perfect opportunity for sexual health education.

"Prisoners are part of our community regardless of how we feel. Do you just work on people you think are 'good'? Prisoners' lives are valued as well. The majority of women who are incarcerated, their crimes were proprietary not violent... Most aren't doing long sentences and eventually will rejoin the same social networks that you and I are involved in."
- PASAN Key Informant

Access to AIDS Service Organizations and HIV and STI Testing

Toronto Public Health has noted that the majority of positive HIV tests are recorded from anonymous testing sites, suggesting that this is the route that persons who are at high risk for HIV use for testing. At this time, there are 12 anonymous HIV testing sites in the City of Toronto; seven are located in central Toronto, two in Toronto North, two in Toronto West, one in Toronto East, and one in north Etobicoke. Six new anonymous testing locations will be created in Toronto in the fall of 2007. Additionally, over 80% of AIDS Service Organizations (ASOs) are located in downtown Toronto (figure 2). As seen in figure 3 below, the bulk of health and community services in Toronto are also located in the downtown area, with fewer services located in inner-suburban communities (Scarborough, East York, York, North York and Etobicoke).

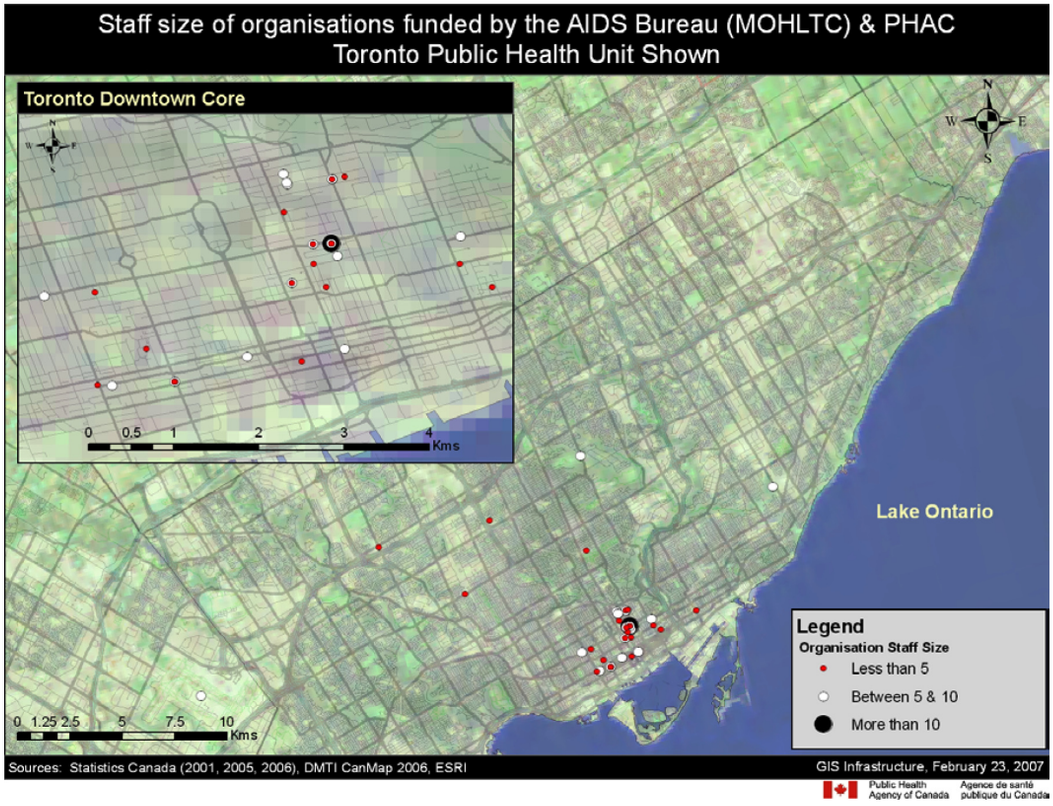


Figure 2: Location of AIDS Service Organizations in Toronto[ix]

As identified by the Black Population census map (see Figure 4 on page 27), the key neighbourhoods with large Black populations are located in inner-suburban communities located in the west/north-west, and east/north-east areas of the City, not in central Toronto. Cross-referencing Figures 2 and 3 with Figure 4, there are clearly identifiable geographical barriers to Toronto's Black communities ability to readily access community testing sites and health services.

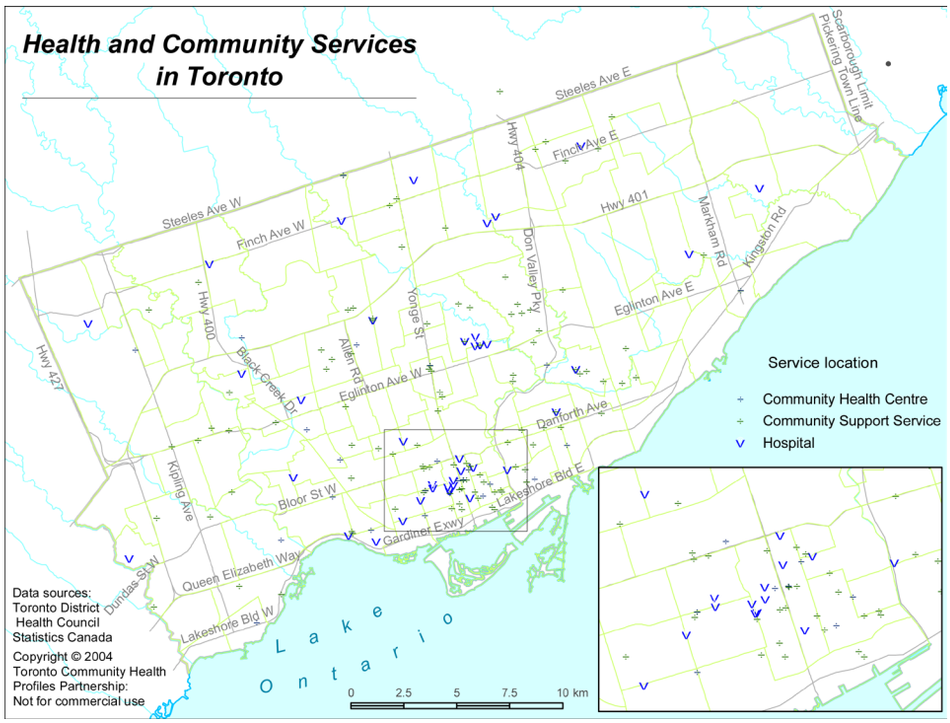


Figure 3: Map of Health and Community Services in Toronto[x]

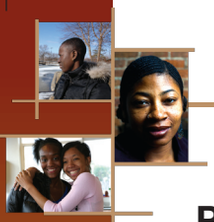
Related programming in toronto

In addition to a community consultation and literature review, Black CAP also completed an analysis of related HIV programming that is funded by Toronto Public Health's AIDS Prevention Community Investment Program in order to help identify gaps in services.

Existing programs

Programming focused on women

- Centre Francophone de Toronto: "Quand la communauté se prend en main"; a project that delivers outreach in French to 10 different communities where HIV/AIDS is endemic. This is done via monthly ethno-cultural dinners where HIV/AIDS is discussed and the creation of HIV/AIDS related articles published ethno-cultural newspapers and newsletters.
- Heritage Skills Development Centre provides bi-monthly networking sessions to minority women to discuss HIV prevention and access to support services.
- WHIWH: "W.H.I.W.H, HIV/AIDS Education Program: Sharing our Model of Care" seeks to educate African and Caribbean women through outreach, resource distribution, and community events etc. and to update HIV positive women on relevant prevention health and treatment issues.
- WHIWH: "Bling Bling", held every February (Black History Month) for young Black women aged 16-24, is an event that allows them to discuss issues that are pertinent to their lives.



Programming focused on African and/or Caribbean communities

- Somali Immigrant Aid Organization: "AIDS Prevention – Community Voice" project looks to provide HIV/AIDS prevention education materials to Somali newspapers, radio programming and distribute culturally sensitive HIV/AIDS materials to the Somali community.
- Black CAP: Outreach program that delivers various workshops: HIV 101, Anti-homophobia and Raising Sexually Healthy Children. In addition, Black CAP conducts significant outreach at various community events/locations, and provides HIV related information and resources.
- Africans in Partnership Against AIDS: Conducts outreach at hair salons, mosques, and cultural events throughout the year (e.g. Afrofest, Caribana); delivers a range of information workshops from female condom training to the basics of HIV/AIDS prevention.

Programming focused on youth

- Dixon Hall: "Regent Park Youth At Risk" project trains youth to be leaders and mentors to other youth, distributing condoms and safer sex education materials to the Regent Park community, and creating HIV/AIDS and STI workshops for different community groups in a range of settings (e.g. basketball league).
- East Metro Youth Services: "HIV/AIDS Prevention" project provides HIV/AIDS outreach in East Toronto to youth 12-24 years of age and their parents.
- The Ethiopian Association in the Greater Toronto Area and Surrounding Regions is conducting HIV/AIDS & STI outreach to Ethiopian Youth aged 15-29 in the Scarborough community and to Ethiopian religious leaders.
- The Jane/Finch Community and Family Centre does outreach in the Jane/Finch area by providing HIV/STI education through workshops and ensuring youth can access HIV/STI prevention resources at the Youth Hub at Yorkgate Mall.
- Le Centre des Jeunes Francophones de Toronto : "Sexe! C'est ta vie…tu décides!" project seeks to provide culturally sensitive HIV/AIDS workshops in French schools and in the community.
- Northwood Neighbourhood Services: "HIV/AIDS Prevention" project provides HIV/AIDS Prevention education and outreach to Black Youth in the Jane/Finch area.
- Rexdale Community Health Centre: "Brothas and Sistas Talk about T.R.U.T.H" project serves youth aged of African and Caribbean descent in Central and North Etobicoke by providing HIV/STI prevention information. Its youth campaign "Drop it like its Hot" allowed women to talk about their sexuality; the logic behind the title was "Do what you want, but do it safely. If not…Drop it like its Hot!"
- Rexdale Community Health Centre also produced a campaign targeted to young women of colour, advising them of the risk of STIs and HIV, as well as informing them of the increase in HIV infection rates.
- Warden Woods Community Centre: "HIV/AIDS Education and Prevention" educates African and Caribbean youth in the Scarborough area about HIV/AIDS and STIs.
- Black CAP: "Mate Masie: Kwanzaa-Yoga" program provides Black youth in four communities in Toronto with HIV/AIDS and STIs prevention education through yoga practice and Kwanzaa.

