

PREVENTION PROGRAMS IN DEVELOPED COUNTRIES: LESSONS LEARNED

A Report on Prevention Initiatives used to address HIV and AIDS prevention for African, Caribbean and Black Populations in developed countries

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GLOSSARY OF ACRONYMS

<i>General Terms</i>	
IDU	Injecting drug use/ people who use injection drugs
MSM	Men who have sex with men
UNAIDS	The United Nations Joint Programme on HIV/AIDS
WHO	World Health Organization
<i>Terms Specific to Canada</i>	
ACAP	AIDS Community Action Program
ACCHO	African & Caribbean Council on HIV/AIDS in Ontario
AWARE	Assisting Women with AIDS-related Education
CHC	Community Health Centre
CIC	Citizenship and Immigration Canada
CMA	Census Metropolitan Area
EYET	East York East Toronto Family Resources
FGM	Female Genital Mutilation
<i>Terms Specific to the United States of America</i>	
ACS	American Community Survey
ADAPT	Adopting & Demonstrating the Adaptation of Prevention Techniques
AED	Academy for Educational Development
APHA	American Public Health Association
CBO	Community-based organization
CDC	Centers for Disease Control and Prevention
DEBI	Diffusion of Effective Behavioral Interventions
DHAP	Division of HIV/AIDS Prevention
ECDC	Ethiopian Community Development Council
HNR	Heightened National Response
REP	Replicating Effective Programs
SAYFSM	Sub-Saharan African Youth & Family Services of Minnesota
STD	Sexually Transmitted Disease
TA	Technical Assistance
<i>Terms Specific to the United Kingdom</i>	
AHPN	African HIV Policy Network
CHAPS	Community HIV and AIDS Prevention Strategy
DH	Department of Health
ECCUK	The Ethiopian Community Centre in the UK
GRASP	Gonococcal Resistance to Antimicrobials Surveillance Programme
GUM	Genitourinary medicine clinics
HBAI	Households Below Average Income
HPA	Health Protection Agency
IP	Implementing Partner
NAHIP	National African HIV Prevention Programme
NHS	National Health Service
ONS	Office for National Statistics
PCT	Primary Care Trust
STI	Sexually Transmitted Infection

EXECUTIVE SUMMARY

Key Findings

A. Canada

According to the 2006 Canada Census¹, there were an estimated 783,800 Black people in Canada, constituting 2.5% of the total population. Slightly over one-half of the Black population in Canada was foreign-born in 2006, most originating from the Caribbean and Africa. In 2005, 12.2% of the estimated 58,000 people living with HIV in Canada were from a HIV-endemic country (historically Caribbean, South American, Central American and African countries). A HIV-endemic country is defined as having a HIV prevalence rate of 1.0% or greater in adults (ages 15-49) and any one of the following: (a) 50.0% or more of HIV cases are attributed to heterosexual transmission; (b) a male to female ratio of 2:1 or less among prevalent infections; (c) HIV prevalence greater than or equal to 2.0% among women receiving prenatal care.

The Public Health Agency of Canada (PHAC) estimated that 16% of the 2,300 to 4,500 new HIV infections in 2005 were attributed to the HIV-endemic exposure category. Among AIDS diagnoses reported in 2007 (all ages), 9.3% were in Black people, with Black women being the most over-represented of all female ethnic groups. The *HIV Prevention Guidelines and Manual: A Tool for Service Providers Serving African and African Caribbean Communities Living in Canada* (2006), highlights a number of key factors that affect HIV prevention in African and African Caribbean communities in Canada: HIV-related stigma, discrimination and denial; racism; gender equity issues; sexual violence; heterosexism and homophobia; attitudes towards sex, health and well-being; multiple sex partners; immigration; and cultural and personal hygiene practices. The Government of Canada has adopted the *Federal Initiative on HIV/AIDS in Canada*, to address the disproportionate rate of HIV infection among eight key populations that include people from countries where HIV is endemic. At the local level, organizations such as East York East Toronto Family Resources, Somerset West Community Health Centre (CHC), Black Coalition of AIDS Prevention (Black CAP) and the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) are implementing HIV prevention projects to raise awareness around HIV/AIDS among African and Caribbean communities.

B. The United States of America

The 2004 American Community Survey (ACS)² estimated that there were 36.6 million Black people in the U.S., constituting 12.8% of the total population. In 2004, 8% of the Black population was foreign-born, the vast majority of whom originated from Latin America and Africa. While recent data indicates that Black people continue to comprise approximately 12% of the U.S. population, HIV surveillance demonstrate that the African Americans population represented 46% of the people

¹ The Census of Population provides the population and dwelling counts not only for Canada but also for each province and territory, and for smaller geographic units such as cities or districts within cities. The census also provides information about Canada's demographic, social and economic characteristics.

