MAKING COMMUNITIES STRONGER:

Engaging African Communities in a Community Response to HIV/AIDS in Calgary

FINAL REPORT

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EXECUTIVE SUMMARY

Developing appropriate HIV/AIDS prevention, treatment, care, and support programs for African newcomer communities in Alberta is of growing concern. In Alberta, the proportion of new HIV cases reported amongst individuals of "Black" ethnicity rose from 5.0% in 1998 to 29.9% in 2008. People from HIV-endemic countries living with, and affected by, HIV/AIDS face language, cultural and social barriers beyond those faced by Canadian-born people affected by HIV/AIDS.

The *Making Communities Stronger: Developing HIV/AIDS Services for African Newcomer Communities in Calgary* study had three main goals. First, the study aimed to understand the HIV/AIDS service needs and priorities of African newcomers in Calgary. Second, the study explored how these needs could be met in conjunction with other African newcomer service priorities such as housing, education, and employment security. The third goal of the study was to ascertain the most appropriate ways for AIDS service organizations (ASOs) in Calgary to engage African newcomer communities in the design and delivery of HIV/AIDS services. The study was a partnership between AIDS Calgary Awareness Association and the Faculty of Social Work, University of Calgary. The research team was guided by a Community Advisory Committee.

Research Methods

The study used community-based research principles and pragmatic qualitative research methods. The study consisted of three inter-related components: (a) working with the Advisory Committee to develop strategies for engaging African newcomers; (b) confidential semi-structured interviews with 41 African newcomers from 15 African countries; and (c) 3 focus groups with 17 allied professionals who provide services to immigrants and refugees in Calgary plus six phone interviews with Canadian researchers and service providers who had already developed and delivered HIV services for newcomers from HIV endemic countries.

Results

Interview Results
Of the 41 participants, 24 (59%) were male and 17 (41%) were female. The age of the participants ranged from 18 to 65, with the majority (71%) in the 34-49 age group. Twenty-three of the 41 participants had either completed some university courses or graduated from university.

HIV/AIDS services development needs to be understood in the context of significant issues members of African communities encounter when settling in Canadian society. Interview respondents identified the following major challenges: adapting to Canadian culture and practices; the change in gender roles; intergenerational conflict; feelings of social isolation and lack of support that would traditionally be provided by the extended family, and the experience of racism. Considerable attention was also given to employment challenges.

Interview participants identified five major issues with respect to use of HIV/AIDS services and supports, including cultural influences and help-seeking behavior; social stigma; stigma and discrimination from health care professionals; lack of knowledge about available services and supports; and issues of confidentiality.

Risk factors identified by participants that could make African newcomer communities vulnerable to HIV/AIDS included denial of HIV; lack of awareness of HIV transmission, prevention and treatment; low perception of HIV risk; inconsistent condom use; lack of family and community dialogue; and concerns specific to women and youth.

Focus Groups Results
Three focus groups were conducted with a total of 17 service providers from health, social, and immigrant-serving agencies. The two major themes that emerged from the analysis of the focus group data included issues related to the provision of HIV/AIDS services to African newcomer communities, and recommendations for engaging with African newcomer communities in order to improve the provision of services to community members.

Consultative Interviews – Service Providers and Researchers
The six interview participants engaged in work with African, Caribbean and Black communities in other regions of Canada stressed the need to work in collaboration with communities to develop and deliver appropriate HIV/AIDS services, the cultural sensitivity required to address issues of HIV transmission risk, and the need to integrate HIV/AIDS prevention program offerings with other health and immigrant services to reduce stigma and barriers to service access.

Strategic Directions

The results of this study indicate that the challenge of HIV in Calgary's African newcomer communities is a complex one rooted in culture, awareness, understanding, communication and community. In summary, the key strategic directions include addressing HIV/AIDS service needs and priorities of African newcomers; meeting these needs in conjunction with other African newcomer service priorities; and appropriately engaging African newcomer communities in the design and delivery of HIV/AIDS services.

The HIV/AIDS service needs and priorities of African newcomers that need to be addressed included community education to raise awareness of HIV risk; HIV prevention education; provision of information about available services; creation of accessible and culturally appropriate services; and reduction of stigma both in newcomer communities and health care settings in order to reduce barriers to accessing services.

Recommendations for appropriately engaging African newcomer communities in the design and delivery of HIV/AIDS services included supporting leadership in the newcomer communities to increase dialogue and awareness about HIV; providing HIV education and outreach services in community-based settings; translating HIV/AIDS materials into key languages; increasing access to confidential translation services; providing culturally appropriate social marketing materials and presentations; and providing cultural competency training to service providers to increase cultural competency.

INTRODUCTION

Calgary has experienced high population growth in the last several years, and the foreign-born population[1] has added to this increase. In 2006, there were an estimated 252,800 foreign-born residents in Calgary, up from 197,400 in 2001 (Statistics Canada, 2007). Of the nine countries from which there was increased immigration to the Calgary area between 1992 and 2002, three are classified as HIV-endemic, namely Nigeria, Sudan, and South Africa (Statistics Canada, 2007). There are also large newcomer groups from Somalia and Ethiopia living in Calgary (Statistics Canada, 2004). A census estimate of population groups from HIV-Endemic Countries found that in 2006, Calgary had approximately 16,415 residents from HIV-Endemic Countries in Africa, 6,095 residents from HIV-endemic countries in the Caribbean, Bermuda, Central and South America and 2,380 from HIV-endemic countries in Asia (Ali, Aslam, Ogunnaike-Cooke, Boulos, & Archibald, 2009). Overall, the proportion of Alberta's population that originated from HIV-endemic countries was 1.6% in 2006 (Ali et al., 2009).

In Alberta, the proportion of new HIV cases reported amongst individuals of "Black" ethnicity rose from 5.0% in 1998, to 11.2% in 2003, to 29.9% in 2008. In addition, in 2008 50.6% of newly diagnosed cases of HIV among females in Alberta were attributed to origin from a country where HIV is prevalent (or "endemic") (Alberta Health and Wellness, 2009; Falconer & Associates, 2008; Public Health Agency of Canada, 2007; Simmonds, Jasperson, & Kruszynski, 2004). The number of the Southern Alberta Clinic's HIV patients from Africa continues to grow (Krentz & Gill, 2009), and AIDS Calgary has collected demographic data that indicate 14% of its active registered clients self-identified as "Black" in 2007/08. Though most of these data do not indicate if these individuals are specifically from HIV-endemic countries, the epidemiologic data strongly suggest that African newcomer communities are a population in Alberta that requires its unique HIV prevention and care service needs to be addressed. People from HIV-endemic countries living with, and affected by, HIV/AIDS face language, cultural and social barriers beyond those faced by Canadian-born people affected by HIV/AIDS (African and Caribbean Council on HIV/AIDS, 2003).

AIDS Calgary Awareness Association is a community-based non-profit agency that has been providing services to the Calgary community since 1983. The organization works to reduce the harm associated with HIV/AIDS by promoting awareness and understanding of HIV/AIDS issues, providing HIV prevention and education, providing support and advocacy on behalf of people living with HIV, and building community capacity in these areas. AIDS Calgary provides HIV/AIDS prevention, education, care and support services. As the Calgary region becomes more ethno-culturally diverse, the complexity of HIV/AIDS service needs continues to increase. AIDS Calgary has responded to the changing HIV/AIDS epidemic throughout its history and remains committed to responding to the growing diversity and needs of the populations it serves (AIDS Calgary Awareness Association, 2005).

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[1] Foreign-born population (also known as the immigrant population) is defined in the 2006 Census as persons who are, or who have been, landed immigrants in Canada. Statistics Canada's definition of the foreign-born population does not include non-permanent residents, who are persons in Canada on employment or student authorizations, or are refugee claimants. The foreign-born population also excludes persons born outside Canada who are Canadian citizens by birth. The latter are considered part of the Canadian-born or non-immigrant population (Statistics Canada, 2007).