- Black CAP: Peer-education program delivers workshops in a range of communities across Toronto to youth.

Men and Women involved in the criminal justice system

- Black Inmates and Friends Assembly (B.I.F.A): Work specifically with imprisoned Black men and women.
- PASAN: "Women and Trans HIV+ Drop-In": Weekly Drop-In for women and 'trans' ex-prisoners who are HIV positive. Black CAP is a partner of this program.

Families

- African Health is looking to expand on the "Raising Sexually Healthy Children" programming as their HIV/AIDS Prevention platform. The program targets the parents of 0-15 year old African children, but will not exclude those parents of Caribbean or other ethnic groups.

Peer-based women's prevention programming

- The "From My Community Project" educates women of African, Caribbean and Aboriginal communities by training and supporting a network of peer educators. This project is in the first stage of implementation.

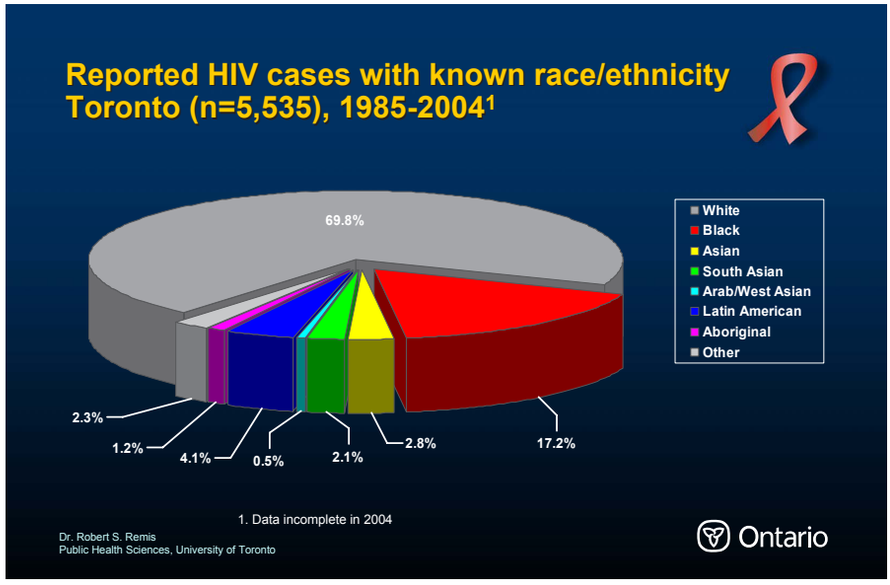
KEY RESEARCH FINDINGS

"Epidemiological trends are a snap shot of the past. Anything can happen in the future."
Key Informant (University of Toronto)

When HIV/AIDS first emerged in North America, the communities most affected by HIV were men who had sex with men (MSM), Injection Drug Users (IDUs), and persons who received blood transfusions. Women, especially young ones, were perceived to be safe or at low risk of contracting the virus as long as they did not share injection drug paraphernalia, had not received a blood transfusion, and their male partners were not bisexual. Since then, as indicated in the data below, HIV has spread beyond the high-risk groups identified above.

A range of instructive data was collected and analysed according to age, gender and ethnic group, to aid in the selection of a priority target group.

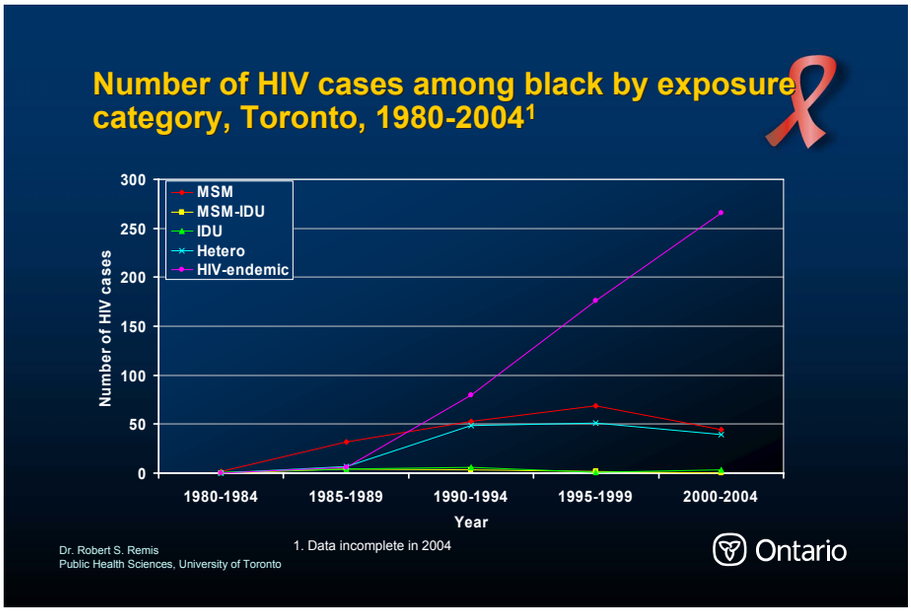
In Toronto, the epidemic has impacted all race/ethnic groups. As seen in Graph 1 below, of the 5,535 HIV cases recorded between 1985 and 2004 Blacks accounted for 17.2% (952 cases) of the total (Remis & Liu, 2006). In 2005, Blacks accounted for 18.5% of all new HIV infections (Remis, 2006) Since Black people account for only 9% of Toronto's entire population (Statistics Canada, 2001), one can see the disproportionate impact of HIV on Toronto's Black communities.



Graph 1: Reported HIV Cases within Toronto, by ethnicity, 1985-2004[xi]

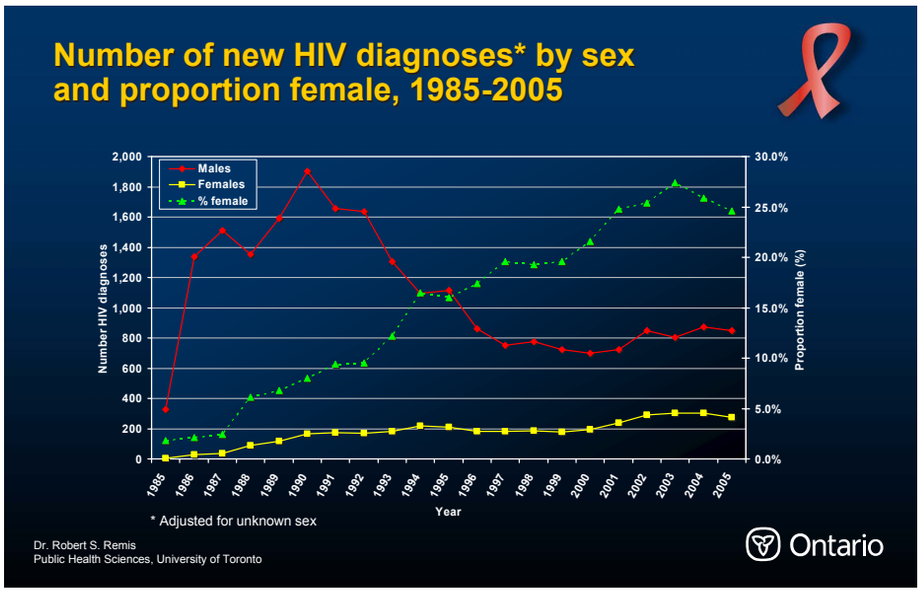
- Graph 1 shows the percentage of HIV cases in Toronto, divided into eight ethnic groups; White, Black, Asian, South Asian, Arab/West Asian, Latin American, Aboriginal, and Other
- Blacks were the leading ethnic minority group for HIV cases in Toronto

Among the Black population in Toronto, the number of HIV cases has been increasing steadily. At the start of the epidemic in the early 1980s, approximately three cases were ascribed to the Black community and by the early 2000s, this number increased to roughly 352 cases (See Graph 2).



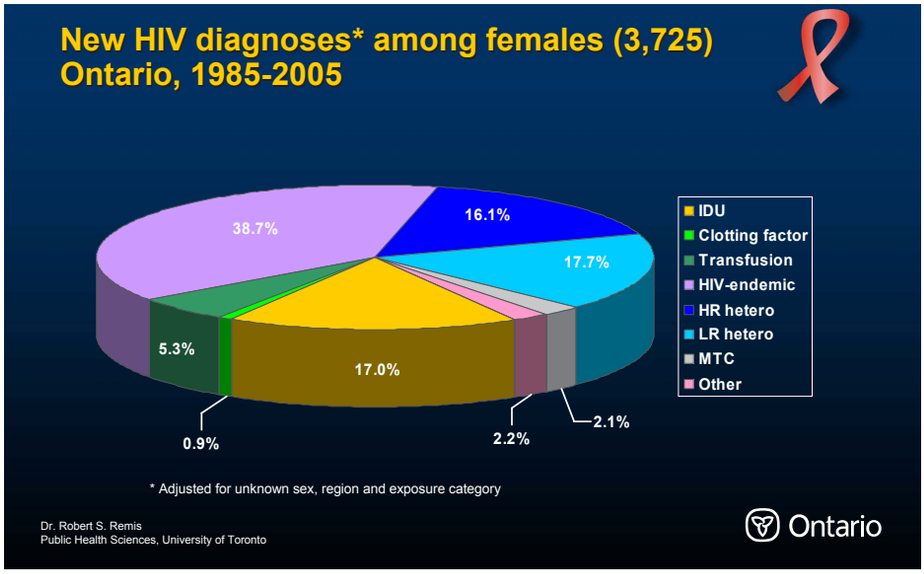
Graph 2: HIV cases recorded in Toronto's Black Population, plotted by exposure category, 1980-2004[xi]

- MSM accounted for the majority of HIV infections between 1980 and 1987.
- HIV cases among heterosexual persons and persons from HIV-endemic countries increased noticeably from 1985 onward.
- By 1990, heterosexual persons accounted for a similar number of HIV cases as MSM.
- Persons from HIV-endemic countries accounted for the majority of HIV cases from 1990 onward. HIV-Endemic is defined as a high prevalence of HIV infection in the general population (generally greater than 0.8% but may attain 20% or higher) and where heterosexual contact is the most common mode of HIV transmission (Remis, 2001).
- The number of HIV cases has decreased among the MSM, MSM-IDU and IDU groups. The number of HIV cases amongst heterosexuals appears to be reaching a plateau, while HIV cases in the HIV-Endemic category are growing at a dramatic rate.



