As of December 1998, estimates suggest that approximately 2,346 Ontario residents originally from sub-Saharan Africa and the Caribbean were living with HIV, constituting about twelve per cent of all HIV infections. Thirty to 40 per cent of these infections occurred after the establishment of residence in Canada, despite the popular belief that the virus was transported into Canada during migration from these regions.

A report by Dr. Susan King of the Toronto Hospital for Sick Children and the HIV Pediatric Network also revealed that, between 1994 and 1996, 70 per cent of maternal transmissions of HIV infection had occurred among persons from 'HIV-endemic' regions of Africa and the Caribbean. The report indicated that African and Caribbean populations had become a significant component of the Canadian HIV epidemic, and that almost ten percent of AIDS cases diagnosed in 1996 were among persons born in Africa or the Caribbean and who were residing in Ontario, compared to three per cent of AIDS cases previously diagnosed.

A report produced by Dr. Robert Remis looked at women living in Montreal who attended an abortion clinic at a general hospital between 1989 and 2000 and found that 60 per cent of the observed HIV cases were among women born in Haiti; these women only accounted for 6.4 per cent of all the women tested at the clinic. Based on these findings, it is clear that the prevalence rate is high within the Haitian community in Montreal.

Stigma, Denial and Discrimination

In most sub-Saharan and Caribbean communities with high HIV/AIDS prevalence it is assumed that HIV is transmitted primarily through sexual intercourse. This presumption has contributed to the stigma, denial and discrimination experienced by people living with AIDS. The World Health Organization (WHO) and UNAIDS have recently revealed that other key routes of HIV transmission exist, including via 'road side' chemists and traditional healers who use non-sterilized needles and knives to administer medication to a significant proportion of the population. Service providers and agencies involved in HIV/AIDS are now advised to discuss the role of sharp objects in the transmission of HIV/AIDS. These issues should be emphasized during counseling and education sessions.

In addition to fear, stigma and discrimination from the community, people living with AIDS have reported experiencing discrimination from misinformed or insensitive health care providers such as community health workers who have had little or no practical experience or knowledge of HIV-related issues. This becomes even more acute when the client is from a community or country.
with high HIV/AIDS-denial of HIV risk or status subsequently becomes a coping mechanism.

**Gender**

A gender-based approach to health does not only include biological factors; social and cultural realities play a part in promoting, protecting or impeding health. Power relations between women and men and between health-care providers and clients are informed by social and cultural norms. Biological and social factors must be analyzed in tandem to understand how women and men approach health and illness.

Women often lack the economic power to remove themselves from relationships that carry major risks; they are not in a position to insist on fidelity, demand condom use, or refuse sex with their partners. There is an apparent failure to establish a connection between gender-based violence and the high incidence of AIDS. Another concern is the practice of circumcision with non-sterile instruments by inexperienced individuals leading to genital mutilation. Whether in a medical or non-medical setting, the use of non-sterile equipment or the transfusion of unscreened blood products can lead to HIV transmission.

**Culture**

There is a great deal of diversity within the various communities with high HIV/AIDS prevalence. For example, in many parts of Africa, children socialize in mixed gender groups until puberty when they are separated into gender-specific groups. In the Caribbean, groups of young men socialize on street corners, in barber shops, and at sporting events, while young women socialize at community, church and family events. These customs affect how information is shared within each group. Effective HIV/AIDS programs must consider these traditions. In addition, many people have been raised in families where issues of sexuality were not discussed. Due to the link between HIV and sex, many people living with HIV/AIDS from sub-Saharan Africa and the Caribbean experience great discomfort around disclosure and discussion of these issues with health care providers.

**Access to Services**

For many communities with high HIV prevalence, HIV/AIDS is one of many issues jockeying for priority status. Communities that experience high HIV/AIDS prevalence often experience tremendous challenges when attempting to access HIV/AIDS services, some of which include:

- homelessness
- poverty
- transience
- lack of employment
- isolation
- lack of services for women and children
- language and cultural barriers
- discrimination
- location of services
- power imbalances between clients and service providers
- lack of access to information; misinformation about services; misinformation about HIV/AIDS
- denial; fear of disclosure to partners, children and close relations
- stigma, especially with respect to presumptions about sexual transmission
- immigration status of the affected and infected

**Strategies**

Non-HIV specific service delivery agencies can play a crucial role in reducing HIV/AIDS within high prevalence communities by integrating HIV/AIDS prevention, support and treatment programs, which can be achieved by developing collaborative relationships with other services.
providers and agencies to ensure effective use of resources.