² The American Community Survey (ACS) is a new nationwide survey designed to provide reliable, timely information for local communities on how they are changing.

living with HIV in 2006. African Americans also accounted for an estimated 45% of new HIV infections in 2006 compared to 35% among Whites. The 2007 rates of AIDS cases were 47.3 per 100,000 in the African American population compared to 5.2 per 100,000 in the White population. Research from Centers for Disease Prevention and Control (CDC)³ indicate that the African American population as a whole is more likely to experience challenges associated with risk factors for HIV infection such as socioeconomic issues (namely poverty), lack of awareness of HIV serostatus, sexually transmitted diseases, homophobia and sexual risk factors. To respond to the HIV/AIDS epidemic facing African Americans, CDC, in collaboration with public health, African American leaders and communities, developed the *Heightened National Response to the HIV/AIDS Crisis among African Americans* to expand the reach of prevention services; increase opportunities for diagnosing and treating HIV; develop new and effective prevention interventions; and mobilize African American communities around HIV/AIDS issues. At the local level, organizations such as the *Sub-Saharan African Youth & Family Services of Minnesota* (SAYFSM) and the *Ethiopian Community Development Council* (ECDC) provide culturally and linguistically competent HIV/AIDS education to members of the African Diaspora.

C. The United Kingdom

According to the Office for National Statistics (ONS)⁴ 2001 Census, there were an estimated 1,148,738 Black people in the UK, representing 2.0% of the total population. In 2001, 91.5% of the Black population was of African (42.2%) and Caribbean descent (49.3%). The Health Protection Agency (HPA)⁵ reports that the prevalence of diagnosed HIV among Black African and Black Caribbean communities in England is estimated to be 3.7% and 0.4% respectively, compared to 0.09% among the White population. In 2007, there were 2,691 new HIV diagnoses among the Black African population, representing 40% of all new diagnoses in the UK. The number of new AIDS cases diagnosed among the Black African population (276) in 2007 has declined from the peak reported in 2003 (550).

African and Caribbean populations in the UK are more likely to experience challenges associated with risk factors for HIV infection such as low income, immigration and settlement issues, poor housing conditions, social exclusion and limited access to training, skills development and job opportunities. In an effort to respond to HIV and sexual health issues at a national level, the Department of Health (DH)⁶ in the UK developed the *National Strategy for Sexual Health and HIV*

³ CDC, part of the U.S. Department of Health and Human Services, is the primary federal agency for conducting and supporting public health activities in the U.S.

⁴ The Office for National Statistics produces independent information to improve understanding of the UK's economy and society.

⁵ The Health Protection Agency is an independent UK organization that was set up by the government in 2003 to protect the public from threats to their health from infectious diseases and environmental hazards. It does this by providing advice and information to the general public, to health professionals such as doctors and nurses, and to national and local government.

⁶ The Department of Health is committed to improving the quality and convenience of care provided by the National Health Service (NHS) and social services. Its work includes setting national standards, shaping the direction of health and social care services and promoting healthier living. NHS refers to the four publicly funded healthcare systems of the United Kingdom (England, Scotland, Wales and Northern Ireland).

in 2001 which details a 10-year plan to address sexual health issues in the UK. Part of the strategy is focused on a nationally coordinated HIV prevention program directed towards African communities, *National African HIV Prevention Programme* (NAHIP). NAHIP works with African-led organizations to identify the HIV health promotion needs of African communities, and supports the implementation of training and national health promotion campaigns through a range of partners across England. Moreover, NAHIP and its partner organizations have developed *The Knowledge, the Will and the Power*, a new plan of action for HIV prevention interventions targeting Africans living in England. At the local level, the *Ethiopian Community Centre in the UK* (ECCUK) provides primary and secondary HIV prevention programmes to African and Caribbean people living in Enfield and Haringey, while *Naz Project London* supports African MSM in East London via peer support groups and a HIV/AIDS information and helpline.

Analysis

Through consultation with the noted community-based organizations from Canada, the USA and the UK, the following strengths and obstacles regarding HIV prevention work with African and Caribbean communities, have emerged:

Strengths:

- Involving African and Caribbean Diaspora communities in most aspects of HIV prevention to build community action and ownership
- Developing peer-led HIV prevention interventions that utilize African and Caribbean populations to gradually engage community members in discussion around HIV/AIDS
- Offering a range of culturally and linguistically appropriate, faith-based, age, gender-specific HIV services, as well as programs that address other issues of importance to African & Caribbean Diaspora communities
- Partnering with service providers, local business, media etc., interested in addressing HIV/AIDS among African and Caribbean communities

Obstacles:

- Attitudes, beliefs: HIV-related stigma, fear and discrimination, myths and misinformation about HIV/AIDS, homophobia
- Immigration
- Environmental pressures: poverty, lack of employment, immigration concerns
- Organizational issues: Lack of culturally and linguistically appropriate HIV prevention services, limited funding
- Limited funding for community-based organizations to tackle HIV prevention among African and Caribbean Diaspora communities.

Recommendations

Based on the strengths and obstacles identified in the analysis, the following is a list of recommendations for organizations planning to or currently doing HIV prevention among African and Caribbean Diaspora communities:

- Involve the African and Caribbean community members in all aspects of HIV prevention to build community action and ownership around HIV/AIDS issues.

Opportunities for community involvement can include: peer education, evaluation, sponsorship, fundraising and sitting on a project advisory panel.