In 2005, the Calgary Coalition on HIV and AIDS (CCHA) conducted a service provider consultation in which it was identified that significant needs and challenges exist in Calgary with respect to serving people coming from HIV-endemic countries (Calgary Coalition on HIV/AIDS, 2005). In order to develop and provide appropriate supports to people from Nigeria, Sudan, South Africa, Somalia, Ethiopia, and other sub-Saharan African countries that are living with, and affected by, HIV/AIDS it was clear that specific communities must be consulted in order to assess the community needs with respect to HIV prevention, care and support. AIDS Calgary started this process by commissioning an environmental scan to assess the feasibility of engaging people from HIV endemic countries that are living with, and affected by, HIV/AIDS in a dialogue about their needs for prevention, support and outreach services (Patten, 2005). Using this environmental scan as a foundation, AIDS Calgary partnered with Dr. Catherine Worthington and Dr. David Este of the University of Calgary, Faculty of Social Work to create a more comprehensive community-based study to address the following research questions:

1. What are the HIV/AIDS service needs and priorities of African newcomers[2]?
2. How can these needs be met in conjunction with other African newcomer service priorities such as housing, education, and employment security?
3. What are the most appropriate ways for AIDS service organizations (ASOs) in Calgary to engage African newcomer communities in the design and delivery of HIV/AIDS services?

AIDS Calgary and the University of Calgary, Faculty of Social Work were able to secure funding from the Canadian Institutes of Health Research (CIHR) HIV/AIDS Community-Based Research Program to carry out this study. This report presents a brief summary of the study background and relevant literature, research methods, results, and key strategic directions resulting from the study.

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[2] For the purposes of this study, the definition of 'newcomers' is the same as that used by Statistics Canada (2007) for 'recent immigrants', which refers to landed immigrants who came to Canada up to five years prior to a given census year. For the 2006 Census, recent immigrants are landed immigrants who arrived in Canada between January 1, 2001 and Census Day, May 16, 2006. Similarly, recent immigrants in the 2001 Census were newcomers at the time of the 2001 Census, i.e., they came to Canada between January 1, 1996 and Census Day, May 15, 2001.

STUDY BACKGROUND and LITERATURE REVIEW

Early studies in the area of HIV and AIDS with newcomers to Canada from Africa and the Caribbean emerged during the 1990s (Adrien, Godin, Cappon et al., 1996; Cappon, Adrien, Godin et al., 1996; Nakyonyi & Africans United to Control AIDS, 1993; Remis & Whittingham, 1999; Singer, Willms, Adrien et al., 1996). The majority of the research was conducted in Toronto, Montreal, Ottawa and Vancouver and included work with immigrants, refugees and refugee claimants from African and Caribbean countries with high HIV prevalence rates ("endemic" regions, defined as those with HIV prevalence rates of 1.0% or over and where over 50% of cases are attributed to heterosexual transmission) (Adrien et al., 1996; McMunn, Mwanje, Paine, & Pozniak, 1998; Remis, Eason, Palmer et al., 1995; Remis & Whittingham, 1999; Willms, Singer, Adrien et al., 1996). These studies noted the importance of not only understanding the demographics of HIV rates among African newcomers in Canada, but also the relevance of personal, socio-cultural, and structural factors affecting HIV transmission (Cappon et al., 1996; Nakyonyi & Africans United to Control AIDS, 1993; Singer et al., 1996; Stewart, Falconer, & The Black Coalition For AIDS Prevention, 1992).

While no formal studies had been conducted on perceptions of HIV/AIDS in African immigrant communities in Calgary, the environmental scan conducted by AIDS Calgary (Calgary Coalition on HIV/AIDS, 2005) as well as other community and research initiatives in Alberta and other regions of Canada, provided background information to help frame this study. The literature reviewed here encompasses the following issues: acculturation and health issues for African newcomers; cultural norms about gender and sexuality; recognition of HIV/AIDS as an issue within African newcomer communities and stigma; perceptions of HIV/AIDS and risk-taking behaviours in newcomer communities; and use of HIV testing and treatment services.

Acculturation, Health and Newcomers

Culture is a central consideration for the study of HIV/AIDS when considering immigrant populations. Culture provides a framework through which people understand and respond to the world around them by providing beliefs, values, and attitudes that shape the lives they lead. Acculturation consists of social and psychological exchanges that take place between individuals of different cultures (Berry, 1998; Ryder, Alden, & Paulhus, 2000). While influences between cultures do not occur in one direction only (from dominant culture to newcomer culture), the newcomer experience is the most relevant for this study. Those who move to a new country or culture balance values and roles from their culture of origin and the new or host culture, and tensions are produced by the acculturation process (Ryder et al., 2000). The resulting role and value conflicts are important when considering HIV services program design. Given our emphasis in this study on building an understanding of HIV health needs in the context of other health and social service needs and priorities, Berry's acculturation model was particularly useful, as it situates the acculturation process within a stress and coping model (Berry, 1997, 1998; Lazarus & Folkman, 1984). According to this perspective, the acculturation process entails the learning of new behaviours, attitudes, and values that the individual needs to incorporate into his or her everyday existence to function in a new environment. This learning process can produce levels of

stress that an individual needs to resolve. How the individual copes with stressors is theorized to determine how the individual adapts.

Despite widespread acceptance of the "healthy immigrant effect", which proposes that immigrants as a group are healthier than other Canadians, this advantage seems to disappear over time (Hyman, 2004). According to a study based on data from the National Population Health Survey, non-Europeans who immigrate to Canada experience a decline in their health status after they arrive in Canada (Ng, Wilkins, Gendron, & Berthelot, 2005). In addition, refugees have, by definition, suffered unusual stresses and assaults on their health prior to coming to Canada and are particularly vulnerable to infectious diseases (Beiser, 2005; DesMueles, Gold, Kazanjian et al., 2004; Ng et al., 2005). Other health problems may be due to the stress of immigration itself, which involves finding suitable employment and establishing a new social support network. The likelihood of deterioration in health is also related to socio-economic status, specifically, low education and low household income. Research in Calgary has identified racism as a pervasive factor affecting employment, housing access, social services access and educational systems engagement for members of minority ethno-cultural groups. In 2003, a community-based study addressing the issues impacting the health and well-being of newcomers in Calgary (Este, Bentley, & Kuol, 2003) found that of the 62 participants, 37% reported that they had experienced racism in general, and 18% experienced limited employment opportunities even though they were well educated. The African Canadian participants reported that these issues had an impact on their well-being in terms of low self-esteem (21%), stress caused by unemployment (13%), general stress (13%) and family stress (10%). Another way in which racism and discrimination may affect newcomers is through access to housing. One study in Calgary found discrimination in the housing market to be the most formidable barrier faced by Black African immigrants in Calgary (Danso & Grant, 2000).

The African newcomers of interest for this study are relatively new to Calgary and thus, many of these newcomer communities in Calgary are not well established. As a result, new immigrants and refugees from these communities may need to rely more heavily on formal support services rather than informal community supports. However, health prevention and treatment services are currently failing many immigrant communities (Committee for Accessible AIDS Treatment, 2006; Tharao & Massaquoi, 2000). Research has documented that immigrants to Canada are less likely than their native-born counterparts to benefit from either prevention or treatment services, because of various factors including linguistic and cultural differences, lack of information or misinformation, and services that do not meet immigrants' needs. Immigrants may be uncertain about how to access the health and social services they need for several reasons, including problems accessing transportation, language barriers, and a lack of knowledge of the importance of the services (Calgary Health Region, 2005). Some newcomers may not have the English proficiency to understand health care issues as presented by health professionals (Health Canada, 2001). Furthermore, newcomers may feel that is culturally inappropriate to openly discuss health issues related to sexuality or to seek information about HIV prevention (Williams, Newman, Sakamoto, & Massaquoi, 2009).

Cultural Attitudes toward Gender and Sexuality

Cultural attitudes toward gender and sexuality among African newcomer communities are important to understand in order to develop and provide appropriate health and HIV services. The prevention and treatment of HIV requires some degree of openness in discussions about sexuality and sexual behaviour. However, the HIV Endemic Task Force (HETF) in Ontario (now known as the African and Caribbean Council on HIV/AIDS in Ontario or ACCHO) reported that in some cultures, discussion of sexuality and sex is taboo (Handa & Nagash, 2003). Among some African communities, there is acceptance of extra-marital sexual relations for men, but not for women (Gardezi, Calzavara, Husbands et al., 2008; UNAIDS, 2004). Homophobia among African newcomer communities may also create risk situations for gay men or men who have sex with men and, if they are married, their spouses (African and Caribbean Council on HIV/AIDS, 2003). In addition, religious beliefs and institutions may reinforce cultural attitudes towards HIV, sexuality, and homosexuality in particular (Williams et al., 2009). Men in marginalized groups face great difficulties with respect to HIV. For example, African-American gay men and men who have sex with men experience inadequate HIV/AIDS services, as well as significant levels of discrimination (Bing, Bingham, & Millett, 2008). Homophobia has been commonly identified in African communities (amongst others) and is known to be a major source of stigma for both HIV-positive men and women. It can be especially troubling for men living with HIV/AIDS (Tharao, Massaquoi, & Telcom, 2006). With the exception of some limited knowledge of the experiences of African–American gay men and men who have sex with men who are living with HIV/AIDS (Bing et al., 2008), relatively little is known about the sexual norms, beliefs and decision-making processes of men of African descent, especially those men who have sex with men.