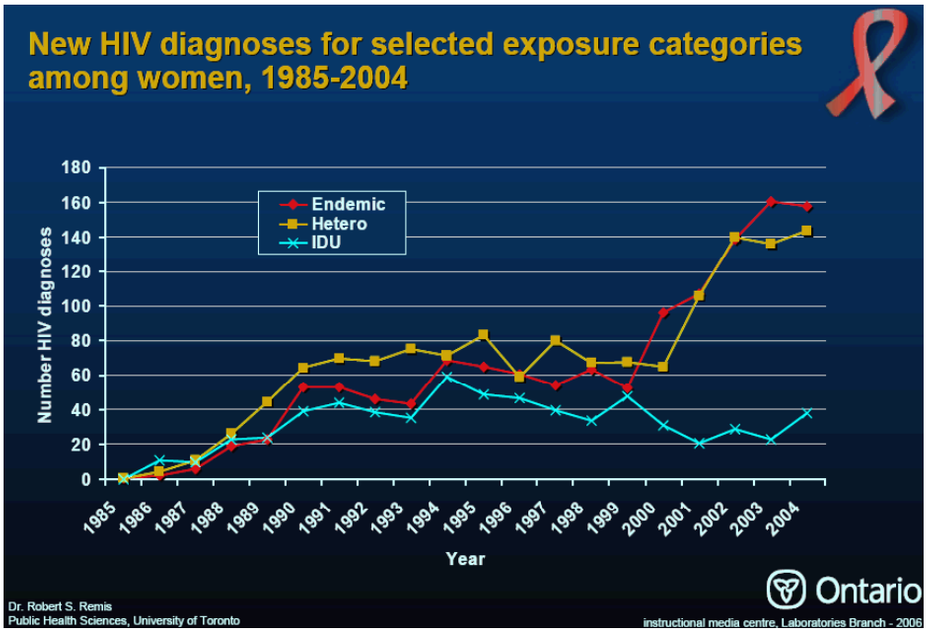
Graph 3: HIV cases for Ontario broken down by sex, 1985-2005[xii]

- In Ontario, women were estimated to account for 25% of all new infections in 2005.
- The increase in new HIV diagnoses per year among females is relatively small compared to males



Graph 4: HIV cases for females in Ontario by exposure category, 1985-2005[xii]

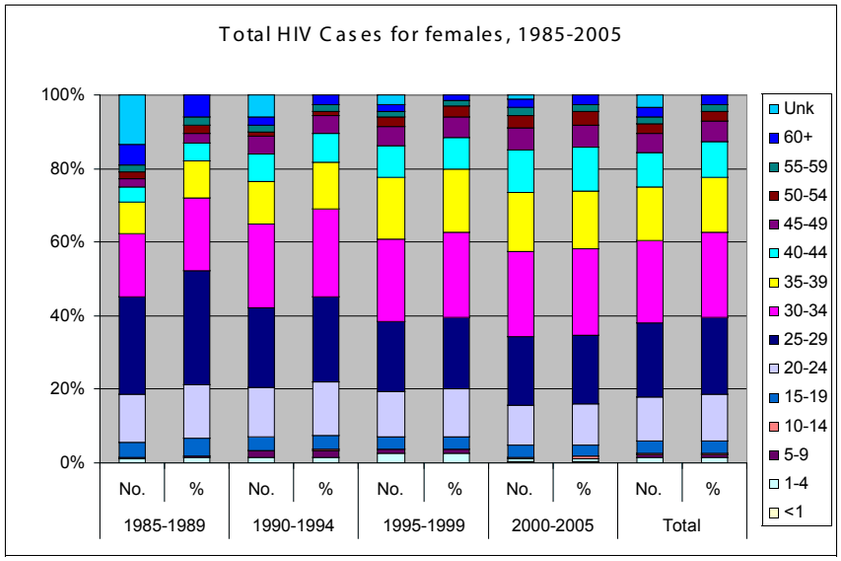
Women account for a growing proportion of positive HIV tests reports with known age and gender among adults in Canada. It was estimated that women accounted for 20% of people living with HIV infection in Canada at the end of 2005. As seen in Graph 4, the majority of HIV infections were accounted for by the HIV-endemic exposure category (38.7%), Low Risk Heterosexuals (17.7%) and IDU exposure category (17%).



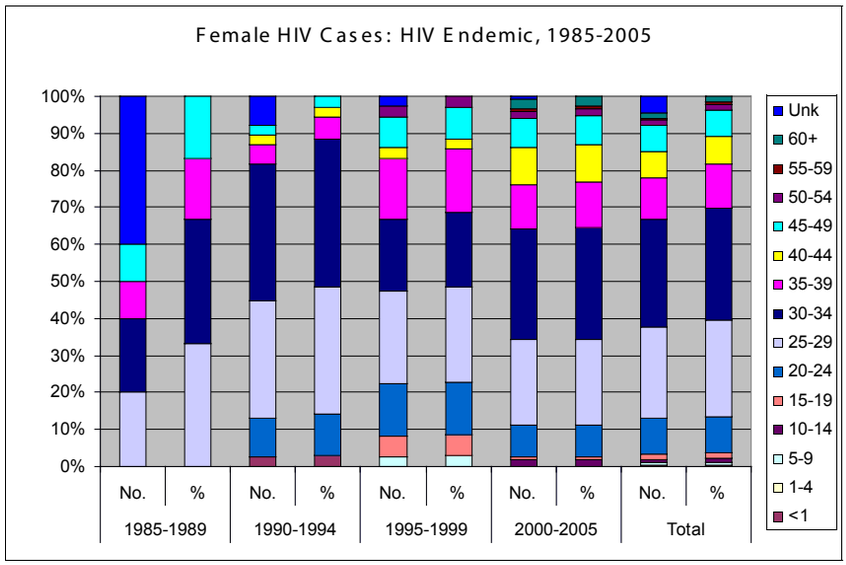
Graph 5: Trends for HIV cases amongst women for each exposure category, 1985-2004[xiii]

- The proportion of HIV diagnoses accounted for by women is increasing steadily.
- The number of HIV diagnoses has remained fairly constant among female IDUs in the last six years and increased significantly in the HIV-Endemic and Heterosexual groups.
- This can be compared against data shown in Graph 2, which looked specifically at Toronto's Black population. The number of HIV cases among the HIV-endemic and Heterosexual groups has also been increasing.

Graphs 6 to 9 present the number of female HIV cases by age group in various exposure categories in Ontario between 1985-2005. The majority of cases were accounted for by the following exposure categories: HIV-Endemic, High Risk Heterosexual & Low Risk Heterosexual. IDU was not included, as it was not considered to be a major exposure category for Black women in Toronto .



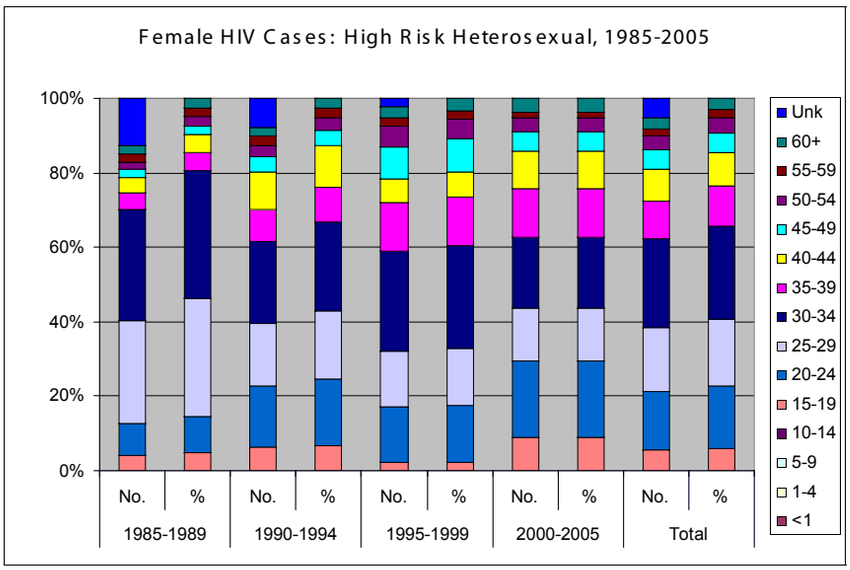
Graph 6: No. of Female HIV Cases by age group for all exposure categories for the period 1985-2005[xiv]



Graph 7: No. of Female HIV Cases by age group for HIV-Endemic for the period 1985-2005[xv]

HIV-endemic risk is defined as originating from a country where there is a high prevalence of HIV in the population (> 0.8% of total population is infected with HIV) and where heterosexual contact is the most common mode of HIV transmission (Remis, 2001). As indicated in Graph 7:

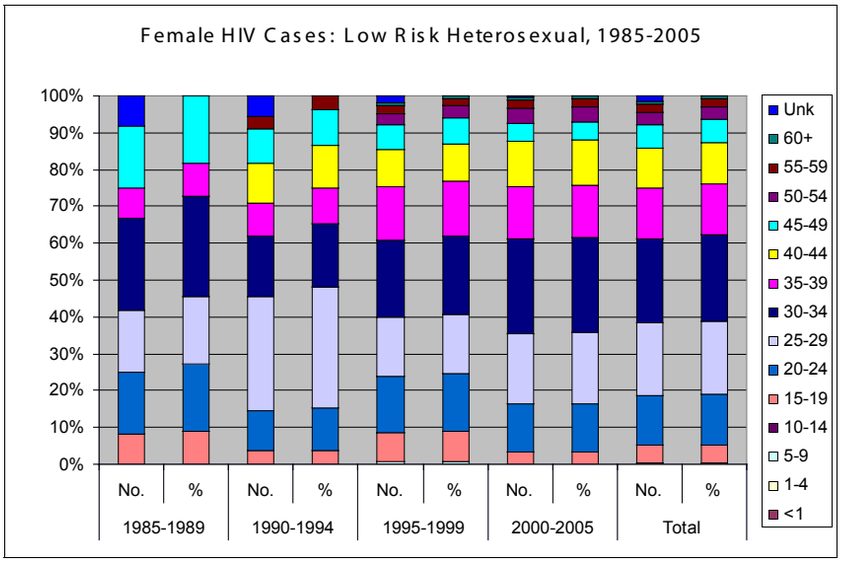
- 15-29 year age group accounted for 35.8% of all HIV cases in the past 20 years
- 30-44 year age group accounted for 47.3% of all HIV cases