An integrative approach can facilitate capacity building among mainstream health care and service agencies, ethno-cultural community based organizations, individuals seeking services and their families, or support network communities. When providing services to people living in Canada who are from communities and countries with high HIV prevalence, capacity building within ethno-cultural communities is key to developing effective, relevant, appropriate and sustainable services.

Capacity building may include a local AIDS service organization mobilizing affected community members to participate in the planning, implementation and management of programs. This provides an opportunity for skill development, which leads to sustainability of programs. Health care providers from high prevalence communities can form networks with other service agencies to ensure appropriate referrals, treatment options, and testing and support for clients.

Local solutions that could assist service providers to better meet the needs of people from communities with high HIV/AIDS prevalence might include:

- networking to identify service providers including those who can offer advice on legal issues, immigration, housing, settlement, treatment, and interpretation
- acquiring and/or developing localized versions of the Living Guide, a directory of HIV/AIDS related services
- establishing resource lists of local and national ethno-racial-cultural organizations and facilities
- creating lists of web sites, advisory committees, networks and cultural groups that interface with ethno-cultural communities

Migrant Population Issues

Health care providers working with HIV/AIDS in communities with high prevalence need to be informed of immigration policies and procedures. In some cases, they are asked to provide documentation for clients as they go through the system; they may be able to lend their expertise to clients in reducing the stresses associated with the settlement process.

Immigrants who have been granted landed status must wait three months to get provincial health coverage. Some people living with HIV/AIDS report that even when they are able to obtain coverage they do not or cannot access care, due to concerns that the immigration department will access their health records and reject them because of their HIV status. The handling of immigration (and refugee) applications can have a harmful impact on health. Although uninsured people living with AIDS can access primary healthcare at community health centres in some large cities, limited resources, funding cuts, and lack of HIV/AIDS experience severely restricts the centres' ability to meet demand.

Unstable and unclear immigration status affects employment eligibility and severely limits income generation; the inability to pay for necessary health care naturally affects the well-being of new residents. Temporary solutions, such as drug recycling and volunteering for clinical trials, are, at best, patchwork methods.

People apply for refugee status due to persecution in their home country. Once their application is acknowledged, they are eligible for 'essential and emergency' health care through the Interim Federal Health (IFH) plan. Coverage is not available until the refugee claim is acknowledged. Many health care providers are unaware of the process to submit IFH claims, with the result that many people living
Medical inadmissibility is the greatest barrier to a potential immigrant who is HIV positive. An applicant may be medically inadmissible because of her/his illness or deemed to be a danger to public health, or because the condition is likely to cause excessive demands on Canada’s social and medical systems. Although HIV has been removed from the list of diseases deemed to be dangerous to public health, the immigrant still has to deal with the issue of excess demand. Chances for success at immigrating to Canada are minimal. Those already in Canada may seek exemption from the rules as laid out by the Immigration Act based on humanitarian and compassionate grounds and apply for a Minister's permit to remain in Canada, but the permit excludes access to Canada’s socialized medical system. Individuals who do remain with a Minister's permit can apply for landed immigrant status after five years, regardless of medical inadmissibility, but the permit must be renewed yearly and, if refused, the applicant may not meet the five year requirement.

Canadian immigration law is currently in transition: a new Immigration and Refugee Protection Act is set to replace the old Immigration Act in 2002.

Under both the old and the new laws, short-term visitors with HIV are usually allowed to enter Canada.

As to immigrants and refugees, the situation will change with the new legislation. Under the old law, refugees with HIV who appear at the border or who are in Canada have been allowed to stay, but immigrants and refugees who are outside Canada have generally not been allowed entry into Canada. Under the new law, most people with HIV will still be unable to immigrate to Canada. However, HIV-positive refugees and HIV-positive spouses, common-law partners, and children of a Canadian citizen or permanent resident will be allowed to come to Canada.

According to both the old Immigration Act and the new Immigration and Refugee Protection Act, foreigners can be refused entry into Canada based on their medical condition if they are likely to be a threat to public health or safety or if they would place excessive demands on government services. Since 1991, Canada has not considered people with HIV to be threats to public health and safety. Although there was some suggestion that this policy might change, then Minister of Citizenship and Immigration Elinor Caplan confirmed in June 2001 that refugees and immigrants with HIV still will not be considered to be threats to public health and will not be excluded on that basis.

Therefore, Canada generally only excludes people with HIV if they can be expected to place an excessive burden on publicly funded health and social services.

Short-term visitors with HIV, unless they are very ill, are not expected to place any demands on government health and social services, so they are generally allowed to come into Canada.