Social values, norms and expectations based on gender vary across cultures. Some African cultures maintain social and religious values regarding gender and sexuality that establish different standards for men and women, which have resulted in gender inequalities that have significant implications for women's health, including their vulnerability to HIV infection (Jarama, Belgrave, Bradford, Young, & Honnold, 2007). Women are over-represented among persons living with HIV from African and Caribbean countries with high HIV prevalence rates (Centre for Infectious Disease Prevention and Control, 2005; Public Health Agency of Canada, 2005, 2007). Women's increased vulnerability to HIV/AIDS is the result of both biological susceptibilities and a multitude of personal, social and structural factors. Gender violence and disempowerment of women may have significant implications for women's ability to exercise sexual control. In strong patriarchal cultures, newcomer women are particularly vulnerable to HIV risk as they may have to deal with domestic violence and other forms of disempowerment which can result in an inability to raise issues of sexuality, fidelity of partners, or condom use (Gardezi et al., 2008; Keeping, 2004; Tharao, Massaquoi, & Brown, 2004). As a result, inequality in sexual negotiations has been found to significantly determine women's heightened risk of HIV infection (Williams et al., 2009). Other factors placing women from African countries at greater risk for infection include cultural practices such as female genital mutilation and vaginal cleansing (Tharao et al., 2006). In addition, studies in Canada have found economic dependency and poverty to be barriers preventing women from accessing services and leaving relationships that put them at risk for HIV infection. Intervention programs must therefore address racism, sexism

and poverty in order to holistically prevent HIV transmission (Newman, Williams, Massaquoi, Brown, & Logie, 2008). Based on these findings, it has been recommended that AIDS service organizations and other community-based organizations provide holistic healthcare services that address personal, structural and socio-cultural barriers affecting Black women in North America (Williams, Newman, & Massaquoi, 2006).

Recognition of HIV/AIDS as an Issue and Stigma

During the environmental scan in 2005, AIDS Calgary conducted an informal survey with some key immigrant-serving organizations in the Calgary area to assess their general ability to respond to the HIV/AIDS-related concerns of their target populations. Responses from the small sample of organizations indicated that (a) the organizations did not recognize HIV/AIDS as an issue affecting their immigrant clients and (b) immigrant community members from African countries did not access these organizations for HIV/AIDS services or information (Patten, 2005). This finding is consistent with national level findings. While epidemiological data indicate that nationally the proportion of HIV test reports attributable to the HIV-endemic exposure category is on the rise (Public Health Agency of Canada, 2007), less than 50% of key informants from Caribbean and African communities in Canada considered it was having a great to extreme impact on their communities (Health Canada, 2000).

HIV/AIDS-related stigma experienced by newcomers from African and Caribbean countries has been the focus of several studies in Canada, as well as the United States and England (Cyr, Thompson, Gilmore, Duchesneau, & Ankouad, 2006; Gardezi, Calzavara, Lawson et al., 2006; Mitra, Jacobsen, O'Connor, & Tugwell, 2006). One of the most common themes found in the experiences of participants in these studies was the racialization of HIV as a Black or "African disease" because Black and African people are portrayed in the media and public institutions as carriers of the virus (Miller, 2005). This racialization was described as a negative factor preventing individuals from seeking prevention and intervention services (Gardezi et al., 2006; Husbands, 2006).

Additional factors stigmatizing, isolating and silencing HIV positive newcomers within their communities include cultural and social norms, as well as religious beliefs (Lawson, Gardezi, Calzavara et al., 2006a). Community members view HIV as a taboo subject and may be afraid of broaching the subject, or disclosing their positive status, for fear of being abandoned by their community for doing so (Tharao et al., 2006). In their countries of origin, HIV positive individuals historically have been at risk for many negative consequences, including abandonment by family and friends, discrimination at work, loss of land or children, and violence and abuse (UNAIDS & World Health Organization, 2001). A study conducted in Toronto examined the sources of HIV denial and stigma and the mechanisms by which these are perpetuated among African newcomer communities (Beyene, 2000; Gray, Calzavara, Tharao et al., 2006). The research revealed that even though individuals in African newcomer communities are accessing HIV testing there are still issues surrounding confidentiality and anonymity that call for education and advocacy around HIV testing practices (Gray et al., 2006; Gray, Calzavara, Tharao, & East African Study Team, 2004; Gray, Calzavara, Tharao et al., 2007).

Perception of HIV and Risk Behaviours

Many African newcomers in Canada perceive themselves to have a low risk of HIV infection for a variety of reasons, including misperceptions about HIV in Canada, lack of knowledge about HIV transmission, and lack of culturally appropriate prevention services (Gardezi et al., 2008). Some recent Canadian studies indicate that newcomers from African and Caribbean countries view Canada as being free from HIV and AIDS while others are unaware of the means of HIV transmission or prevention (James & African and Caribbean HIV/AIDS Community Capacity Building Project, 2006; Tharao et al., 2006). In addition, when immigrants are geographically separated from their partners, they may engage in sexual risk behaviours with other partners and may be unaware of the need to negotiate safer sex. Travel to their countries of origin with high HIV prevalence rates may also increase opportunities for risk of infection (Fenta, 2001; Gray et al., 2006).

Use of HIV Testing and Treatment Services

HIV testing is an important component of HIV prevention and care services, but it appears that awareness and use of HIV testing is an issue among African newcomers to Calgary. In AIDS Calgary's environmental scan (Patten, 2005), community members and organizations identified that there is lack of awareness of the availability of free and confidential HIV testing amongst immigrants. HIV testing of immigrants to Canada began in 2001; people who immigrated to Canada prior to this date would not necessarily know their HIV status (Krentz & Gill, 2009). Immigrants or refugees from countries without public health care systems may be inexperienced in accessing free and confidential HIV testing services and may not understand their rights with respect to HIV testing.

As with HIV testing, the environmental scan conducted by AIDS Calgary indicated that among African newcomers to Calgary there is a general lack awareness of the availability of, and how to gain access to, HIV treatment for those living with HIV (Patten, 2005). Immigrants from most HIV-endemic countries may be unfamiliar with public health care provision of medications and HIV treatment, have difficulty locating needed services from different AIDS service organizations and other community-based organizations, or experience a lack of opportunities for peer support (Tharao & Massaquoi, 2001; Williams et al., 2006). In addition, they may not have an accurate understanding of their rights to access health services due to complex immigration and refugee policies (Inigo & Li, 2006). As noted earlier, based on previous research, it is likely that people living with HIV/AIDS within African newcomer communities may fear alienation from community members or deportation. They may face racism, lack of employment or underemployment, low access to affordable housing, poverty, addiction, violence, mental health concerns, lack of access to financial assistance, insensitive health care professionals, and stigma. Significantly, such factors also make it difficult for them to access services (Antle, Donoghue, Shindler, Laziri, & Porter, 2006; Stakeholders Involved in the Canadian Response to HIV/AIDS, 2005; The Immunodeficiency Service, 2007). There may also be fears about lack of confidentiality in HIV treatment services. In addition, AIDS service organizations may make some African people uncomfortable due to their appearance of focusing on gay men or injection drug users (Health Canada, 2000).

Other projects undertaken in Alberta prior to this study have documented the challenges and successes in increasing use of available HIV/AIDS services. In 2004-05, the African Canadian Society of Alberta led a project to improve knowledge, attitudes and practices of African immigrants in Edmonton with respect to HIV/STI (sexually transmitted infections) transmission and prevention and to establish a referral system to HIV testing, treatment and support services like HIV Edmonton, Community Public Health Centres, STI Clinics, and HIV Clinics. The African Canadian Society of Alberta learned that students were the most receptive audiences for HIV/AIDS information and that people living with HIV within African communities were very reluctant to access treatment, care or support services due to fears of lack of confidentiality and discrimination.