Graph 8: No. of Female HIV Cases by age group for HR-Heterosexuals for the period 1985-2005[xv]

High-Risk (HR) Heterosexual is defined as a heterosexual who is at high risk for HIV, i.e., is sexually active with a person of the opposite sex known to have HIV/AIDS or a risk factor for HIV/AIDS. As identified in Graph 8:

- 15-29 year age group accounted for 38.6% of all HIV cases in the past 20 years
- 30-44 year age group accounted for 42.3% of all HIV cases



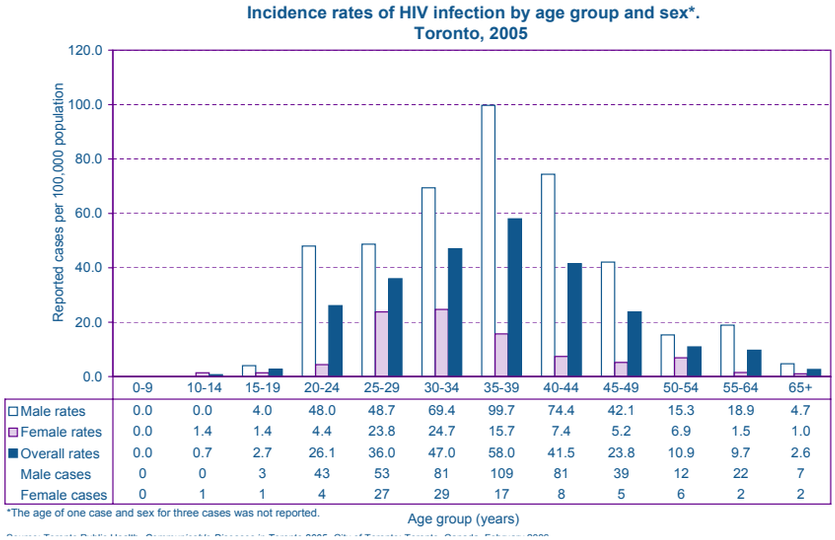
Graph 9: No. of Female HIV Cases by age group for LR-Heterosexual for the period 1985-2005[xv]

Low Risk (LR) Heterosexual is a heterosexual who is in sexual contact with a member of the opposite sex who is not HIV positive or at risk for contracting HIV. It was seen that the age groups 20-29 and 30-39 recorded the highest number of HIV cases throughout the 20-year period. As identified in Graph 9:

- 15-29 year age group accounted for 38.1% of all HIV cases in the past 20 years
- 30-44 year age group accounted for 47.7% of all HIV cases in the past 20 years

Sexually transmitted infection	Number of cases	Proprtion of total STIs
Chlamydia	6497	50 %
Gonorrhea	1659	13 %
Hepatitis B Carriers	1469	11 %
Hepatitis C	1165	9 %
Hepatitis B, unclassified	852	7 %
HIV	555	4 %
Syphilis late latent	482	4 %
Syphilis, (infectious)	252	2 %
AIDS	NA	NA %
Hepatitis B Acute Cases	34	<1 %

Table 1: Reportable Sexually Transmitted and Blood-borne Infections, Toronto, 2005[xvi]

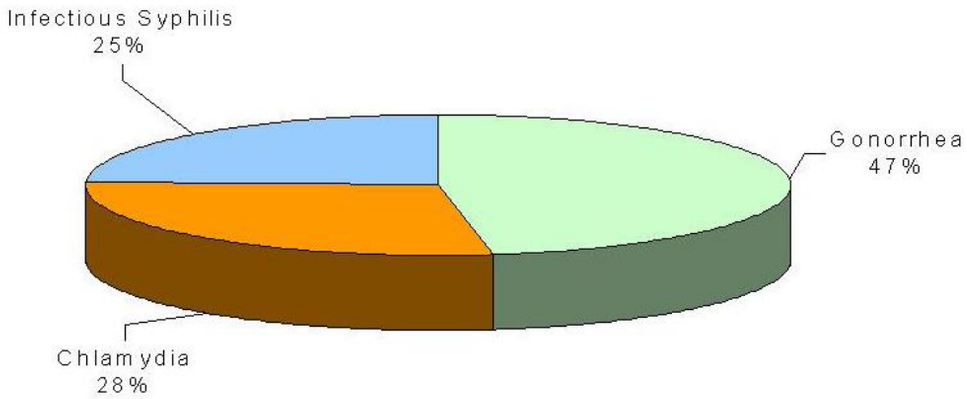


	0-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-64	65+
Male rates	0.0	0.0	4.0	48.0	48.7	69.4	99.7	74.4	42.1	15.3	18.9	4.7
Female rates	0.0	1.4	1.4	4.4	23.8	24.7	15.7	7.4	5.2	6.9	1.5	1.0
Overall rates	0.0	0.7	2.7	26.1	36.0	47.0	58.0	41.5	23.8	10.9	9.7	2.6
Male cases	0	0	3	43	53	81	109	81	39	12	22	7
Female cases	0	1	1	4	27	29	17	8	5	6	2	2

Graph 10: Incidence rates of HIV infection by age group and sex, Toronto, 2005[xvi]

- For females, the highest incident rates of HIV infection were among women aged 30-34 (29 cases) and 25-29 (27 cases)
- HIV was the 6th most reported STI in Toronto for 2005 (See Table 1)

In addition to being an indicator for unsafe sex practices, STIs also increase one's susceptibility of acquiring and transmitting HIV by two to five-fold. Thus, STI related statistics should also be considered. This can then be compared to the demographics of varying regions of Toronto.



Graph 11: Proportion of newly acquired STIs among STI co-infected HIV positive, Toronto, 1992 to 2004[xvi]

- The most common newly acquired STI co-infection was gonorrhea (See Graph 11), which accounted for 47% of all new reported STIs.

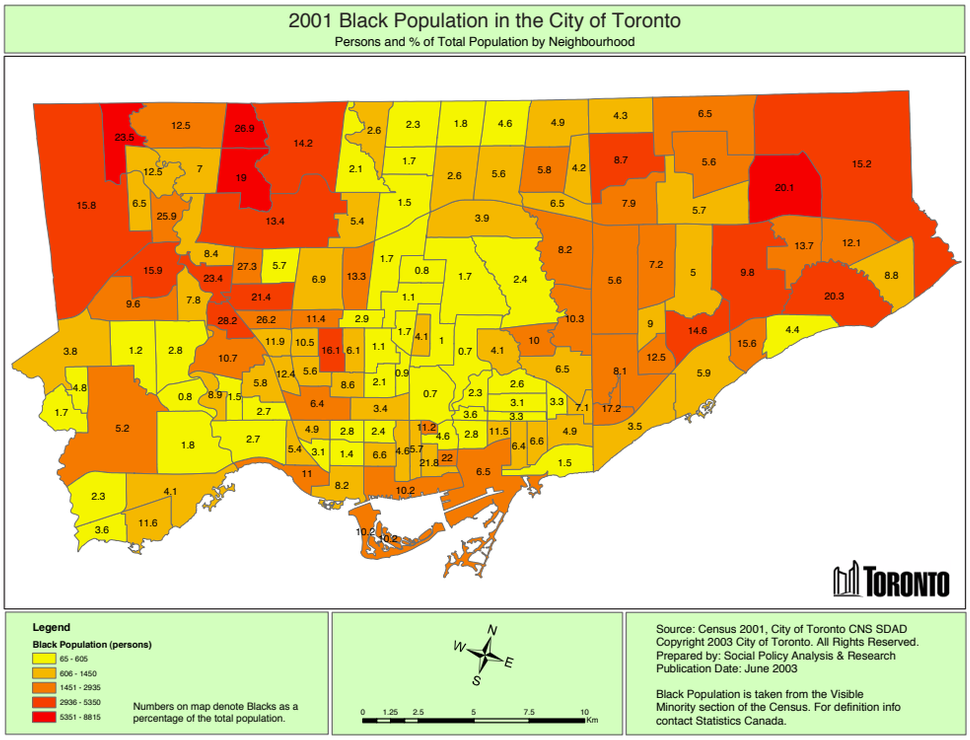


Figure 4: Percentage of Black Population in each Neighbourhood, Toronto 2001[xvii]

As identified in Figure 4, populations of approximately 3 000 or more Black persons lived in the following neighbourhoods, hereinafter referred to as key Black neighbourhoods:

1. West Humber-Clairville (N 1)
2. Mount Olive-Silverstone-Jamestown (N 2)
3. Kingsview Village–The Westway (N 6)
4. Black Creek (N 24)
5. Glenfield-Jane Heights (N 25)
6. Downsview-Roding-CFB (N 25)
7. Brookhaven-Amesbury (N 30)
8. Oakwood-Vaughan (N 107)
9. Weston (N 113)
10. Mount Dennis (N 115)
11. L'Amoureaux (N 117)
12. Rouge (N 131)
13. Malvern (N 132)
14. West Hill (136)
15. Woburn (N 136)
16. Eglinton East (N 138)

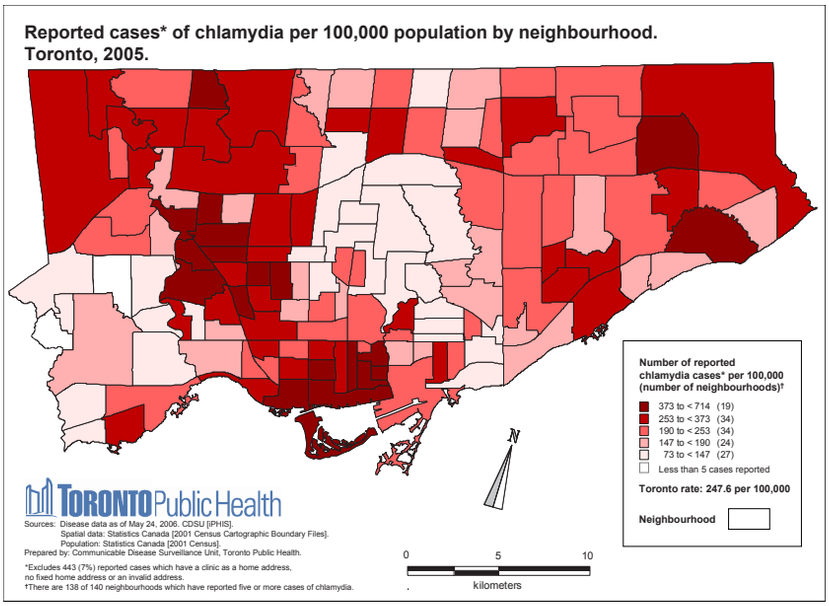


Figure 5: Reported Cases of Chlamydia by Geographic Location[xvi]