- Develop/adapt and implement peer-led HIV prevention interventions that draw upon African and Caribbean populations to gradually engage community members in discussion about HIV/AIDS issues.
- In collaboration with community members, local and/or national health organizations, develop culturally and linguistically appropriate, faith-based, age and/or gender-specific HIV prevention interventions that respect the current 'stage of change' of community members. Create an environment where participants can gradually discuss myths, stigma, fears and attitudes.
- Offer culturally and linguistically appropriate HIV information, resources and services (HIV testing, referral, media campaigns, service provider training etc.) in a variety of formats (individual, group, web-based), as well as programs that address other issues of importance to African & Caribbean Diaspora communities (transportation, immigration and settlement services).
- Collaborate with other organizations working to develop, implement, evaluate and support HIV prevention among African and Caribbean populations, including small businesses, schools and media who can assist with sponsorship and fundraising.
- Identify and engage local, national and international funding bodies.
- Advocate for a national strategy for HIV/AIDS prevention among African and Caribbean Diaspora communities; for surveillance that tracks HIV/AIDS among African and Caribbean Diaspora populations; and to all levels of government regarding the issues that face African and Caribbean Diaspora communities such as poverty, immigration policy and deportation.

Conclusion

While African and Caribbean Diaspora communities comprise less than 8% of all Black populations in Canada, the USA and the UK, these populations are over-represented in terms of HIV prevalence, incidence and AIDS cases. African and Caribbean communities in these countries are also more likely to experience challenges that place them at higher risk for HIV infection. These challenges are numerous and include socioeconomic issues, HIV-related stigma, discrimination and denial, immigration and migration, racism, sexism, sexual and physical violence, heterosexism and homophobia, sexual risk factors, social exclusion, attitudes towards sex, health and well-being, lack of awareness of HIV serostatus, operationalization of terms like African American, and cultural and personal hygiene practices. Each of these countries has developed a national initiative to address HIV/AIDS that include efforts focused on people from countries where HIV is endemic or native-born Black populations. However, only the UK has created a plan of action specific to African Diaspora populations that identifies obstacles to HIV prevention, and focuses on how to overcome these barriers in order to achieve change.

At the local level, community-based organizations in each of these countries have implemented peer-led HIV prevention interventions that engage community members in informal, non-intrusive settings. These interventions have been largely successful at involving the broader community in HIV prevention, building rapport, and developing culturally and linguistically appropriate tools. In terms of obstacles, these community-based organizations are faced with budget cuts while simultaneously attempting to address stigma, discrimination and fear regarding HIV/AIDS along with systemic issues such as immigration. Given the action plan developed in the UK, it will be important to learn from this resource. In doing so, other African and Caribbean Diaspora communities can create new strategies in reducing HIV transmission and enhanced quality of life for people living with HIV/AIDS.

INTRODUCTION

According to the World Health Organization (WHO) and UNAIDS, in 2007 there were an estimated 33.2 million (30.6 - 36.1 million) persons living with HIV in 2007 worldwide, 2.5 million (1.8 – 4.1 million) persons newly infected with HIV, and an estimated 2.1 million (1.9 – 2.4 million) deaths of persons with AIDS⁷. While these statistics provide evidence that HIV transmission knows no boundaries – geographic, socioeconomic, gender, age, etc. – international HIV/AIDS surveillance demonstrates that there are key populations who are most affected by this pandemic. In industrialized countries such as Canada, the United States of America (U.S.) and the United Kingdom (UK), men who have sex with men (MSM), people who use injection drugs (IDUs), women and people who come from countries where HIV is endemic account for a disproportionately high percentage of persons living with HIV (See Appendix A for a list of HIV-endemic countries). A HIV-endemic country has a HIV prevalence rate of 1.0% or greater in adults (ages 15-49) and any one of the following: (a) 50.0% or more of HIV cases are attributed to heterosexual transmission; (b) a male to female ratio of 2:1 or less among prevalent infections; (c) HIV prevalence greater than or equal to 2.0% among women receiving prenatal care.

Of particular concern are populations from the African and Caribbean Diaspora, who in each of these three countries are over-represented in HIV prevalence, incidence and newly diagnosed AIDS cases. In short, the HIV/AIDS pandemic is a health crisis for the African and Caribbean Diaspora living in Canada, the USA and the UK, "...at all stages of HIV/AIDS – from infection with HIV to death with AIDS."⁸

The following report:

- a. Provides a demographic profile of African and Caribbean Diaspora populations living in Canada, the USA and the UK;
- b. Details HIV/AIDS statistics from these countries, comparing national rates to those of African and Caribbean Diaspora populations;
- c. Discusses some of the key risk factors and barriers to prevention that specifically impact African and Caribbean Diaspora communities in Canada, the USA and the UK;
- d. Compares and contrasts selected HIV prevention interventions that focus specifically on African and Caribbean Diaspora populations in each of these countries;
- e. Based on the analysis of these interventions, highlights a series of recommendations for organizations doing HIV prevention work among the African and Caribbean Diaspora.

⁷ World Health Organization. (2009). *AIDS Epidemic Update*. Retrieved on April 24, 2009 from http://data.unaids.org/pub/EPISlides/2007/2007_epiupdate_en.pdf

⁸ Centers for Disease Prevention & Control. (Revised August 2008). *HIV/AIDS Fact Sheet: African Americans*. Retrieved on March 9, 2009 from <http://www.cdc.gov/HIV/topics/aa/resources/factsheets/aa.htm>

2.0 HIV/AIDS AND AFRICAN AND CARIBBEAN DIASPORA COMMUNITIES LIVING IN CANADA

2.1 Demographic Profile

There is much diversity among the Black communities living in Canada. These populations vary in terms of their roots, with some who have been in Canada for generations, while others were born primarily in Africa and the Caribbean. Based on data collected by Statistics Canada, the following profile highlights some of the key demographic characteristics of Canadian-born and foreign-born Black communities including population size, place of residence, age, education, employment and income.