Under the old law, refugees with HIV who appeared at the border or who were in Canada could not be expelled or turned away from the country. This policy was in conformity with international law. Their HIV status was not a bar to admission into Canada as a refugee.
Refugees with HIV applying from outside the country, along with immigrants, were generally found "medically inadmissible" on the ground that they would place excessive demand on health and social services.

Persons found medically inadmissible were able to apply for a minister's permit, allowing them to remain in Canada for a temporary period. In most provinces and territories, people on Minister's permits were not eligible for publicly insured health and social services.

The new law exempts refugees, whether inside or outside Canada, as well as sponsored spouses, common law partners, and children of Canadian citizens or permanent residents from inadmissibility based on "excessive demand." Since people with HIV are not (at least not generally) considered to be threats to public health and will not be excluded on that basis, this means that refugees and certain close family members of Canadian residents will not be denied entry to Canada based on their health condition if they are HIV positive.

For all other immigrants, a case-by-case assessment will be made about whether the person "might reasonably be expected to cause excessive demand on health or social services."

On 15 January 2002, HIV was added to the list of routine tests included in the medical examination that foreigners who plan on staying in Canada for 6 months or longer must undergo. HIV testing is performed on all applicants who are 15 years of age or older, as well as on children who have received blood or blood products or whose mother is known to be HIV positive, and on all potential adoptees.

Program Development and Access

Outreach strategies for health promotion and wellness in communities with high HIV/AIDS prevalence are more effective when they address concerns related specifically to those communities. Vulnerability issues—race, class, sexuality, fear, isolation, stigma and denial—must also be addressed. Programs are often best received when their messages acknowledge that people from communities with high HIV/AIDS prevalence are diverse in culture, language and expression. Effective programming is participatory—programs that involve the community through advisory committees, community consultations and focus groups are the most successful.

To design effective programs and services, community-based organizations and service providers must get to know the recipient population by determining a number of factors:

- Where do they gather?
- What are their cultural norms and practices?
- What do they watch, read, listen to?
- Who are their community leaders?
- What is the language of communication?
- To what faith do they belong?

By clarifying the concerns and practices of a specific community, service providers can work within specific frameworks to create effective and sensitive programming. And by working with other groups that cater to the community—churches, community newspaper and radio stations, advocacy
groups messages are delivered within a comfortable context.

**Best Practices**

**Care and Support**

A multidisciplinary case management approach, facilitated by a support worker from a community-based AIDS service organization, is an effective way to assist a family coping with HIV/AIDS. The support worker can listen to concerns, then identify what is required to implement an effective care strategy and arrange meetings with relevant service providers at which priorities are addressed. As a result, the client is not bounced from one service provider to another. The multidisciplinary approach provides a coordinated effort, facilitates introductions, and provides a more compassionate approach for someone experiencing multiple stresses other than HIV/AIDS. Initial and follow up meetings can take place at a location that is safe for both the client and attending staff person.

Outreach gatherings such as community kitchens, summer picnics and potlucks provide a much needed safe space for people infected and affected with HIV/AIDS to meet one another, provide informal peer support, assist in alleviating isolation, and provide opportunities to celebrate life.

**Prevention**

Many ethno-cultural community AIDS Service Organizations use strategies that are fluid and easily modified. The foundation of the strategy creates HIV/AIDS messages that are culturally appropriate, using colloquial language, expressions, and symbols. For example, the Black Coalition for AIDS Prevention (Black CAP) in Toronto, Canada uses powerful images on posters, and messages delivered by video, television, and Public Service Announcements on community-based radio stations that are geared to the Black community. Black CAP’s outreach workers conduct workshops and outreach activities at venues and social events throughout the Black community such as barbershops, festivals, and youth jams.

One of the critical issues that must be addressed within the context of prevention education is the high prevalence of mother to child transmission within the sub-Saharan African and Caribbean communities. Prevention messages should therefore emphasize the need for prenatal HIV testing.

**Care**

A model of supportive housing should be extended to communities with high HIV/AIDS prevalence. During the 1980s and early 1990s, people living with AIDS not only struggled with hospitals that were unprepared for HIV-related complications—they also struggled with stigma and discrimination from hospital staff, family and community. As a result, community activists, health care providers, and people with AIDS opened hospices such as Casey House Hospice, Bruce House and Fife House in Ontario. Communities with high HIV prevalence currently face similar issues, which are compounded by language and cultural boundaries and settlement concerns.

**Emerging Trends**

Recent reports have identified other areas of high prevalence—in South Asia, South East Asia, Eastern Europe, Brazil and some parts of Latin America.