- Chlamydia was the most commonly reported STI in Toronto for 2005 (See Table 1)
- The darker the colour in Figure 5, the higher the number of chlamydia cases
- Cross-referencing Figures 4 and 5 indicates that 15 of the 16 key Black neighbourhoods also have high numbers of reported chlamydia cases

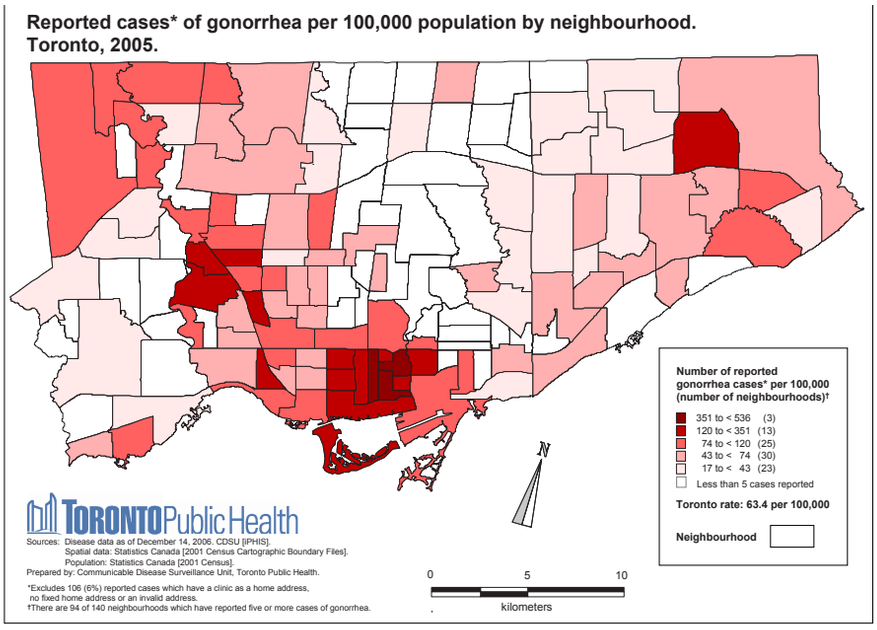


Figure 6: Reported Cases of Gonorrhoea by Geographic Location[xvi]

- Gonorrhoea was the second most reported STI in Toronto for 2005 (See Table 1)
- Of the 16 key Black neighbourhoods from Figure 4, two had the second highest incidence of gonorrhoea and five had the third highest incidence.

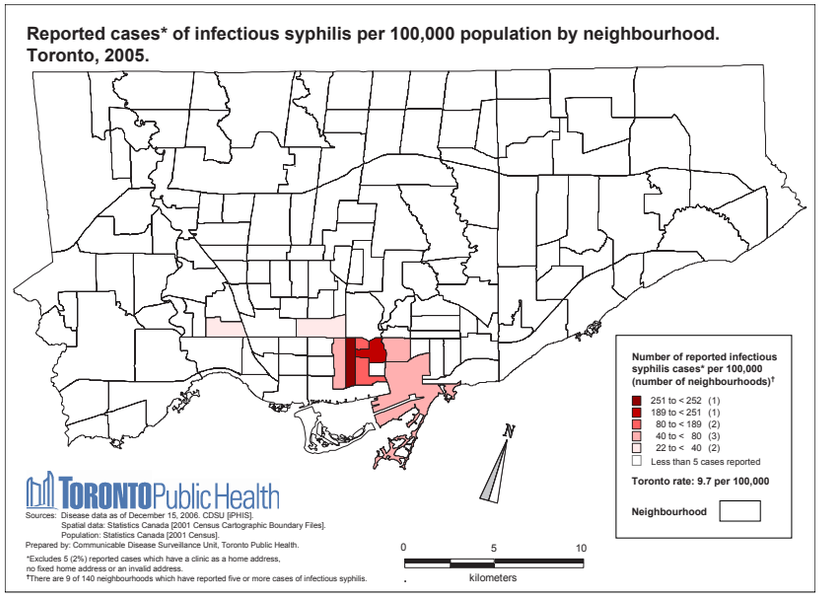
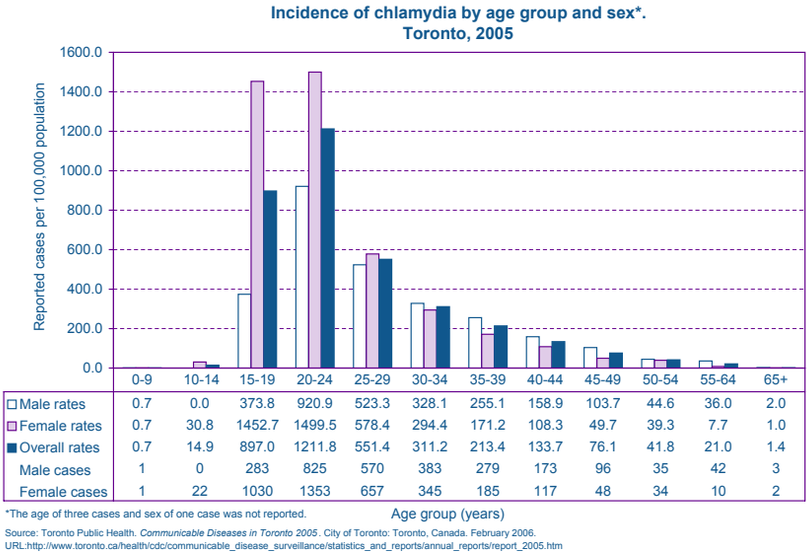


Figure 7: Reported Cases of Syphilis by Geographic Location[xvi]

- As seen from the map, the majority of recorded cases of syphilis were focused in the downtown area of Toronto
- Fewer than five cases of syphilis were found to coincide with the location of the 16 key Black neighbourhoods

There is an insignificant correlation between increased HIV risk and being infected with syphilis and living in one of the 16 key Black neighbourhoods identified in Figure 4. However, there is a strong incidence of chlamydia within 15 of the 16 key Black neighbourhoods as well as a fairly high incidence of gonorrhoea within 7 of the 16 key Black neighbourhoods. Thus, the chlamydia and gonorrhoea epidemiological data will be further examined to determine which specific groups (i.e. age range and gender) are at greater risk of contracting STIs and HIV/AIDS.



	0-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-64	65+
Male rates	0.7	0.0	373.8	920.9	523.3	328.1	255.1	158.9	103.7	44.6	36.0	2.0
Female rates	0.7	30.8	1452.7	1499.5	578.4	294.4	171.2	108.3	49.7	39.3	7.7	1.0
Overall rates	0.7	14.9	897.0	1211.8	551.4	311.2	213.4	133.7	76.1	41.8	21.0	1.4
Male cases	1	0	283	825	570	383	279	173	96	35	42	3
Female cases	1	22	1030	1353	657	345	185	117	48	34	10	2

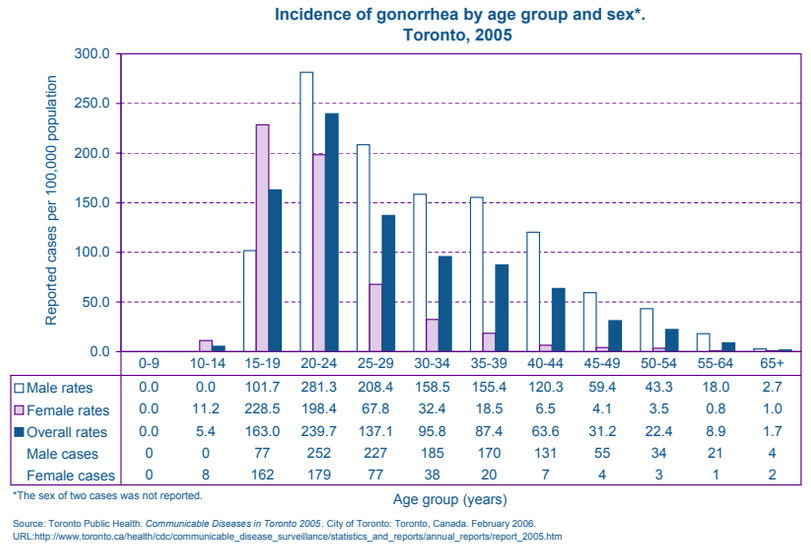
*The age of three cases and sex of one case was not reported. Age group (years)

Source: Toronto Public Health. *Communicable Diseases in Toronto 2005*. City of Toronto: Toronto, Canada. February 2006.
URL:http://www.toronto.ca/health/cdc/communicable_disease_surveillance/statistics_and_reports/annual_reports/report_2005.htm

Graph 12: Incidence of Chlamydia by Age Group and Sex, Toronto 2005[xvi]

As mentioned earlier, chlamydia was the most commonly reported STI in Toronto in 2005, accounting for 50% of all STI cases (See Table 1)

- The majority of female cases of chlamydia in 2005 were focused in the 15-19, 20-24, and 25-29 age ranges, accounting for 80% of all cases.
- The gender ratio of chlamydia cases was 3 female cases to every 1male case for age groups 15-19 and 20-24.