According to the 2006 Census of Canada, Black people were the third largest visible minority group⁹ in Canada (after South Asian¹⁰ and Chinese communities respectively), growing 18.4% from 662,200 individuals in 2001 to an estimated 783,800 in 2006. Black people accounted for 15.5% of the visible minority population (5,068,100) and 2.5% of the total population (31,612,897) in 2006. Approximately over one-half (52.5%) of the Black population was foreign-born, originating primarily from the Caribbean and Africa: Jamaica (25.8%), Haiti (14.9%), Trinidad and Tobago (5.2%), Ethiopia (4.5%), Somalia (4.4%), Ghana (4.4%), Guyana (3.5%), Nigeria (3.3%), Barbados (3.2%) and the Democratic Republic of Congo (3.1%) [9].

Ninety-seven percent of Black people lived in urban areas and 47% of the Black population (310,500) lived in the Toronto census metropolitan area¹¹ (CMA) in 2001 [3]. In Toronto, 57% of the Black population was foreign-born. Montréal, Québec was home to the second largest Black population in Canada (139,000). Fifty-five percent of Black people in Montréal were foreign-born [5].

Children under the age of 15 accounted for nearly 30% of the Black population in 2001, compared with 19% of the total population. In addition, 17% of Black people were aged 15 to 24 years compared with 13% of the overall population. Five percent of Black people were aged 65 years or over as compared to 12% of the Canadian population as a whole [5].

In 2001, foreign-born and Canadian-born Black populations of prime working age (age 25 to 54) were just as likely as all Canadian-born persons aged 25 to 54 to have a university education — about one in five [5].

⁹ Visible minorities are defined by the *Employment Equity Act* as “persons, other than Aboriginal peoples, who are non-Caucasian in race or non-White in colour”. “Black” is one of the groups which make up the visible minority population, as identified by Employment Equity regulations.

¹⁰ South Asian origins are comprised of Bangladeshi, Bengali, East Indian, Goan, Gujarati, Kashmiri, Nepali, Pakistani, Punjabi, Sinhalese, Sri Lankan and Tamil communities.

¹¹ Area consisting of one or more neighbouring municipalities situated around a major urban core. A census metropolitan area must have a total population of at least 100,000 of which 50,000 or more live in the urban core.

In 2001, Canadian-born Black people had a 7.9% unemployment rate compared with 9.6% for the foreign-born Black population [5]. The foreign-born Black population aged 25 to 54 earned less than all foreign-born persons in the same age group (\$28,700 versus \$34,800) in 2001. Age-standardizing¹² the average employment income of the foreign-born Black population increased it to \$29,200 [5].

2.2 HIV/AIDS Statistics

HIV Surveillance¹³

The Public Health Agency of Canada (PHAC) produced estimates of HIV prevalence to the end of 2005 and HIV incidence in 2005. Based on these estimates, the following summary outlines HIV surveillance data regarding gender, age and transmission category.

HIV Prevalence

An estimated 58,000 people in Canada were living with HIV (including AIDS) at the end of 2005, of which approximately 27% (15,800 persons) were undiagnosed. This represents an increase of about 16% from 2002 (50,000 persons). Women accounted for 20% of people living with HIV in Canada at the end of 2005. There were an estimated 11,800 (10,000 to 13,500) women living with HIV (including AIDS) at the end of 2005, representing a 23% increase from 2002 (9,600) [1]. At the end of 2005, MSM comprised the largest proportion of prevalent infections (51% [29,600]), followed by IDU (17% [9,860]), the heterosexual/non-endemic category (15% [8,620]), the heterosexual/endemic category (12% [7,050]) and less than one percent was attributed to other exposures (400). The largest absolute increase was among MSM (13%) with 3,400 more prevalent infections since 2002. Both the heterosexual/non-endemic and heterosexual/endemic exposure categories increased by 24%, while there was an increase of 11% among the IDU category [1].

HIV Incidence

The number of people in Canada newly infected with HIV in 2005 was estimated to be 2,300 - 4,500 in 2005 compared to 2,100 to 4,000 in 2002. Women accounted for 27% of new infections in Canada in 2005. There were 620 to 1,240 new HIV infections among women in 2005 compared to 490 to 970 (24%) in 2002. Regarding exposure category, a slightly higher proportion of new infections among women were attributed to the heterosexual category in 2005 compared to 2002

¹² All employment and unemployment rates are age-standardized. Rates for Canadian-born Blacks age 25 to 54 are age-standardized to the same age distribution as all Canadian-born persons in this age group while rates of foreign-born Blacks are standardized to the age distribution of all foreign-born people.

¹³ Note from PHAC: Surveillance data understate the magnitude of the HIV epidemic and consequently do not represent the total number of people infected with HIV (prevalence) or the number newly infected each year (incidence). Some of the reasons for this include the fact that surveillance data are subject to delays in reporting, underreporting and changing patterns in HIV testing behaviours (who comes forward for testing). In addition, surveillance data can only tell us about persons who have been tested and diagnosed with HIV or AIDS and not those who remain untested and undiagnosed. Furthermore, because HIV is a chronic infection with a long latent period, many persons who are newly infected in a given year may not be diagnosed until later years.