Implications for Our Study

The existing research literature and previous work in Alberta highlight the unique concerns and challenges of African newcomer communities and service providers in the face of HIV/AIDS. The rising number of new HIV infections among people who identify as "Black" in Alberta is a strong indicator that HIV is a significant issue and service needs are growing in this population. In contrast, newcomer communities and some service providers do not appear to recognize HIV as a pressing issue in their communities, which underscores the importance of developing culturally sensitive HIV prevention education, testing and treatment services in Calgary. Thus, in this study, we approached the issue of HIV/AIDS within the context of the acculturation process and broader health and social issues. In addition to investigating HIV/AIDS service needs and priorities of African newcomers to Calgary, we also examined how these needs can be met within the context of newcomer priorities, and we investigated strategies for the most appropriate ways for AIDS service organizations in Calgary to engage African newcomer communities. In interviews and focus groups, HIV/AIDS was not addressed in isolation and was not the sole focus of the discussion, but was addressed within a network of concerns and issues. We also took great care to engage respected community leaders as key informants in a confidential and respectful manner to minimize any potential impact of HIV stigma or sensitivities around discussion of sexuality, racism, or the acculturation process. Also, we tried to engage with male and female community leaders from many cultural groups, to acknowledge differences between cultural groups and gender roles and norms. Thus, insights from the literature were used to inform and enhance our research design, methodology and community engagement processes throughout the study.

RESEARCH METHODS

The *Making Communities Stronger: Engaging African Communities in a Community Response to HIV/AIDS in Calgary* was the first comprehensive research study in Calgary to explore the HIV/AIDS service needs of African newcomers to Calgary, how these needs could be met in conjunction with other newcomer priorities, and strategies for community engagement in service development. This study used qualitative research methods within a community-based research framework. In order to achieve the study goals to (1) describe the HIV/AIDS service needs and priorities of African newcomers to Calgary, (2) investigate how these needs can be met in conjunction with other African newcomer priorities, and (3) determine the most appropriate ways for AIDS service organizations to engage African newcomer communities in the design and delivery of HIV/AIDS services, the study consisted of three inter-related components: (a) development of strategies for engaging African newcomers in discussions about their perceptions, priorities, and service needs related to HIV/AIDS; (b) confidential semi-structured interviews with African newcomers; and (c) focus groups and interviews with allied professionals who provide services to immigrants and refugees in southern Alberta and other regions of Canada. Through the use of a qualitative approach, a variety of perspectives on Calgary's HIV/AIDS health and social services were gathered. While these views should not be considered representative of all African newcomer and service provider views in Calgary, they do offer guidance on factors to be considered in services planning.

This section of the report describes the research methods that were used to conduct this study. Initially, a brief description of the study's research approach is presented followed by a description of the strategies used to engage individuals from various African newcomer communities in the city. The sampling approaches employed by the research team are then described, followed by data collection and data analysis methods utilized, steps taken to ensure the trustworthiness of the results, and research ethics considerations. The section concludes with comments on the limitations of the study.

Research Approach

Community-based research (CBR) refers to an approach to research that is guided by the needs of a community and directly involves the community in the planning and implementation of scientifically accepted research methods. CBR focuses on community issues through interaction with community members, organizational representatives and researchers who work in collaboration on all aspects of the research process (Flicker, Savan, Kolenda, & Mildenberger, 2008). All members involved in the process contribute their expertise to enhance understanding of the issue and integrate this knowledge with action to benefit the community. Community-based research builds upon the strengths and resources within the community, and facilitates partnerships throughout the research process. This study was a partnership between AIDS Calgary and academics at the University of Calgary, Faculty of Social Work. The research team was guided in all aspects of the study by an Advisory Committee made up of community members and service providers.

Developing Engagement Strategies – Advisory Committee

A study Advisory Committee was formed in order to ensure that the study would effectively engage African community members and that the results would be useful for African communities and agencies serving these communities. Representatives from ethno-cultural associations that had already implemented HIV programs, leaders from the Nigerian, Sudanese, Ethiopian, Somalian and South African communities, and immigrant and refugee service providers were invited to participate on the Advisory Committee. The Committee was comprised of eight representatives from African communities and service providers from immigrant-serving and HIV organizations, all of whom had strong connections with, and trust from, a range of African communities in Calgary. Throughout the study the research team and Advisory Committee members used strategies to engage African community members and leaders in a process that investigated HIV/AIDS service needs among African newcomer communities in Calgary. The advisory committee met as a group, and members were also consulted individually to provide direction on components of the research, including the refinement and elaboration of research questions for interviews and focus groups; identification of research ethics issues; development of strategies for recruiting interview participants; and analysis of interview and focus group data.

Participant Recruitment and Sampling

Qualitative studies generally employ various methods of purposive sampling. The investigators purposefully seek "information rich cases that will illuminate the question under study" (Lincoln & Guba, 1985). Participants were recruited through members of the Advisory Committee and through one of the co-principal investigators who has conducted a number of studies with members of Calgary's African communities. The specific sampling strategies that were used in the study were criterion sampling and maximum variation sampling. Criterion sampling involves selecting individuals that meet some predetermined criteria of importance (e.g., sex, age, cultural group), while maximum variation sampling involves selecting a diverse sample to address the goals of the study (Patton, 2002). In this study, particular attention was paid to ensure that the sample of individual interview participants was diverse with respect to age, gender, length of residency in Calgary, cultural group, occupational and employment background, and experiences with health and social services. To be considered for participation in the individual interview process, participants had to be 18 to 64 years of age, have lived in Calgary for one year or more, been born in an African country, and be proficient in English. For the focus groups, those invited included professionals who were providing services to newcomers within the African community in Calgary, and those who were employed by a human service or health care organization that provides services to people of African descent.

Interviews with African Newcomers

Trained interviewers (three African community members, and two others with international research or practice experience) conducted confidential, semi-structured interviews with 41 adult African newcomers from east, west, central, and southern Africa. Interviews lasted between 40 and 90 minutes. The purpose of these interviews was to explore and gain a deeper understanding of the HIV/AIDS service needs and priorities of

African newcomers to Calgary and to investigate how these needs could be addressed. Interviews included questions about social issues faced by African newcomers to Calgary; how HIV/AIDS is perceived among community members; how HIV risk is perceived; and how health and HIV/AIDS services are perceived and used.

Focus Groups

Three focus groups with 17 participants in total were held with allied service providers from health, social and immigrant-serving organizations in Calgary. The primary purposes of the focus groups were to gather additional perspectives in relation to the study's three main research questions; enhance the trustworthiness of the study by complementing the knowledge that emerged from the individual interviews; and gather additional detailed information about how service providers perceive that HIV/AIDS service needs can be met in conjunction with other newcomer service priorities.

Consultative Interviews

To further inform our understanding of the most appropriate ways for AIDS service organizations to engage African newcomer communities in the design and delivery of HIV/AIDS services, five telephone interview consultations were conducted with researchers and service providers from other regions of Canada who have developed and delivered HIV services for African, Caribbean and Black communities. The aim of these consultations was to enhance our understanding of potential program strategies, and allow us to learn from the challenges and successes of other agencies from across Canada. Questions for the discussions were specific to the research conducted or the program implemented by each respondent.

Data Analysis

With the permission of the study participants, all interview and focus group sessions were audio taped. Once transcribed, all the interviews and focus groups were played back and re-read to ensure the accuracy of the transcripts, fill in any gaps in the text and begin the process of becoming acquainted with the data.

Given the nature of the research design, an inductive analysis approach was used (Patton, 2002). Two team members identified categories and themes from the individual interviews to develop an initial coding framework. The research team reviewed this framework, and a revised framework served as the foundation for in-depth analysis of 36 selected transcripts. Data analysis was facilitated with the use of the computer software N6, which was used in the management and analysis of textual data through coding and recoding, organizing families of codes, and retrieval of textual data. Two members of the research team reviewed the analysis to enhance credibility. Then, a subset of five transcripts was used to confirm thematic results from the main analysis of the 36 transcripts. For the focus group data, two team members conducted preliminary coding of focus group transcripts, and one team member reviewed and confirmed themes. Telephone interview transcripts from consultative interviews were coded by one team member, and reviewed and confirmed by another team member.