	0-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-64	65+
Male rates	0.0	0.0	101.7	281.3	208.4	158.5	155.4	120.3	59.4	43.3	18.0	2.7
Female rates	0.0	11.2	228.5	198.4	67.8	32.4	18.5	6.5	4.1	3.5	0.8	1.0
Overall rates	0.0	5.4	163.0	239.7	137.1	95.8	87.4	63.6	31.2	22.4	8.9	1.7
Male cases	0	0	77	252	227	185	170	131	55	34	21	4
Female cases	0	8	162	179	77	38	20	7	4	3	1	2

*The sex of two cases was not reported. Age group (years)

Source: Toronto Public Health. *Communicable Diseases in Toronto 2005*. City of Toronto: Toronto, Canada. February 2006.
URL:http://www.toronto.ca/health/cdc/communicable_disease_surveillance/statistics_and_reports/annual_reports/report_2005.htm

Graph 13: Incidence of Gonorrhoea by Age Group and Sex[xvi]

- Women accounted for the majority of gonorrhoea cases in the lower age groups i.e. 10-14, 15-19 and 20-24.
- Males accounted for the majority of cases from age 20-24 to 65+, similar to chlamydia.

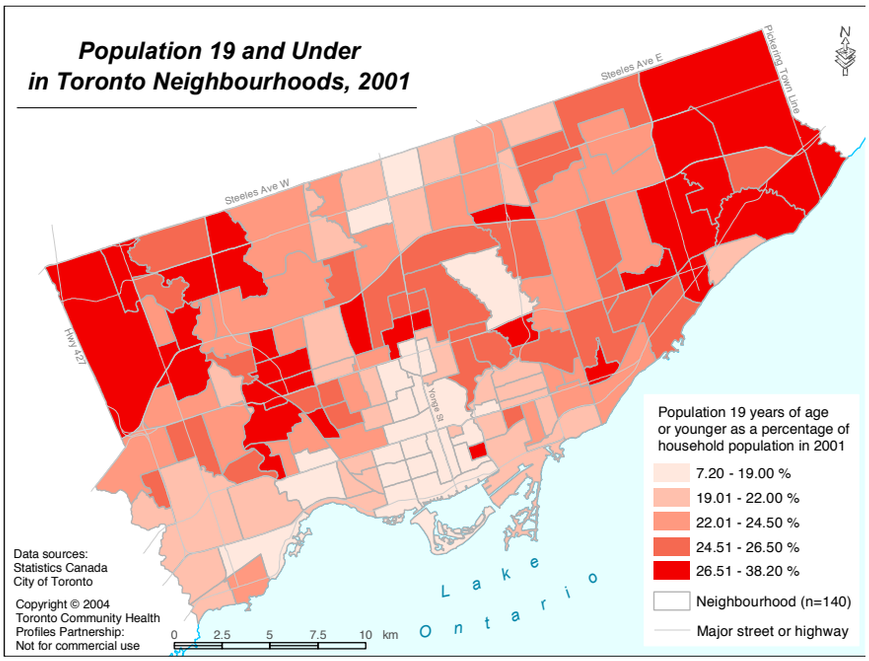


Figure 8: Population 19 and Under in Toronto Neighbourhoods, 2001[xvii]

15 of the 16 key Black neighbourhoods also had a youth population 19 and under that accounted for 25% to 38.20% of the population. These neighbourhoods included Mount Olive-Silverstone-Jamestown, Black Creek, Malvern, West Hill and Weston.

DISCUSSION

HIV Prevention for young Black women in Toronto is a complex issue. As identified in this report, numerous issues contribute to young Black women's risk for HIV and STIs, including poverty, sexual violence, homophobia, racism, inaccurate sexual health knowledge, stigma, age, biology, and sexual inequality. As such, organizations must consider these factors in the design and delivery of HIV and STI prevention programming.

The data presented earlier from Toronto Public Health indicates that more youth are engaging in sex at younger ages and are not adequately protecting themselves, as evidenced by the levels of sexually transmitted infections (STIs). Furthermore, young women between ages 15 and 29 accounted for the majority of gonorrhoea and Chlamydia cases in Toronto. As mentioned earlier, the presence of a STI increases one's risk of contracting HIV by up to five-fold.

The geographic locations where high incidences of STIs were found correlated with the key Black neighbourhoods. These neighbourhoods were also under-serviced in relation to healthcare facilities, i.e., hospitals, community health centres and community support services. This geographical barrier to accessing services hinders visits to healthcare professionals.

The stigma surrounding sex, sexuality, and HIV/AIDS is a barrier that affects HIV prevention measures as well as the ability of persons living with HIV/AIDS (PHAs) to care for themselves. In addition to the isolation that some PHAs experience from their own communities, they have few supports and resources that address their needs. This is especially true for youth who are born HIV-positive and are left to navigate issues of sexuality and romantic relationships with little advice. Some HIV-positive youth must also struggle with the stress of caring for their ailing HIV-positive parents too.

Poverty can limit young women's ability to access resources and HIV prevention information and can also facilitate issues of sexual inequality in their relationships. When young women living in poverty are completely financially dependent on their partner, and so have very little power in their relationships and are unable to negotiate condom use or question their partner's sexual fidelity. For young women who are already HIV positive, the stresses of living in poverty can also dramatically speed up the progression of the disease, as well as limit their medication options.

Sexual violence, such as rape or childhood sexual abuse (CSA), has long been overlooked in HIV/AIDS prevention campaigns as a risk factor for HIV transmission. It is not just the act itself, but the after-effects that place women at risk. For instance, some women repeatedly engage in unprotected sex with multiple partners to help them cope with the post-traumatic stress of childhood sexual abuse. Some women who have experienced any form of intimate partner violence (IPV) may continue to have sex with that partner in order to avoid being hurt again. Women living in poverty who are in sexually abusive relationships are at an added disadvantage, as they may not be able to leave the relationship due to financial dependence on their partner.

Homophobia is an issue that is rarely discussed in the Black community unless there is a negative undertone. It is therefore not acknowledged as a factor that drives the HIV/AIDS epidemic. In addition to the homophobia aimed at gay men, Black women who identify as lesbian or queer are also at increased risk of contracting HIV. Some women who feel they are not freely able to engage in same-sex relationships enter heterosexual relationships as a cover-up. These relationships may be for protection from harsh judgements or for financial reasons in the instances where some women have sex with men for money (i.e. survival sex).

To compound this issue, there is still the lingering myth among Black communities that HIV/AIDS is a gay disease. This is the reason that some heterosexual members of African-Caribbean communities give for not practicing safe sex or getting tested for HIV. As a result, Black men who are publicly known to be HIV positive may face the brunt of homophobic remarks, even when they are not gay or bisexual. Consequently, to avoid ostracism and isolation, many PHAs keep their HIV status a secret. Also, to protect the identification of one's true sexual orientation and/or to prove one's masculinity, some men will engage in unprotected sex with multiple women and also have children.

Defining masculinity by having multiple sex partners and unprotected sex are major issues that need to be addressed within Black communities. Black men are also expected to be tough and seeking help of any kind is seen as weakness. This can present an additional challenge for Black men seeking services from a health care system that is often inaccessible to their communities due to larger socio-economic factors. Inevitably, the health status of Black men, especially their sexual health, can impact the health status of their sexual partners. Thus, the benefits of any preventative health measures that a woman may be taking would be severely reduced if her male partner was not doing the same.

The biology and cultures of some Black women also affects their ability to engage in proper HIV prevention. For example, women who have experienced female genital mutilation (FGM) are at increased risk for HIV due to the physical effects of the FGM procedure. As well, studies have shown that Black women may also be at increased risk for contracting HIV due to the unique composition of their vaginal environments. This indicates how important it is for Black women to care for their sexual health and to avoid certain practices that would irritate their vagina, such douching. Unfortunately, cultural and social beliefs like "the vagina is dirty" and "women shouldn't know anything about their sexuality" are barriers to some women taking the initiative to care for their sexual health.

Lack of recognition of the diversity of Toronto's Black communities has also been to the detriment of the fight against HIV/AIDS. Due to the difference in cultures, languages spoken, and values surrounding sex and sexuality, past HIV/AIDS prevention messaging has been over-looked or ignored by some communities because it was not felt to reflect their reality or was not accessible due to language barriers.

We acknowledge that while other women of colour may also experience some of the aforementioned issues, many issues are specific to the realities of young Black women in Toronto. As such, focused, targeted, evidence-based, and community-driven prevention is the best way to reduce new HIV and STI infections among these women.

RECOMMENDATIONS

The following is a list of recommendations contained in this report. Recommendations have been classified into four specific areas.

Target specific communities

1. Create a non-stigmatizing HIV awareness programming targeting young Black women aged 15-29.
2. Prevention responses must be representative of specific target populations and be 'non-mainstream'; additionally, religious, linguistic, cultural and age differences must be taken into consideration.
3. Prevention responses must target specific geographic communities with high concentrations of Black persons, HIV and STI infections, and youth.
4. Ensure that there are women-only prevention education and sexual health activities, so they feel safe to discuss their issues.
5. The message of "Condoms Equal Responsibility" needs to be promoted to combat the stigmas associated with females who carry them.
6. Consider sexual health education for parents, especially mothers, and children. Consider complementing programming with "Raising Sexually Health Children" workshops delivered by Black CAP and African Health.
7. Consider male-only HIV and STI educational and support sessions that are available in tandem with the women-only sessions. The sessions should be organized within an overarching health framework that considers the specific health and social issues they face.
8. A male counselling group should be established for male newcomers to Canada of African and Caribbean origin.
9. Where possible in all workshops and sessions, a prominent community member should be used to advocate the need for respect and equality in relationships.
10. Develop non-stigmatizing HIV prevention messaging specifically addressing the realities of Black women who have been incarcerated.
11. Develop partnering with organizations that work with Black inmates to ensure that HIV prevention messaging reaches the Black prison population.
12. Develop support resources for children growing up with HIV and information about healthy sexuality for youth growing up HIV-positive and how to reduce the stigma that surrounds HIV-positive youth.

Partner with others who can support programming

13. Black communities' religious leaders must be involved in addressing the issue of HIV/AIDS.
14. Establish satellite partnerships for anonymous testing sites within 'hard-to-reach' communities, thus removing the transportation and access barriers to communities outside the downtown core.
15. Ensure that school outreach programming builds and expands on existing sexual health programming.

16. Ensure HIV prevention outreach is conducted at youth hostels and shelters.
17. Establish links to complementary programming that address the social determinants of health, including income, health, and housing needs of Black women.