(76% versus 74% respectively). The remainder of new infections among women was attributed to IDU [1]. The trend in age distribution since the beginning of the HIV/AIDS epidemic has seen a decreasing proportion of positive tests among younger adults and an increasing proportion among older adults. In 2007, the proportion of adults between 15 and 39 years of age was 55.2% (representing a decrease of 18.3% from previous years) while the proportion among adults 40 years of age and older was 44.8% (representing an increase of 18.3% from previous years) [7]. MSM continue to comprise the largest number of new infections (45%), followed by the heterosexual/non-endemic category (21%) and the heterosexual/endemic category (16%). The 2005 estimated infection rate among individuals from HIV endemic countries was at least 12.6 times higher than other Canadians [1].

AIDS Cases¹⁴

The number of AIDS diagnoses reported to PHAC has steadily declined over the last 10 years in Canada. The following summary outlines AIDS surveillance data based on gender, age, transmission category and race/ethnicity.

In 2007, 238 AIDS diagnoses were reported, bringing the total number to 20,993 since 1979. In 2007, women accounted for 19.1% of AIDS diagnoses, representing a decrease of 36.6% from the previous year. The proportion 40 years of age and older has accounted for the majority of cases since 2000, and in the year 2007, exceeded 60% of all reported AIDS diagnoses for the first time. The largest proportion of diagnoses among adults in 2007 (35.4%) was attributed to injecting drug use¹⁵. Heterosexual contact accounted for 32.3% of cases, while sexual contact between men accounted for another 31.3% of diagnoses [7].

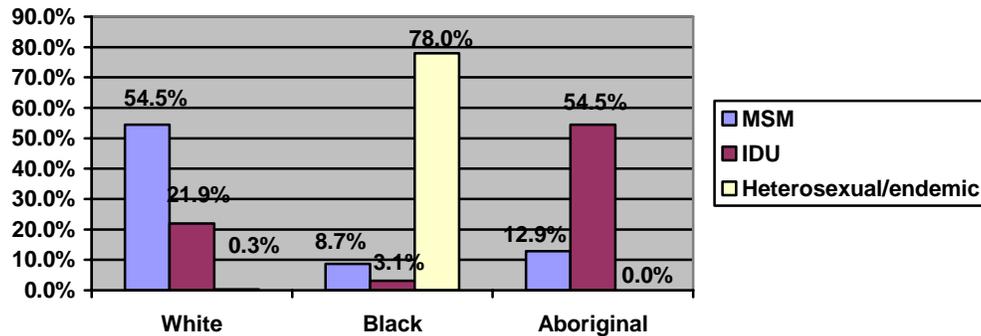
Race/ethnicity¹⁶: Among diagnoses (all ages) reported in 2007, 66.4% were among the White population, followed by the Aboriginal population (14.0%), persons who reported another race/ethnicity (10.3%), and the Black population (9.3%). AIDS surveillance data for the last 10 years indicate marked ethnic disparities in reported exposure category among adults (Figure 1). "Females are overrepresented among reported AIDS cases in Black Canadians and Aboriginal persons. Between 1979 and 2007, in cases (all ages) with reported Black or Aboriginal ethnic status, 35.2% and 27.2%, respectively, were female. In cases reporting White, Asian/Arab or Latin American ethnic status, on the other hand, 6.1%, 8.2% and 8.0% of cases, respectively, were female." (Public Health Agency of Canada, 2007, p. 11).

¹⁴ Note from PHAC: It is important to note the limitations associated with reported AIDS diagnoses. AIDS surveillance data have not been available from the province of Quebec since June 30, 2003, so the counts reported in this report are not representative of the true number of AIDS diagnoses in Canada. Furthermore, the province of Ontario undertook an IT-application change for AIDS case management and reporting in 2005. As a result of this conversion, reported AIDS diagnoses from Ontario for the second half of 2005 and onward do not contain any exposure category or ethnic status data. Caution must be used when interpreting trends over time nationally.

¹⁵ In 2007, 57.9% of all AIDS diagnoses in adults reported to PHAC had unreported data or no identified risk for exposure category.

¹⁶ Ethnic status data were not provided for 55.0% of all AIDS cases reported to PHAC in 2007.

Figure 1: Percentage of AIDS diagnoses in Adults by Selected Ethnic Status and Exposure Category, 1998 to 2007



Source: Public Health Agency of Canada, 2008

2.3 Risk Factors and Barriers to Prevention

Due to the diversity within Black communities in Canada, "...individual responses to and acceptance of HIV education, prevention and testing can vary greatly depending on religious affiliations, time of migration, country of origin, attitudes towards sexual diversity and the status of women." (African and Caribbean Council on HIV/AIDS in Ontario, p. 12). This section describes the key factors that affect HIV prevention among African and African Caribbean communities in Canada based on the African and Caribbean Council on HIV/AIDS in Ontario's (ACCHO) manual, *HIV Prevention Guidelines and Manual: A Tool for Service Providers Serving African and African Caribbean Communities Living in Canada*:

1. **"HIV-related stigma, discrimination, and denial** often have a negative impact on health including social support networks, employment and/or working conditions, personal health practices, and coping skills." (ACCHO, p. 12-13)
2. **Racism:** "For many African and African Caribbean people, racism limits access to information and services and creates barriers to coping and protecting oneself from HIV transmission. Many African and African Caribbean people have experienced racism within Canadian society in general and with healthcare providers and agencies in particular. This is one important reason many are reluctant to seek the assistance of service providers, reveal information during a risk assessment, or seek support, treatment and/or care." (ACCHO, p. 14)
3. **Women, Gender and Equity:** "The increasing prevalence of HIV/AIDS in women in Canada is the result of a complex mix of biological factors and social factors. Like many women in Canada, women from African and African Caribbean cultures are often socialized to be subordinate to the men in their lives. This gender imbalance, which is usually supported by religious teachings and socio-cultural norms, often limits women's ability to negotiate safer sex to the point where they will not take an HIV test or ask their partners to use condoms." (ACCHO, p. 14-15)

4. **“Sexual and physical violence** against women and children has a direct impact on the ability of women and children to practice HIV prevention. In many African and African Caribbean cultures, underlying issues of violence are never discussed within the family and/or community. The few girls or women who come forward often face stigma and reprisal from family for speaking out and/or seeking support. Many African women have fled persecution from war-torn countries of Sub-Saharan Africa where they may have been raped and tortured, which may have resulted in physical injury, pregnancy, and exposure to HIV. Their ability to practice HIV prevention may be affected by the aftermath of sexual violence (e.g., depression, loss of value, loss of sense of well-being).” (ACCHO, p. 16)
5. **Heterosexism and Homophobia:** “Research has revealed that homophobia has a significant impact on HIV prevention methods (e.g. men and women believing that only gay men are at risk for HIV transmission, men who have sex with men but do not identify as gay believing that they do not need to use HIV prevention methods). Homophobia is often perpetuated within religion and secular organizations, as well as by staff and leadership. As a result, gay, bisexual, and heterosexual men who have sex with men may be targeted for overt or covert hostility, isolated or marginalized. The discrimination or hostility often creates an environment which prevents African and African Caribbean men from discussing HIV prevention methods, particularly if they have sex with other men.” (ACCHO, p. 18)
6. **Attitudes towards Health and Well-being:** “Choices about health care and HIV prevention may be driven by different perceptions of health and well-being, as well as pragmatism. The experiences that members of the African and African Caribbean community have had with the health care system – both in Canada, abroad, and in their country of origin may also affect whether they perceive service providers and/or their services as trustworthy. It may be difficult for some African and African Caribbean people to accept health promotion messages that appear to challenge their views about the “proper” role of women and men, heterosexism and homophobia, HIV prevention in common-law or marital relationships.” (ACCHO, p. 18-19)
7. **Attitudes towards Sex: Sex as a Taboo Subject:** “Many African and African Caribbean cultures restrict or prohibit public displays and discussions about sex and sexuality except in the form of playful jests and metaphors used during informal conversation, in music, and when “hanging out” with peers. Sometimes, there is so much secrecy about issues related to reproduction, sexuality, and sexual orientation, that there is denial about sexual involvement even when sexual activity is taking place.” (ACCHO, p. 19)
8. **Multiple Sex Partners:** “Within African Caribbean culture, ‘functional polygamy’ is often not openly discussed, although it may be implicitly understood and practiced, and may exist alongside and within the context of marriage and long-term relationships. Many African and African Caribbean men do not choose to use condoms or limit the number of sexual partners to protect themselves or their partners. Instead, they prefer to think that they do not have HIV or other STIs, and they choose partners who they assume are also uninfected.” (ACCHO, p.19-20)

9. **Immigration and Migration:** "African and African Caribbean people living in Canada for periods of time and then returning to their country of origin may not consider themselves or members of their "home" community at risk for infection and may underestimate the need to consistently practice HIV prevention. The immigration process itself, where one member of a family to come to Canada first to get established, may contribute to risk of HIV transmission for some people. This means that partners may be apart for a year or more, and may be involved in sexual relationships that could put them at risk. Also, countries in Africa and the Caribbean are often destinations for sexual tourism by both nationals and non-nationals. People may not negotiate safer sex because they perceive tourists and nationals who live abroad as "safe" from HIV infection." (ACCHO, p. 21)

10. Cultural and Personal Hygiene Practices:

- **Male circumcision** is a common practice in many African cultures. It is common for one instrument to be used to circumcise many young men, which means the risk of HIV is high due to blood-to-blood contact. Men who have been circumcised within this context should be advised to have an HIV test if they cannot be certain that a new, sterilized knife was used." (ACCHO, p. 22)
- **Female Circumcision:** "Female genital mutilation (FGM) refers to the partial or complete removal of the female external genitalia for reasons other than medical therapeutic purposes. A traditional practitioner usually performs FGM with an instrument and without anaesthetic. The risk for HIV transmission is particularly high if multiple female genital mutilations are being done with the same instrument that is rarely sterilized. The procedure often results in physical trauma to the vaginal lining during sexual intercourse, which increases the risk of the woman acquiring HIV or other STIs. There are many African women who have undergone the FGM procedure who now live in Canada." (ACCHO, p. 22)
- **Vaginal Cleansing/Douching** is a method of maintaining personal vaginal hygiene or concealing sexual activities that is common practice among many African Caribbean women. Products used for vaginal cleansing include herbs, soap, or other over-the-counter douching products. These products may cause vaginal dryness, irritation, ulceration, or may remove the natural bacteria that maintain the pH balance of the vaginal lining, thereby allowing harmful bacteria to flourish. All of these factors may increase risk of infection." (ACCHO, p. 23)