- since 1994, HIV prevalence in much of Asia and the Pacific has increased by over 100 per cent.
- women account for 45 per cent of all adults infected, up 25 per cent from seven years ago
- in South and South East Asia, HIV/AIDS has already killed more than 1 million people
• in Eastern Europe and Central Asia, 50 per cent of people living with HIV/AIDS were infected during the past two years

Although there have been no studies conducted to indicate the prevalence of HIV/AIDS within the above mentioned communities in Canada, anecdotal information from agencies within those communities indicate that HIV/AIDS is a growing concern.

According to UNAIDS, no individual or country is beyond the reach of HIV. However, the distribution of the virus is not random: HIV tends to spread along the pre-existing fault lines of society, fuelled by societal and structural factors such as poverty, disorder, discrimination and the subordinate status of women. Action needs to be broad-based and multi-sectoral. Strategies must take into account the epidemic's disproportionate focus on vulnerable individuals and communities—those who are confronted with other critical health and socioeconomic issues.

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**Web Sites**

- [www.unaids.org](http://www.unaids.org)
- [www.aidslaw.ca](http://www.aidslaw.ca)
- [www.acas.org](http://www.acas.org)
- [www.black-cap.com](http://www.black-cap.com)
- [www.2spirit.com](http://www.2spirit.com)
- [www.actoronto.org](http://www.actoronto.org)
- [www.interlog.com/~aids](http://www.interlog.com/~aids)
- [www.asia.bc.ca/default.htm](http://www.asia.bc.ca/default.htm)
- [www.catie.org](http://www.catie.org)

**List of Ethnocultural Communities Working in the Fight Against AIDS in Canada**

**Black Coalition for AIDS Prevention (Black CAP)**

790 Bay Street, Suite 940, Toronto ON M5G 2G8
Tel.: (416) 977-9955; Fax: (416) 977-2325
E-mail: [blackcap@black-cap.com](mailto:blackcap@black-cap.com)
Web: [www.black-cap.com](http://www.black-cap.com)

**Africans in Partnership Against AIDS (APAA)**

517 College Street, Suite 338, Toronto ON M5G 4A2
Tel.: (416) 924-5256; Fax: (416) 924-6575
E-mail: [apaa@on.aibn.com](mailto:apaa@on.aibn.com)

**Asian Community AIDS Services (ACAS)**

33 Isabella Street, Suite 107, Toronto ON M4Y 2P7
Tel.: (416) 963-4300; Fax: (416) 963-4371
E-mail: [info@acas.org](mailto:info@acas.org)
Web: [www.acas.org](http://www.acas.org)

**Alliance for South Asian AIDS Prevention (ASAAP)**

20 Carlton Street, Suite 126, Toronto ON M5B 2H5
Tel.: (416) 599-2727; Fax: 416-599-6011
E-mail: [aids@interlog.com](mailto:aids@interlog.com)
Web: [www.interlog.com/~aids](http://www.interlog.com/~aids)

**National Black Women Foundation (Umojo)**

5021 Kingsway, Suite 341, Burnaby, BC V5H 4A4
Tel.: (604) 605-0124; Fax: (604) 605-0171
E-mail: [natbwf@inermes.com](mailto:natbwf@inermes.com)

**GAP-VIES**

2577A, Jean-Talon est., bur. 101, Montréal QC H2A 1T8
Tel.: (514) 722-5655; Fax: (514) 722-0063
E-mail: [gap-vies@sympatico.ca](mailto:gap-vies@sympatico.ca)

**Asian Society for the Intervention for AIDS (ASIA)**

119 West Pender Street, #210, Vancouver, BC V6B 1S5
Tel.: (604) 669-5567; Fax: (604) 669-7756
E-mail: [asia@asia.bc.ca](mailto:asia@asia.bc.ca)
Web: [asia.bc.ca/default.htm](http://asia.bc.ca/default.htm)

**VIVER (Portuguese-Speaking HIV/AIDS Coalition)**

399 Church Street, 4th Floor, Toronto ON M5B 2J6
Tel.: (416) 340-8484 ext. 290; Fax: (416) 340-8224

**United Caribbean AIDS Network (UCAN)**

790 Bay Street, Suite 940, Toronto ON M5G 1N8
Tel.: (416) 977-9955 ext. 33; Fax: (416) 340-2325
E-mail: [ucan@black-cap.com](mailto:ucan@black-cap.com)

**Centre Medico Social Communautaire (CMSC)**

22 College Street, Main Floor, Toronto ON M5G 1K3
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Fax: (416) 922-2672

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