Address myths, homophobia and stigma

18. Prevention messaging needs to debunk myths about HIV/AIDS.
19. New HIV prevention messaging must not stigmatize PHAs, should be inclusive, and recognize that PHAs may be part of the audience to whom prevention messages are being delivered. The issue of 'positive prevention needs to be considered in the development of new programs.

Consider the following when designing and delivering prevention programs

20. Address the issue of multiple partners from a harm reduction perspective and promote condom use with all sexual partners.
21. Develop updated and age-specific information in an accessible format.
22. Conduct sexual health sessions outside of the school setting, so youth are more receptive to the messaging.
23. Consider peer-based approaches to sexual health education.
24. Incorporate the issues of CSA and IPV into HIV and STI prevention messaging.
25. Address the association between sexual violence and increased HIV/AIDS risk within HIV Prevention programs.
26. Incorporate self-esteem building activities into HIV prevention programming.
27. Negotiation skills should be taught to Black women, especially young Black women, so they can address the issue of safer sex with their partner. This is under the condition that it would pose no safety risk to the woman. Consider educational opportunities for male partners as well.
28. Develop a support program for young Black mothers that incorporates sexual health, coping skills, and self-esteem building.
29. Develop prevention messages that recognize how lesbians are also at significant risk of HIV infection.
30. Incorporate anti-homophobia training into prevention programming.
31. Develop sexual health information that reflects the culture and lifestyle of Black female youth.
32. Develop support resources for children growing up with HIV and include in future HIV Prevention programming information about healthy sexuality for youth growing up HIV positive and how to reduce the stigma that surrounds HIV-positive youth.
33. Sessions should be framed within an overarching health framework that considers the specific health and social issues that Black communities face, including gun violence.
34. Ensure that programming within a community is established in an area that is accessible to all youth regardless of gang or neighbourhood affiliation.
35. Develop accessible information that advises women of their biologically increased susceptibility of contracting HIV.

36. Develop information resources that teaches women how to care for themselves and lower their risk of contracting HIV
37. Properly educated circumcised men or persons considering circumcision as an HIV preventative measure to use additional preventative measures to protect themselves and their partner from transmitting/acquiring HIV.

AREAS REQUIRING FUTURE ACTION

Throughout the consultation process, Black CAP also identified a number of pressing issues in relation to HIV prevention that require a response. While they were not heard in the majority of interviews or especially present in the literature, we have identified these areas as requiring stronger responses, research, and recognition within the broader ASO sector. These areas include:

- Transgendered/Transsexual Women's Issues & Needs – Recognition of and a response to the HIV and STI specific risks that 'trans' women face. These issues were not frequently raised and knowledge or understanding of 'trans' issues is virtually non-existent. Future service responses must recognize the specific needs of Black transgendered/transsexual women who are at significant risk for HIV and STIs.
- Substance Use – the impact of substance use and the relationship between substance use and risk for HIV for heterosexual males and females was not incorporated into mainstream prevention messages.
- Targeted responses to childhood sexual abuse (CSA) and intimate partner violence (IPV); our assessment of these areas indicates that CSA and IPV are increasingly common, therefore, specific strategies must be undertaken to address the specific related risks.

APPENDICES

Appendix 1: List of Interviewees/Organizations

INTERNAL STAKEHOLDERS (Black CAP, APAA, African Health, ACCHO)

1. Shannon Ryan, Executive Director (Black CAP)
2. Michael-Ann George, Outreach Coordinator (Black CAP)
3. Lena Soje, Support Coordinator (Black CAP)
4. Elisa Hatton, Kwanzaa and Yoga Youth Project Coordinator (Black CAP)
5. Keith Cunningham, Peer Outreach Worker (Black CAP)
6. David Lewis, MSM Prevention Coordinator (Black CAP)
7. Fanta Ongoiba, Executive Director (APAA)
8. Twanda Chirenda, Outreach Coordinator (APAA)
9. Rachael Traore, Prevention Coordinator (APAA)
10. Rosemary Erskine, Executive Director (African Health)
11. Jessica Msamba-Lewycky, Prevention Worker (African Health)
12. Esther Amoako, Coordinator (ACCHO)

EXTERNAL STAKEHOLDERS

1. David Parnell, Ontario Gay Men's HIV Prevention Campaign Coordinator, AIDS Committee of Toronto (ACT)
2. LLana James, Provincial Project Coordinator, African and Caribbean Council on HIV/AIDS in Ontario, (ACCHO)
3. Marilyn Oladimeji, President of the Ontario Coalition of Rape Crisis Centres (OCRCC)
4. Anthony (Tony) Caines, AIDS Community Projects Officer, Toronto Public Health AIDS, Prevention Community Investment Program
5. Winston Husbands, Director of Research, AIDS Committee of Toronto (ACT)
6. Peter Newman, Professor of Social Work, University of Toronto
7. Alana Lowe, ReAct Coordinator, Metropolitan Action Committee on Violence Against Women and Children (METRAC)
8. Alice Layiki, Prevention Worker, Somerset West Community Health Centre
9. Philip Banks, Director, AIDS Vancouver
10. Michelle Chai, Community Health Promoter, Planned Parenthood of Toronto (PPT)
11. Rose-Ann Bailey, Youth Program Coordinator, Rexdale Community Health Centre
12. Crystal Layne, Toronto Teen Survey Coordinator, Planned Parenthood Toronto (PPT)
13. Notisha Massaquoi, Executive Director, Women's Health in Women's Hands Community Health Centre (WHIWH)
14. Trevor Gray, Youth Outreach & Education Coordinator, Prisoners HIV/AIDS Support Action Network (PASAN)

15. Rai Reese, Women's Coordinator, PASAN
16. Ken English, Policy Analyst for AIDS Bureau, Community Health Unit, Ministry of Health and Long-Term Care
17. Ben Haughton, Youth Coordinator, ACT
18. Wangari Tharao, Researcher & Health Promoter, WHIWH and ACCHO Co-chair
19. Kerry Carpenter, Community Outreach Worker, WHIWH
20. Ty Smith, Managing Director, T.S. Consulting
21. Rohan Thompson, MAAP Coordinator, North York Community House
22. Diane Dyson, Research Analyst, United Way
23. Catharine Grossie, Registered Nurse, Massey Centre for Women
24. Danielle Layman-Pleet, Executive Director, Voices of Positive Women

Appendix 2: Interview Format/General Questions

1. As (Position) of the (Organization), what is your role?
2. How long has the (Program) been running for? Is it still running?
3. How have you found the responses of the Black communities?
4. What trends have you noticed in the communities you serve, notably, those relating to the Black communities?
5. What issues or needs should I be aware of?
6. Where do you see Black CAP's role in meeting the sexual health needs of (subset of Toronto's Black communities)?
7. Is there any research that your organization has produced in relation to (topic)?
8. Would you be able to sit on an Advisory Committee if one was created for this strategy?
9. Do you see an opportunity to partner with Black CAP?

Appendix III: End Notes

I. Warren-Jeanpiere, L., From Mothers to Daughters: A Qualitative Examination of the Reproductive Health Seeking Behaviour of African American Women Women's Health and Urban Life, Vol. 5 (2), pg. 42-61

II. Mensah, J., Lovell, A., How Do Scarborough's Black Youth Access the Health Care System? Black Health Alliance, November 2005

III. iWyatt, G.E., Carmona, J.V., Loed, T.B., & Williams, J.K., (2005). HIV-Positive Black Women with Histories of Childhood Sexual Abuse: Patterns of Substance Abuse and Barriers to Health Care. Journal of Health Care for the Poor and Underserved 16: 9-23

IV. Toronto Community Health Profiles Partnership.(2004). Teen Births, 1997-2001. Retrieved February 15th 2007 from: http://www.torontohealthprofiles.ca/documents/thematicMaps/621_TeenBirthRateper1000_9701.pdf

V. (2007). HIV Prevention: Male circumcision. Retrieved April 16th 2007, from http://www.unaids.org/en/Policies/HIV_Prevention/Male_circumcision.asp

VI. (2003). Housing and Homelessness Report Card 2003. Retrieved March 20th 2007, from http://www.toronto.ca/homelessness/pdf/reportcard2003.pdf

VII. Ornstein, M. (2000, March). Ethno-Racial Inequality in Toronto - Analysis of the 1996 Census . Ontario Council of Agencies Serving Immigrants. Retrieved March 20th 2007, from http://ceris.metropolis.net/Virtual%20Library/Demographics/ornstein1.pdf

VIII. Statistics Canada. (2003). Statistics Canada: Canada's national statistical agency. Retrieved Mar. 28, 2007, from http://www.statcan.ca/english/freepub/89-614-XIE/2005001/tables/table8.5.htm

IX. Ministry of Health and Long-Term Care and the Public Health Agency of Canada, Ontario Region. (2007). The View from the Front Lines: Summary and Preliminary Analysis of Data Provided by Community-based HIV/AIDS Services in Ontario. Toronto: AIDS Bureau

X. Toronto Community Health Profiles Partnership. (2004). Health and Community Services in Toronto. Retrieved March 15th 2007 from: http://www.torontohealthprofiles.ca/documents/thematicMaps/621_TeenBirthRateper1000_9701.pdf

XI. Remis, R.S., Liu J., (2006, June) Race/ethnicity among persons infected with HIV in Ontario Presented at Community Planning Meeting AIDS Bureau, OMHLTC Toronto, Ontario, Canada. Retrieved January 15th 2007 from Ontario HIV Epidemiological Monitoring Unit (OHEMU) website: http://www.phs.utoronto.ca/ohemu/doc/ethnicity2.pdf

XII. Remis, R.S., Liu, J., (2006, December) The HIV epidemic in Ontario: Update to 2006, Presented at OACHA. Retrieved January 8th 2007 from: http://www.phs.utoronto.ca/ohemu/doc/Epi2006%20Remis%20Dec06.pdf

XIII. Remis, R.S, Marid, M.F., Liu, J., Epidemiologic Characteristics of HIV Infection and AIDS among Women Toronto 1981-2005, Ontario HIV/AIDS Epidemiologic Monitoring Unit, Department of Public Health Sciences, University of Toronto June 2005

XIV. xivRemis, R.S. (2006). Number and proportion of new HIV diagnoses among women by age at diagnosis and 5-year period, Ontario, 1985 to 2005. Unpublished Raw Data

XV. Remis, R.S. (2006). Number and proportion of new HIV diagnoses among women by selected exposure category age at diagnosis and 5-year period, Ontario, 1985 to 2005. Unpublished Raw Data