2.4 Selected HIV Prevention Programs/Projects

The following section describes Canada's federal initiative to address HIV/AIDS among people from countries where HIV is endemic, and local HIV prevention interventions that are focused specifically on African and Caribbean communities:

Through the *Federal Initiative to Address HIV/AIDS in Canada*, the Government of Canada has committed to developing approaches to address HIV/AIDS among eight key populations: people living with HIV/AIDS, MSM, IDU, Aboriginal peoples, prison inmates, youth at risk, women and

people from countries where HIV is endemic. With regards to people from countries where HIV is endemic, PHAC intends to:

- develop a population-specific HIV/AIDS status report regarding people from countries where HIV is endemic that will include up-to-date information on the population's demographic profile, the state of HIV infections, the factors that increase vulnerability to HIV/AIDS, currently funded research, the lived experience of people affected by HIV/AIDS and an analysis of the response;
- develop *E-Track*, a second-generation HIV surveillance system, to gather more detailed information on HIV-associated risk behaviours, HIV testing and exposure to certain intervention programs among individuals within ethnocultural populations in Canada and particularly among people from countries where HIV is endemic;
- Through its community programming, including the AIDS Community Action Program (ACAP), provide support for community-based organizations to deliver prevention, care and support services to all people living with HIV/AIDS and those vulnerable to HIV infection, including people from countries where HIV is endemic.

A 2005 national environmental scan, *Springboarding a National HIV/AIDS Strategy for Black Canadian, African and Caribbean Communities Project*, identified organizations, research and initiatives focused on addressing HIV/AIDS among Black Canadian, African and Caribbean communities. The following are just a few examples of community-based HIV prevention projects and programs focused on specifically on African and Caribbean Diaspora communities in Canada that were presented in that report:

- East York East Toronto Family Resources' **AWARE (Assisting Women with AIDS-related Education)** project provides peer-based outreach and support to culturally diverse women in the East York area of Toronto, promoting HIV/AIDS awareness and healthy choices in relation to lifestyle and community action. Peer Outreach Workers deliver information and facilitate workshops regarding women's reproductive health, HIV/AIDS and related topics, as well as providing referrals and information on existing community programs. The core elements of AWARE include: recruitment and training of peer outreach workers, outreach to women where they consistently congregate (i.e., family resource centres), and group workshops in collaboration with other local AIDS service organizations.
- In Ottawa, **Operation Hairspray** is delivered through a partnership between the Somerset West Community Health Centre and Ottawa Public Health. It is an innovative peer-led health promotion initiative, which seeks to engage African and Caribbean hairdressers and barbers as a channel to reach people from countries where HIV is endemic. Phase I of the project focused on: recruiting a project advisory group that is reflective of African and Caribbean populations; recruitment, training and implementation of hairdressers and barbers as peer educators. Phase II of the project is meant to go beyond barber shops and hair salons to engage African and Caribbean restaurant, clothing and grocery store owners from in peer education regarding HIV prevention

Of particular import as well are several projects that are being implemented by the Black Coalition of AIDS Prevention (Black CAP) and the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) which are both based in Toronto, Ontario.

Black Coalition of AIDS Prevention (Black CAP) is an organization that works to reduce HIV/AIDS in Toronto's Black, African and Caribbean communities and enhance the quality of life of Black people living with or affected by HIV/AIDS. The following is a summary of some of their initiatives:

- 1.) **One Night Your Choice:** This initiative consisted of three phases:
 - **Phase One:** The creation of a youth committee to affirm the recommendations in a report entitled 'Who Feels It Knows: Challenges of HIV Prevention for Young Black Women in Toronto', completed by Black CAP in 2006, which revealed the issues that young Black women in Toronto were facing within their lives, and how they impacted their ability to practice adequate HIV prevention. The committee then planned a media campaign, the main goal of which was to reveal to young Black women how they are at risk for HIV within their lives through innovative messaging.
 - **Phase 2:** After the launch of the media campaign, Black CAP began facilitating women's only sexual health workshops for established youth groups across Toronto. The curriculum included HIV/AIDS, STIs, relationships and homophobia. Youth who have been infected or affected by HIV/AIDS were encouraged to attend these workshops.
 - **Phase 3:** Black CAP's research study also identified that women who have sex with women (WSW) required a focused HIV prevention initiative. As such, an advisory committee of service providers and community members are currently in the process of developing tools to educate young Black WSW how they are at risk for HIV. These tools (a postcard and poster) will be launched at 2009 Pride events in Toronto and in the future at other events where Black WSW congregate.

- 2.) **THINK campaign and Get the Low Down resource website:** The main goal of this multi-media campaign was to reveal to young BMSM how they are at risk for HIV within their lives through innovative messaging. The media tools consist of a postcard series on topics such as safe sex in bathhouses, being HIV positive, sexual roles, myths, sex while on vacation and relationships. Each of the postcards links young BMSM to the Get the Low Down website where they can access information about HIV, STIs, condoms, testing, being HIV positive, as well as an online forum where youth can ask questions of experts. The website also includes two resource guides that Black CAP developed for gay, lesbian, bisexual, transgender, queer and questioning Black youth and their parents; Dealing with Being Different.