Research Ethics

As a community-based research study involving several health regions, this study went through ethics review at three institutions, including the Community Research Ethics Board of Alberta (CREBA) (sponsored by the Alberta Heritage Foundation for Medical Research); the University of Calgary Conjoint Faculties Research Ethics Board (CFREB); and the Calgary Health Research Ethics Board (CHREB). All members of the research team followed strict research ethics principles and protocols to reduce risks of possible harm to participants. Procedures to ensure the confidentiality and anonymity of all individual interview participants and security of the data were followed. Interviewers received training in research ethics and confidentiality requirements, supportive communication and interviewing techniques, and information to provide referrals to participants if they exhibited signs of psychological distress during the interview.

Study Limitations

The aim of the study was to assist with services development in Calgary and was conducted with a small sample of African newcomers in the city. Thus, there are limitations to the generalizability or transferability of the findings to the wider population of African newcomers in Calgary and other centres in Canada. The study did not attempt to access a representative sample of all African newcomers or service providers working with African newcomers in Calgary and, therefore, we do not claim that the sample provides a representative picture of the experiences of either of these groups. In addition, since this study was conducted to capture the needs and views of a range of African newcomer communities and service providers, the results cover a broad range of topics and issues, but are not extensive in any one particular area. Likewise, the study did not specifically target African newcomers living with HIV to participate in the study or ask participants to disclose their HIV status, thus limiting inclusion of experiences from this perspective. Further study is needed on various issues related to HIV prevention, care and treatment, health, acculturation and African newcomer communities in Calgary in order to understand each of these issues in more depth. However, we hope that the information generated by this study provides a foundation for services development and further exploration of these issues.

Interviews with African Newcomers

This section of the report summarizes the results from the individual interviews with African newcomers. A profile of the participants is provided, followed by the major themes from the interviews that provide information for the HIV/AIDS service delivery system and African newcomer communities in Calgary.

Interview Participant Characteristics

A total of 41 participants from African newcomer communities were interviewed, of whom 24 (59%) were male and 17 (41%) were female. The age of the participants in the individual interviews ranged from 18 to 65, with the majority (71%) in the 34-49 age group (see Table 1).

Table 1: Age of Participants

Age	Number of participants	%
18-33	9	22%
34-49	29	71%
50-65	3	7%
66+	0	0.0
Total	41	100.0

The level of education achieved by the participants is shown in Table 2. The majority (23, or 56%) had at least some university education.

Table 2: Education Level of Participants

Education	Number of participants
Less than High School Diploma	1
High School Diploma	9
Technical School	3
College	3
Some University	3
Completed University	20
Unknown	2
Total	41

Table 3 provides a breakdown of the specific African communities to which the participants belonged. Participants from 14 countries were interviewed. The largest number of participants were from Nigeria (8, or 20%) and the Sudan (6, or 15%).

Table 3: Community Membership

Community	Number of Participants
Nigeria	8
Sudan	6
Ghana	5
Kenya	4
Botswana	4
Ethiopia	3
Zimbabwe	2
Somalia	2
South Africa	2
Swaziland	1
Tanzania	1
Senegal	1
Congo	1
Ivory Coast	1
Total	41

Major Themes Identified by Interview Participants

1. Settlement Experiences and Health of Newcomers

Although the focus of the study centered on HIV/AIDS services and African newcomer communities in Calgary, we realized it was important to understand the salient issues members of these communities encounter when settling in Canadian society to put HIV in context. Interview respondents identified the following major inter-related challenges: a) adapting to Canadian culture and practices; b) employment challenges; c) changes in gender roles; d) feelings of social isolation and lack of support; e) intergenerational conflict; and f) the experience of racism.

a) Adapting to Canadian Culture and Practices. Participants described the significant challenges of integration and cultural adaptation faced by many newcomers. Even though newcomers expect to face challenges in their adjustment to Canadian society, the reality of the experience may not match what they had anticipated. One female described the experience as follows:

> *I think people who are coming from Africa [have] high expectations and then when they just [arrive] they [are in] shock because they didn't [know] that that [things would be the way they were] . . . . Everybody is . . . expecting this but it [still] came [as a shock] . . . it's a culture shock to us.*

Another male participant commented on the dramatic lifestyle changes newcomers experience in Canada, compared to what they knew in Africa:

Most of these things have been . . . culture shock, you know? The change is not gradual. The change is just jumping from nothing to a very high level . . . . one of my friends was [the] son of a poor person. In his life he never . . . [ate] good food . . . . He has never [driven in his] own car. So when he came here, he is driving his own car, you see? He was telling me say[ing], "See, I'm doing what the [rich] are doing in Africa . . . I can now do it here . . . " It's a sudden change which affects us most . . . . You never work in your life, you are here, you work . . . . And you have the opportunity . . . but back home, nothing.

Still other participants noted the cultural differences in parenting styles, employment seeking, career advancement, and views about the importance of higher education as additional aspects of culture shock for newcomers.

b) Employment Challenges. Considerable attention in interviews was given to employment challenges. More specifically, interview participants reported two issues – the inability to acquire employment that matched either the educational or the occupational training of members of the African communities, and the resultant underemployment that often occurred. Study participants identified language barriers, lack of recognition of foreign credentials, lack of Canadian experience, and discriminatory practices by employers as concerns related to employment.

Interview participants reported that these employment challenges might lead to decreased self-esteem and individual stress or family breakdown, and these might in turn lead to HIV risk. One male participant described the experiences of individuals he knew:

Most of them [are] . . . engineers from . . . [the] University of Alberta, [the] University of Calgary, and yet they are painting people's houses for a living . . . . I mean in the beginning we didn't mind -- but you know, after two years, three years, four years, five years, filling out applications, sending resumes to people, and then you just say, "You know what? The system doesn't care for me. I don't care for the system; just work, pay my bills indefinitely." I think that is what brings about the carelessness, the irresponsibility, and you just say, "You know what? I'll just party on the weekend, pick up some girls, and I'll make my life kind of worthwhile."

c) Changes in Gender Roles. Changing gender roles, often as a result of women's employment, was noted as having a great impact on families. One male explained the impact of a woman's employment on traditional gender roles:

Back home . . . the man was the breadwinner. He comes here and now the woman is getting the money and then sometimes -- not all of the time -- but in certain cases it leads to disrespect [of the man] and it leads to a breakdown of the kind of ties they used to have when they were back home.

Another male participant added:

"Everything goes wrong . . . . you don't get along with family members, hence you move out to live with friends, and [there are] other social issues that get involved [such as] drinking and going out".

Another aspect of the change in gender roles is newcomer women's desire for increased freedom in Canada, according to several participants. One male explained that introducing *"the philosophies of the West",* such as feminism, *"to address a different culture . . . is causing the problem"* and *"bring(s) tension in the family"* because newcomers may not be familiar with the concepts, or the implications of recommendations made by service providers such as taking legal action to address domestic violence.

d) Social Isolation and Lack of Social Support. The experience of social isolation was a theme raised by many participants as part of the challenge in adapting to Canadian society. One female participant stated that some newcomers she was aware of *"don't have a sense of belonging. It's difficult for them to integrate into society"*. Another participant pointed out that newcomers may come to Canada without their spouse and children, which creates a context for HIV risk:

> *There are a number of those cases . . . where you don't have families living together. You have part of the family still in Africa, part of the family here. And a man who is here on his own . . . a lot could happen to affect him and eventually his wife by the . . . behaviour pattern or sexual partners that he gets involved with . . . . he doesn't go outside his community to find another partner. He will look in the same community and then . . . it's very easy for that disease [HIV] to spread like wildfire . . .*

Thus, participants saw social isolation and lack of support as important components of the settlement experience, and this lack of support created a context for HIV risk.

e) Intergenerational Issues. Intergenerational issues were another theme evident in participants' comments about cultural adjustment and its impact on African newcomer families. One male participant described difficulties between parents and teenagers that result from teens attempting to *"split from the family"* because they desire the *"freedom"* allowed to other Canadian teens. The issue of higher education was discussed, as parents place a high value on education for their children while teenagers seemed to view it as less important for their futures. One female participant explained the issue as follows:

> *Social issues – one of them is education . . . . Children in terms of those who are in their teenage years when they come [to Canada]. When they realize they can actually work and earn money, then education becomes a problem because it's . . . deemed no more important and it brings its own social consequences, like kids moving out at sixteen and teenage pregnancy becomes a factor . . . . A gang starts with the boys -- some amount of prostitution with the girls . . . .*

Participants viewed the lack of importance placed on higher education by teenagers as problematic because of the value placed on it in Africa as a critical step in gaining employment. Some participants, such as the woman quoted above, made direct links

between the low value placed on education by teenagers and the risk of violence and exploitation, which create a context for HIV risk as well.

f) Racism. Considerable attention was given to the issue of racism and the various ways this was experienced by newcomers. Several participants talked about experiences of racism and discrimination in the hiring practices of potential employers. As one male explained, *". . . There are still elements of ethnocentrism even in Canadian culture,"* because employers will not hire people *". . . who are African newcomers that are really competent and are qualified enough . . . ."* Another participant noted that racism and discrimination are *"quite enormous"* in Calgary, stating:

> *It is present in the social gatherings. It is in the church. It is in the employment areas . . . It is in the mall . . . When I was shopping . . . the white person saw me in the aisle and just shifted to the other aisle. Then the person will wait until you get out of that aisle . . . before [they] come over to that aisle . . . to pick up something.*

Thus, participants saw the impacts of racism and discrimination in social situations, unemployment or underemployment, and the use of drinking, partying, and casual relationships to cope with these frustrations, which, in turn, create a context for increased HIV risk.

In summary, these structural, cultural and role challenges, as well as economic disadvantage, may put newcomers and their communities at greater risk for HIV infection. These findings are consistent with the experiences of African newcomers interviewed in Toronto (Lawson et al., 2006a). These settlement adaptation and stress issues are well documented in the literature specific to immigrant and refugees to Canada (Reitz & Banerjee, 2007; Wayland, 2007); and in studies that examine the experiences of African newcomers (Danso & Grant, 2000; Igondaro, 2006). These themes provide an important context for understanding issues specific to HIV/AIDS services development for African newcomer communities in Calgary.

2. HIV/AIDS Risk Factors and African Newcomer Communities in Calgary

During the course of the interviews, participants identified a series of risk factors that either individually or collectively could make African newcomer communities vulnerable to HIV/AIDS. These risk factors included a) denial; b) cultural norms; c) lack of awareness; d) low perception of HIV risk in African newcomer communities; e) inconsistent condom use; and f) specific concerns related to women and youth.

a) Denial. A key risk factor that emerged was denial. Some participants stated that there are community members who insist they are not at risk for HIV:

> *I think a lot of people . . . feel it's a disease that doesn't affect them. I mean they are aware of it. They are aware that there's a disease but because they are so far removed from reality they are not having any direct contact with people that have the disease or knowing of someone in the community in Calgary that has the disease. People feel it's a disease that's outside their own little community.*

b) **Cultural Norms.** Some community members explained that sex is not an acceptable topic of conversation within many immigrant communities, which can make it very difficult or impossible for dialogue about HIV to occur. Discussing this issue, one participant explained that parents cannot talk to their children about AIDS because it is viewed as a *"taboo kind of thing to Africans . . . . based on our own community it is something that is hardly ever talked about".* One female participant explained that silence about sex was part of community norms:

> *. . . if you talk about sex, people look at you [as though] you're losing it, or . . . you are a loose [woman]. They think, "Oh, why is she talking about sex?" So people feel like even with their own kids, [they shouldn't] discuss these things. You don't [talk to] your kids about safe sex and all these things because in our community in general, sex has always been like a very private thing that everybody has to learn on their own.*

c) **Lack of Awareness.** The lack of awareness around HIV in terms of what it is, how it is transmitted, and how it can be prevented or treated was cited as another potential risk factor:

> *Well, I think there is high risk . . . they have sex -- it's not protected -- and then . . . . it's not discussed so the awareness [of what HIV is] is low and [the awareness of how it is spread] is also low, and then once both are low, then everybody become[s] careless and they are not being precautious [when they have sex].*

d) **Low Perception of HIV Risk in African Newcomer Communities.** Some participants maintained that members of African newcomer communities perceive they are at low risk for HIV/AIDS because HIV/AIDS is not visible in Canada. One male participant remarked, *"AIDS in Canada or in North America or Europe, it is not seen by people. They don't see the symptoms of AIDS in people walking around".* In particular, HIV screening that most newcomers to Canada undergo was seen as a protection against HIV:

> *I think some would believe that because they are in Canada and . . . had to go undergo testing before . . . getting a visa, [that they] have to [have a] clean immune system, no HIV, yeah. So maybe some would be like, "Well, [I] had [the] greatest risk of [contracting] AIDS in Africa so now that I am here I'm clean." And Canada has a low HIV rate apparently, so some would believe that, "Well, I'm clean I can do anything I want."*

Several interview participants remarked that even personal contact with someone living with HIV did not increase perceived HIV risk among community members. As one woman said:

> *I think one of the things [that would help people] decide to use prevention would be [to be] educated or [if] a good friend has HIV or they know of a sister who has HIV or a dear friend. I normally find it has to be someone close to them who has been afflicted by the HIV/AIDS that will make them think and decide, but then I still know a lot of people who throw caution to the wind. They seem to think that, "It can't*

happen to me. HIV is a myth. It only happens to bad people." So I believe 90% of my community don't use it – don't use protection.

e) Inconsistent Condom Use. As the previous participant quote suggests, inconsistent condom use surfaced as a factor that put communities at risk:

I think they don't use condoms . . . it's like using a condom is not their style. They do not want it. [Maybe a few] they [are starting] to learn but [they are] few – the people that have [HIV or AIDS] already, I don't think that they are protecting themselves or other people.

f) Concerns Related to Youth and Women. Some participants expressed the view that youth in the community were at greater risk for HIV because of their behaviour:

I think they do consider it like a serious issue but I don't see it, really. Like the seriousness is not there, you know? I know they know it, like it's something damaging the community, but teenagers just don't [really] take it [seriously]. Like you know how they go on with their life. For me I see it, they don't take it [seriously] . . . not at all.

Another participant echoed this sentiment when he stated, *"I think the young people don't care about it and [the] adults are more aware [of it] because they have seen it maybe destroy lives back home."*

From a gendered perspective, female respondents maintained that the traditional acceptance of infidelity among men posed a threat and created fear among some African women. They stated that these women are concerned about becoming infected by their husbands who may be having sex with other women. One woman explained the dilemma as follows, *"I mean you trust your husband but at the same time your husband could be cheating on you and then [come] back to you and sleep with you."*

The HIV/AIDS risk factors for African newcomers in Calgary identified by participants are also present to a great extent in the literature. For example, African, Caribbean and Black community members in Ontario did not perceive that HIV/AIDS was having a great impact on their communities, and some community members believed themselves to be at low risk of HIV infection for the same reasons cited in this study, including misperceptions about HIV in Canada and lack of knowledge about HIV transmission (Gardezi et al., 2008; Health Canada, 2000; Tharao et al., 2006). Other studies have also found that cultural norms dictate that sex – and therefore HIV/AIDS – are taboo subjects for discussion; several studies have documented these cultural norms, and the resulting lack of communication about sex and HIV/AIDS in African newcomer communities (Jarama et al., 2007; Othenio, 2007). Inconsistent condom use described by our study participants is also well documented in other studies among those from the African diaspora (Beyene, 2000; Gardezi et al., 2008). Lastly, cultural norms placing newcomer women at heightened risk for HIV, including men's sexual partnerships outside marriage and women's lack of power and safety in negotiating condom use, are congruent with the findings of several recent studies and reports (Tharao et al., 2006; Williams et al., 2009).

However, our study results from Calgary newcomer communities are not entirely congruent with other findings. Organized religion has been identified in the literature as a factor that may influence community members' ability to discuss sex, sexuality, and condom use, but was not identified as a factor by community participants in this study (Williams et al., 2009). In addition, participants in this study did not directly discuss domestic violence, a factor relevant to women and HIV risk, or homosexuality, an HIV risk factor relevant to men. The lack of discussion of these issues suggests that they are not perceived and/or acknowledged by community members, and therefore must be handled sensitively in any program or service development initiatives.