XVI. Shahin, R., (2007, January). STI Update: January 11 2007. Paper presented at Public Health Toronto STI Update Information session, Toronto, Ontario, Canada

XVII. City of Toronto: Social Policy Analysis & Research (2003, June). 2001 Black Population in the City of Toronto: Persons and % of Total Population by Neighbourhood. Retrieved December 10th 2006 from: http://www.toronto.ca/demographics/atlas/toronto/visibleminority_black.pdf

XVIII. Toronto Community Health Profiles Partnership. (2004). Health and Community Services in Toronto. Retrieved December 10th 2006 from: http://www.torontohealthprofiles.ca/documents/thematicMaps/Map03_PercPopLE19_2001.pdf

Appendix IV: References

1. (2001). Statistics Canada. Retrieved January 15th 2007 from: http://www12.statcan.ca/english/census01/Products/Analytic/companion/etoimm/subprovs.cfm#toronto

2. (2003). Housing and Homelessness Report Card 2003. Retrieved March 20th 2007, from http://www.toronto.ca/homelessness/pdf/reportcard2003.pdf

3. (2005). Income of Black Women in Canada. Canadian Association for Social Workers

4. (2007). HIV Prevention: Male circumcision. Retrieved April 16th 2007, from http://www.unaids.org/en/Policies/HIV_Prevention/Male_circumcision.asp

5. (2007, March 28). WHO and UNAIDS announce recommendations from expert consultation on male circumcision for HIV prevention. Retrieved April 16th 2007, from http://www.who.int/mediacentre/news/releases/2007/pr10/en/index.html

6. Beard, H. (2005). Getting Real: Black Women Taking Charge in the fight against AIDS. Retrieved December 10th 2006 from Black AIDS Institute Website: http://www.blackaids.org/image_uploads/article_170/05%20women.pdf

7. Canadian HIV/AIDS Legal Network. (2005, February). Women prisoners and HIV/AIDS (Info Sheet 11). Retrieved March 27 2007, from http://www.aidslaw.ca/publications/interfaces/downloadFile.php?ref=710

8. Caribbean Community Secretariat (CARICOM), & Pan American Health Organization (PAHO). (2006). Report of the Caribbean Commission on Health and Development. Ian Randle Publishers.

9. Chang, V.Y., Bendel, T.L., Koopman, C., McGarvey, E.L., & Canterbury, R.J. (2003). Delinquents' Safe Sex Attitudes: Relationships with Demographics, Resilience Factors, and Substance Use. Criminal Justice and Behaviour, 30(2) 210-229

10. Coghlan, M., Hyman, I., & Mason, R. (2006, December) Perceptions of Intimate Partner Violence (IPV) among young Canadian women. Women's Health and Urban Life, Vol. 5 (2), 62-83. Retrieved January 15th 2007 from http://hdl.handle.net/1807/9494

11. Fulco, T.F., James, C.A., Hart, T.A., Roberts, K.E., Hagan, C.M.P., Wekerle, C., & the MAP Team. (2006, November) Child sexual abuse (CSA) as a predictor of adolescent sexual risk behavior among female youth in the Canadian Child Welfare System. Paper presented at the research conference of the Ontario HIV Treatment Network, Toronto, Ontario, Canada

12. Hay, T., Allen, D. (1997) Child Sexual Abuse: Fact Sheet. Retrieved January 15th 2007 from Public Health Agency of Canada Website: http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/html/nfntsxagrsex_e.html

13. Heise, L., Ellsberg, M. and Gottemoeller, M. (1999). Ending Violence Against Women. Population Reports, Series L, No. 11.

14. Husbands, W. (2006, November) Living, Learning and Serving: Responding to HIV/AIDS in Racialized Communities. Charles Roy Memorial Lecture presented at Ontario HIV Treatment Network Research Conference, Toronto, Ontario, Canada.

15. James, L. (2006) HIV Prevention Guidelines and Manual: A Tool for Service Providers serving African and African Caribbean Communities Living in Canada Toronto: Women's Health In Women's Hands & African Caribbean Council on HIV/AIDS in Ontario

16. Kaushic, C. (2007). Increased susceptibility to HIV Infection in Women: Biological considerations. Unpublished paper, McMaster University, 2007.

17. Lawson, E., Gardezi, F., Calzavara, L., Husbands, W., Myers, T., Tharao, W.E., (2006) HIV/AIDS Stigma, Denial, Fear and Discrimination: Experiences and Responses of People from African and Caribbean Communities in Toronto, The African and Caribbean Council on HIV/AIDS in Ontario (ACCHO), and The HIV Social, Behavioural and Epidemiological Studies Unit, University of Toronto

18. Mensah, J., & Lovell, A. (2005). How Do Scarborough's Black Youth Access the Health Care System? Toronto: Black Health Alliance

19. Ministry of Health and Long-Term Care and the Public Health Agency of Canada, Ontario Region. (2007). The View from the Front Lines: Summary and Preliminary Analysis of Data Provided by Community-based HIV/AIDS Services in Ontario. Toronto: AIDS Bureau

20. Newman, P., Williams, C., Massaquoi, N., Sakamoto, I. (2006) Sisters, Mothers, Daughters & Aunties: Protecting Black Women from HIV. Unpublished Raw Data

21. Ornstein, M. (2000, March). Ethno-Racial Inequality in Toronto - Analysis of the 1996 Census . Ontario Council of Agencies Serving Immigrants. Retrieved March 20th 2007, from http://ceris.metropolis.net/Virtual%20Library/Demographics/ornstein1.pdf

22. Raj, A., Santana, C., La Marche, A., Amaro, H., Cranston, K. & Silverman, J.G. (2006) Perpetration of Intimate Partner Violence Associated With Sexual Risk Behaviors Among Young Adult Men. American Journal of Public Health, 96(10), 1873-1878.

23. Reitz, J. G. (2005, February). Tapping Immigrants' Skills:New Directions for Canadian Immigration Policy in the Knowledge Economy. Institute for Research on Public PolicyIRPP Choices, 11. Ontario Council of Agencies Serving Immigrants. Retrieved March 20th 2007, from http://migration.ucdavis.edu/rs/images/uploads/1._J_REITZ_2_CHOICES

24. Remis, R.S., Liu J., (2006, June) Race/ethnicity among persons infected with HIV in Ontario Presented at Community Planning Meeting AIDS Bureau, OMHLTC Toronto, Ontario, Canada. Retrieved January 15th 2007 from Ontario HIV Epidemiological Monitoring Unit (OHEMU) website: http://www.phs.utoronto.ca/ohemu/doc/ethnicity2.pdf

25. Remis, R.S., (2001, November) Epidemiology of HIV infection among persons from HIV-endemic countries in Ontario Data presented to Community Forum, Ontario HIV Endemic Task Force, Toronto, Ontario, Canada. Retrieved January 8th 2007 from: http://www.phs.utoronto.ca/ohemu/doc/Pres011_CF.ppt

26. Remis, R.S., Liu, J., (2006, December) The HIV epidemic in Ontario: Update to 2006, Presented at OACHA. Retrieved January 8th 2007 from: http://www.phs.utoronto.ca/ohemu/doc/Epi2006%20Remis%20Dec06.pdf

27. Remis, R.S, Marid, M.F., Liu, J., Epidemiologic Characteristics of HIV Infection and AIDS among Women Toronto 1981-2005, Ontario HIV/AIDS Epidemiologic Monitoring Unit, Department of Public Health Sciences, University of Toronto June 2005

28. Remis, R.S. (2006). Number and proportion of new HIV diagnoses among women by age at diagnosis and 5-year period, Ontario, 1985 to 2005. Unpublished Raw Data

29. Remis, R.S. (2006). Number and proportion of new HIV diagnoses among women by selected exposure category age at diagnosis and 5-year period, Ontario, 1985 to 2005. Unpublished Raw Data

30. hahin, R., (2007, January). STI Update: January 11 2007. Paper presented at Public Health Toronto STI Update Information session, Toronto, Ontario, Canada

31. Toronto Community Health Profiles Partnership. (2004). Health and Community Services in Toronto. Retrieved December 10th 2006 from: http://www.torontohealthprofiles.ca/documents/thematicMaps/Map03_PercPopLE19_2001.pdf

32. Toronto Community Health Profiles Partnership.(2004). Teen Births, 1997-2001. Retrieved February 15th 2007 from: http://www.torontohealthprofiles.ca/documents/thematicMaps/621_TeenBirthRateper1000_9701.pd

33. Toronto Community Health Profiles Partnership. (2004). Health and Community Services in Toronto. Retrieved March 15th 2007 from: http://www.torontohealthprofiles.ca/documents/thematicMaps/621_TeenBirthRateper1000_9701.pd

34. Toronto HIV/AIDS Commuity Planning Initiative. (2007). Toronto HIV/AIDS Community Planning Initiative (TCPI): Final Draft Report.

35. Trocmé, N., & Wolfe, D. (2001) Child Maltreatment in Canada: Selected Results from the Canadian Incidence Study of Reported Child Abuseand Neglect. Ottawa, Ontario: Minister of Public Works and Government Services, Canada.

36. Warren-Jeanpiere, L., (2006) From Mothers to Daughters: A Qualitative Examination of the Reproductive Health Seeking Behaviour of African American Women Women's Health and Urban Life, Vol. 5 (2), pg. 42-61

37. Whyte, IV, J. (2006). Sexual Assertiveness in Low-Income African American Women: Unwanted Sex, Survival and HIV-Risk. Journal of Community Health Nursing, 23(4), pp. 235-244.

38. WHO/UNAIDS Technical Consultation. (2007, March 28). New Data on Male Circumcision and HIV Prevention: Policy and Programme Implications. UNAIDS. Retrieved April 16th 2007, from http://data.unaids.org/pub/Report/2007/mc_recommendations_en.pdf

39. Williams, C., Massaquoi, N., (2007). Access to Primary Healthcare for Black Women and Women of Colour. Report for Ministry of Health and Long-Term Care

40. Wyatt, G.E., Carmona, J.V., Loed, T.B., & Williams, J.K., (2005). HIV-Positive Black Women with Histories of Childhood Sexual Abuse: Patterns of Substance Abuse and Barriers to Health Care. Journal of Health Care for the Poor and Underserved 16: 9-23

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