3. HIV/AIDS Services Utilization

Interview participants identified five major issues with respect to use of HIV/AIDS services and supports by African newcomers, including a) cultural influences and help-seeking behaviour; b) social stigma; c) stigma and discrimination from health care professionals; d) lack of knowledge about available services and supports; and e) issues of confidentiality.

a) Cultural Influences and Help-Seeking Behaviour. A dominant theme within the interviews centered on how cultural values and practices influence the help-seeking behaviour of African newcomers in Calgary. As one woman explained:

> *We do not think it is necessary for us to go like one once a year [for checkups] . . . it is not something that we are used to doing.*

Some of the respondents claimed they would not access health services unless they were ill from something unfamiliar. A male participant from Swaziland stated, *"If I were sick and could not explain why, then I would probably use it [the health service]."*

Another issue that participants indicated could influence help-seeking behaviour was differences between health care systems in African and Canada. A lack of understanding of the Canadian health care system could result in not seeking care. One participant described the difference in health care system in some regions of Africa when he said, *"In some areas in Africa they do not have health insurance. They do not have drug cards . . . they do not have family doctors."*

Thus, those unfamiliar with services freely available in Canada might not realize care was accessible or affordable, or consider using services.

b) Social Stigma. Stigma around HIV was identified as an important barrier to services use. Some participants indicated that HIV was feared and seen as a *"taboo"* disease. As one female participant explained:

> *So even though I need it and it's there, I will not use it because like if a service is built in downtown where everybody will see me coming for advice or information – where anybody will see me walking in. Another Ghanaian seeing me walking in thinks automatically that I have AIDS and since it's not openly discussed, she will go*

*and say, "Hey, do you [know] that she has AIDS? I saw her at the AIDS centre." And
you will never know, but everybody will be whispering and sympathizing with you for
something you have no idea about simply because you walked into an AIDS Calgary
office.*

Respondents stated that the fear of being stigmatized or discriminated against by
community members, based on assumptions or knowledge about a person's HIV status, is a
major barrier to using HIV/AIDS services.

c) Stigma and Discrimination from Health Care Professionals. Study participants also
indicated that members of the community experienced discrimination by health care
professionals. Commenting on this perception, one male participant stated:

*But in the Canadian context . . . people from Africa who have HIV/AIDS are much
more likely to be discriminated against by the health services. Yes, because of the
stigma that is around it already, Africans have the largest population of HIV/AIDS
patients. [If they] see you as Africans [then] the first thing is that possibility.*

The impact of this stigma and discrimination on service use by HIV-positive African
newcomers was described by one newcomer as follows:

*. . . [if] he or she is an African and [if] he or she has HIV/AIDS, the treatment is
different. Nurses [and] . . . doctors will see you [in] a [certain] way. I won't say all of
them, but some seem this way and that alone is very, very depressing because it
goes against the person's sense of worth. I mean, [they will ask themselves,] "Why
are [they] treating me this way? . . . . And you begin to wonder, are you the only
person in Canada who has HIV/AIDS? . . . Is it only Black people in Canada who have
HIV/AIDS? . . . At the end of the day, you feel like, "I should not even go back. I
should not even disclose [anything]."*

d) Lack of Knowledge about Available Services and Supports. Many participants said
that African newcomers and health care providers need to share information that potentially
would increase the use of services by members of the African community. In particular,
several participants emphasized that information needed to be disseminated about health
services to community members so individuals could make better informed decisions
around health service utilization:

*I don't think there's enough information being given to people as to where they can
go either to get information about how to prevent getting infected [with HIV] in the
first place or how to deal with the infection once they are diagnosed with the
disease. I do not think there's enough of that information . . . pamphlets or videos . .
. disseminated to places where people congregate, particularly in casual
environments.*

In addition, distributing information in a variety of languages was seen as being important.

e) Issue of Confidentiality. The issue of confidentiality emerged as a key determinant of the use of services by members of the African newcomer communities. Many participants commented that even if individuals were ill, they would not access HIV services unless they were assured they would be treated confidentially. As one participant described:

> *If the feeling of having that sickness becomes overwhelming, suddenly that person will go . . . They will think] of offering [themselves for an HIV test if] it is [quietly and secretly] done. In other words, it's [done] confidentially [and] I mean in which case the agencies might say, "Hey, we're [offering] out these services. It may be we can come to your house so that nobody sees you, nobody knows that, you know, just come in and we'll talk about, and do the test there."*

The five major issues identified by participants with respect to the use of HIV/AIDS services and supports are very similar to issues identified in the recent literature on HIV among members of African and Caribbean newcomer communities. The cultural influences on help-seeking behaviour described by participants were also found to be an issue among African and Caribbean-born women in other North American cities (Foley, 2005; Williams et al., 2009). The social stigma surrounding HIV/AIDS in Calgary's African newcomer communities and the resultant fear of being ostracized by the community if a person is thought to have the disease, is a common theme in the literature about responses to HIV/AIDS in Ontario's Black and African communities (Lawson et al., 2006a; Mitra et al., 2006). The additional stigma and discrimination from health care professionals noted by participants is also well documented (Gardezi et al., 2008; Lawson et al., 2006a; Lawson, Gardezi, Calzavara et al., 2006b). Lack of awareness about available HIV/AIDS services and supports, as well as concerns about confidentiality while accessing services, are also predominant themes in the findings of studies with African newcomer communities in the United States, Britain and other parts of Canada (Burns & Fenton, 2006; Foley, 2005; Tharao et al., 2004). Thus, our results echo other studies' results, and suggest these issues are also key factors to address when developing HIV services for African newcomers in Calgary.

Focus Groups

Focus Group Participants

Three focus groups were conducted with a total of 17 service providers from health, social, and immigrant-serving agencies who were knowledgeable about the salient health and social issues that newcomers from Africa encounter as they attempt to settle in Canada.

Major Themes Identified by Focus Groups

The two major themes that emerged from the analysis of the focus group data included 1) issues related to the provision of HIV/AIDS services to the African newcomer communities and 2) recommendations for engaging with African newcomer communities for improving the provision of services to community members.

1. Issues Related to the Provision of HIV/AIDS Services to African Newcomer Communities

The service provider participants in the three focus groups identified several issues that were similar to those discussed in the individual interviews. Language barriers, stigma, and lack of knowledge about HIV/AIDS emerged as the major themes related to provision of HIV/AIDS services to African newcomer communities in focus groups.

a) Language Barriers. The existence of language barriers was consistently identified as a major challenge by the service providers. One participant commented on this obstacle when she said, *". . . We often do not have in-house interpretation for those specific groups [African newcomers] so we are doing whatever we can via the telephone to provide language services and support."*

b) Stigma. The fear of being stigmatized by their communities emerged as another factor contributing to the limited use of HIV/AIDS services:

> *A lot of fear, shame. That is common, especially from the females . . . they do not want anybody [to know they use HIV services], especially people they know here that live in the city.*

Another participant remarked, *"I think I would have to say stigma – I think that stigma is a huge thing. I think stigma for those who are living with HIV is very severe."*

c) Lack of Knowledge – Preventing HIV/AIDS. Focus group participants spoke about the lack of knowledge related to HIV/AIDS prevention strategies. As one participant said. *"In terms of prevention . . . HIV awareness and understanding sexual risk behaviours, understanding about negotiating with partners . . . it is about general education."*

2. Engagement Strategies

The general consensus of participants in focus groups was that service providers needed to work in collaboration with African newcomer communities to develop services for HIV/AIDS prevention and care. The major strategies identified were a) dialogue with African newcomer communities; b) creative social marketing strategies to increase the awareness of HIV/AIDS; and c) training and education in cultural competence for health care professionals.

a) Dialogue with African Newcomer Communities. Many focus groups participants maintained it was important for service providers to work together with this population, as captured in this comment:

> *I think it would be really great to get all of the leaders in the communities involved to get some discussion going in each community about HIV . . . that would hopefully facilitate reduction in stigma.*

Another participant stated, *"I think having a 'go-to' person in the community is important. I think it needs to be that personal contact, especially in the context of HIV."*

b) Social Marketing Strategies. The use of social marketing strategies to increase the level of HIV/AIDS awareness was identified by focus group participants as another key tool. One participant described one possible tool:

> *. . . a well-designed, acceptable poster to Sudanese or the Ethiopian community that would speak about HIV or that would be in a diverse language that could be up in the immigrant-serving agencies.*

Another participant indicated it was important to promote services:

> *. . . it is about how we market ourselves as service providers, right? How we are advertising and who we are advertising to and what are the services that we are talking about that we provide.*

c) Training and Education in Cultural Competence. Some of the service providers felt there was a need for staff in their organizations to receive some *"cultural competency training"* focused on gaining a better understanding of the cultures of the various African newcomer communities, as well as some knowledge as to how to work effectively with community members:

> *I think the lack of knowledge of caregivers . . . is a problem . . . having somebody come in to educate us on how to work better with these populations – a huge gap is knowing what we need to do and what we need not to do . . . .*

Focus group participants were asked, *"Do you think that your staff has the competency to work effectively with African newcomers?"* One participant responded:

> *I know our staff do not and they [know] that too, and we have had conversations around this many, many times . . . . As service providers we need to open our minds and learn about different cultures and see that there is a different way of being.*

The themes of stigma, language barriers and newcomers' lack of knowledge about HIV/AIDS evident in the focus group discussions reflect observations by service providers in Toronto, Britain and the United States (Burns, Imrie, Nazroo, Johnson, & Fenton, 2007; Foley, 2005; Tharao et al., 2004). The need for cultural competency training, collaboration with newcomer communities in service planning, and appropriate social marketing strategies have been identified by leaders in the African and Caribbean newcomer communities in Canada as important steps to increasing HIV/AIDS awareness and access to services (James & African and Caribbean HIV/AIDS Community Capacity Building Project, 2006; Tharao & Teclom, 2006).

Consultative Interviews – Service Providers and Researchers

Five consultative interviews were conducted with service providers and researchers in other regions of Canada who have worked with African, Caribbean and Black communities in the development and delivery of HIV/AIDS services. Participants in these interviews stressed the need to work in collaboration with communities to develop and deliver

appropriate HIV/AIDS services; the cultural sensitivity required to address issues of HIV transmission risk within the context of sexuality, gender relations, cultural health beliefs, racism, and settlement and acculturation issues; and the need to integrate HIV/AIDS prevention program offerings with other health and immigrant services to reduce stigma and barriers to service access.

In keeping with the literature, leaders in the African newcomer and Black communities in Canada and other stakeholders agreed that stigma and discrimination from Canadian society, as well as within African newcomer and Black communities, must be addressed in order to prevent HIV infection and provide services for HIV positive individuals within a rights-based and anti-oppressive framework (Elford, 2006; James & African and Caribbean HIV/AIDS Community Capacity Building Project, 2006; Stakeholders Involved in the Canadian Response to HIV/AIDS, 2005).

Community Roundtable

Preliminary results were discussed with community members and service providers at a Community Roundtable and dinner held in March of 2009. The Roundtable was organized in order to share the study results, encourage community and service provider communication about the results, identify gaps in services, and begin dialogue about possible future action based on the results. The Community Roundtable included 47 participants from various African newcomer communities in Calgary, service providers from HIV and immigrant-serving organizations and researchers involved in the study. The Roundtable, facilitated by staff from AIDS Calgary Awareness Association and the academic partners, consisted of two main components: a presentation of the research results, and small group discussion about the results, including strategies to address service issues and priority areas for possible next steps in the community. Small group discussion summaries were then shared with the larger group to determine common themes from the discussions.

Roundtable participants identified key improvements that could be made in the areas of HIV education, prevention and access to services for African newcomers in Calgary. The common themes on these topics included a) providing communities and immigrant-serving organizations with HIV prevention and treatment information in African newcomers' first languages; b) ensuring service providers receive cultural sensitivity training; c) providing HIV education to youth at younger ages in various settings, such as schools, community and religious gatherings; and d) increasing the visibility and frequency of HIV prevention messaging in African newcomer communities. Participants also developed ideas about the most important action priorities and next steps for the community in light of the study's results. Several common priorities and plans for action were developed through the small group discussions, such as building partnerships between community associations and HIV/AIDS and immigrant-serving organizations, normalizing the public discussion of sexual health and HIV prevention in African newcomer communities, and engaging newcomer communities through the strategic involvement of their community leaders.

STRATEGIC DIRECTIONS

This research project set out to answer three key research questions in order to understand the challenge of HIV/AIDS in African newcomer communities in Calgary. As the insights shared in this report highlight, this challenge is a complex one rooted in culture, awareness, understanding, communication and community. In order to overcome this challenge, it is clear that the approach taken must work within these many factors. Through interviews, focus groups, and roundtable discussion, communities and service providers have provided a series of key strategic directions that can assist in developing stronger, more appropriate services and supports for African newcomer communities in Calgary. In summary, these include the following:

1. HIV/AIDS service needs and priorities of African newcomers
- **Awareness:** raise community awareness with a focus on HIV risk and prevalence in Canada and among African newcomer communities (including the HIV testing process during immigration).
- **Prevention:** provide education focused on talking about sexuality in a culturally sensitive way, HIV prevention, condom use, condom negotiation, HIV testing; need to focus on youth and gender dynamics.
- **Services:** provide information on services and supports available for HIV prevention, testing, care and support for people living with HIV (including confidentiality of services); create more accessible and culturally appropriate services.
- **Stigma in the Community:** address deep-rooted stigma and discrimination associated with HIV in order to reduce barriers to accessing services.
- **Stigma in Health Settings:** address stigma and discrimination related to HIV and African origin by health care providers and other service professionals in order to reduce barriers to accessing services.

2. Meeting these needs in conjunction with other African newcomer service priorities such as housing, education, and employment security
- **Integration of HIV Education:** integrate HIV education with other essential services such as employment training, language training, general education and settlement and integration services.
- **Health Care System:** provide education on Canadian health care system, use of preventive health care services, availability of free services and benefits of preventive health care.
- **Employment:** enhance service supports related to employment, recognition of foreign credentials, and employment training (economic well being is a key determinant of health and relates to HIV vulnerability).

3. Appropriate ways for AIDS service organizations (ASOs) in Calgary to engage African newcomer communities in the design and delivery of HIV/AIDS services
- **Support Leadership in the Community:** engage community in dialogue about HIV, and work collaboratively with community leaders and members to raise awareness, reduce stigma and carry out HIV education and support programs; use

peer mentorship and grassroots programming approach.

- **Outreach:** reach out to communities to increase visibility of HIV as in issue, provide HIV education in community-based settings or groups such as cultural associations, churches etc.; provide services discretely in the community (e.g. HIV testing in people's homes).
- **Address Language Barriers:** translate written materials into key language groups; improve access to high quality, confidential translation services.
- **Culturally Appropriate Social Marketing, Materials and Presentations:** create materials and presentations specifically tailored to for unique African newcomer communities, with key messages regarding HIV prevention and services available; materials must avoid further stigmatization of African newcomer communities.
- **Cultural Competency of Service Providers:** provide education for service providers to increase cultural competency and improve ability to provide appropriate services to members of African newcomer communities.

From Research to Action

The results of this community-based research study provide a strong evidence base for HIV/AIDS program design and development to better serve African newcomer communities in Calgary. Based on the key strategic directions identified in this study, AIDS Calgary has begun a process of program planning and resource mobilization to expand and enhance services for African newcomer communities in Calgary. Research results have been utilized in several funding applications in an effort to secure funds to support this work and to ensure the sustainability of any new programming undertaken. Results have also been disseminated through several conferences to service providers from throughout Alberta, the prairie provinces and Canada in an effort to ensure uptake of learnings and practical application to service development.

If sufficient funding support is secured, AIDS Calgary hopes to pilot a new community development and outreach initiative in Calgary. This program would focus on community mobilization and engagement through formation of an advisory committee of key stakeholders from African communities, immigrant serving organizations and AIDS service organizations. This advisory committee would engage African communities in their own responses to the issues and foster the development of community leadership to address HIV/AIDS. With the support of a dedicated community development/ outreach worker, this advisory committee would guide development of culturally appropriate HIV/AIDS awareness raising strategies such as community events, workshops and presentations and development of educational/social marketing resources. Through partnership development and knowledge sharing, the advisory committee would also function to enhance participant capacity related to HIV/AIDS, cultural competency and services development. Overall, through a meaningful process of engagement and collaboration, this initiative would strive to encourage community dialogue on HIV/AIDS, increase accessibility of HIV/AIDS education, services and supports and to begin the long process of addressing the unique needs of African newcomer communities in Calgary.

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