- 3.) **Many Men, Many Voices (3MV):** Developed by Diffusion of Effective Behavioural Interventions (DEBI) in the United States, 3MV is a group-level intervention program designed to prevent HIV and sexually transmitted diseases among Black men who have sex with men (MSM) who may or may not identify themselves as gay. The intervention addresses factors that influence the behaviour of Black MSM: cultural, social, and religious norms; interactions between HIV and other sexually transmitted diseases; sexual relationship dynamics; and the social influences that racism and homophobia have on HIV risk behaviours. The MSM HIV Prevention Coordinator at Black CAP is the first person in Canada to be trained in the delivery

of this model and has subsequently re-formatted the intervention to suit the needs of young BMSM in Toronto (i.e., three-day retreat instead of 7 sessions of 2 to 3 hours; inclusion of techniques to impact the core beliefs of Black MSM through hypnosis; participation of adult BMSM as mentors).

4.) **Roots of Risk:** This community level HIV prevention campaign uses a mix of evidence-informed approaches to provide information and support to Black youth living in Toronto. The Roots of Risk project uses a combination of the POL (popular opinion leader) model, creative social marketing methods, and youth engagement opportunities to deliver prevention education programming to straight, gay, bi, lesbian and trans Black youth at heightened risk for HIV. The Roots of Risk project leverages the social networks of youth in Toronto and uses personal and social relationships to transfer important information related to risk reduction. The project is also focused on the promotion of two Black CAP's previously developed HIV prevention campaigns through popular media.

The African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) is made up of organizations and individuals committed to HIV prevention, education, advocacy, research, treatment, care and support for African and Caribbean communities in Ontario. The goal of ACCHO is to reduce the incidence of HIV among African and Caribbean people in Ontario and to improve the quality of life for those infected and affected by HIV/AIDS. ACCHO's goals include:

- Coordinate strategy development, implementation, revision/renewal, and monitoring and evaluation;
- Develop and synthesize knowledge and policy, and set priorities to support the implementation of the Strategy and the vision of ACCHO;
- Support the work of agencies in implementing the Strategy; and
- Develop and maintain the effectiveness and relevance of ACCHO through initiatives such as organizational development, and ongoing monitoring and evaluation of ACCHO's membership and activities.

Keep it alive is an initiative of the ACCHO that was developed by and for African and Caribbean people in Ontario to raise awareness about HIV/AIDS among African and Caribbean communities in Ontario. The campaign encourages adults and youth from Africa and the Caribbean to fight against HIV/AIDS stigma, to know their HIV status by getting tested, and to practice safer sex. The campaign is part of the Strategy on HIV/AIDS for African and Caribbean communities in Ontario. This Strategy is a framework to help African and Caribbean communities and organizations respond to HIV/AIDS. The Strategy is also a guide for communities and governments to work together to prevent the spread of HIV. This initiative includes the following core elements:

- **Media Campaign:** Launched in 2006, the Keep it Alive campaign targets specific populations within African and Caribbean communities (youth, families, francophone and same sex) through different types of media (print, radio, music and TV). ACCHO invited community members to submit a written or video excerpt of them explaining how they would initiate a conversation about HIV/AIDS with an important person in their life. ACCHO and media organization, Top Drawer Creative, then supported the selected finalists to be the spokesperson for the campaign. The campaign was disseminated across southern Ontario, depicting healthy images of Black people with messaging relevant to each sub-population.

- Website: Each component of the Keep it Alive media campaign led community members to the website, www.preventaids.ca where they could access detailed information about HIV i.e., how it is acquired, prevention and anonymous testing. Furthermore, the website has tools for service providers working with African and Caribbean populations around HIV prevention: HIV Prevention Guidelines and Manual and an educational video.
- Strategy Workers: The Ontario Ministry of Health and Long-Term Care's AIDS Bureau, funds positions in various organizations that work with African and Caribbean communities across Ontario (i.e., Ottawa, Kitchener, Niagara Region) to support the implementation of the Strategy on HIV/AIDS for African and Caribbean communities in Ontario. Six times per year, ACCHO facilitates joint meetings of these Strategy Workers to share learnings, synchronize their work and discuss challenges.

See Appendix B for detailed project overviews and Section 5 for a summary of the strengths and obstacles of these HIV prevention interventions.

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3.0 HIV/AIDS among African and Caribbean Diaspora Communities Living in the United States

3.1 Demographic Profile

This section presents a portrait of the native- and foreign-born Black or African American¹⁷ populations in the United States. Information on population size, country of origin, place of residence, age, education and income are based on data from the 2004 American Community Survey (ACS).

In 2004, there were an estimated 36.6 million Black people in the U.S., constituting 12.8% of the total population. The foreign-born Black population was about 2.6 million, or 8% of the total Black population. Ninety-six percent of the foreign-born Black population was from two regions—Latin America (66%) and Africa (30%) [10]. In April 2002, the Population Reference Bureau¹⁸ reported that the largest percentages of foreign-born Black people came from Haiti (18%); Jamaica (15%); the Dominican Republic (7%); Trinidad & Tobago (4%); and Ghana, Guyana, other Caribbean countries, and Nigeria (roughly 3% each) [9].

While Black people resided in every state in 2004, about one of every four Black people lived in three states (New York, Florida, and Georgia). Twenty-five percent of the Black populations in New York, Massachusetts and Minnesota were foreign-born, while 14% or more were foreign-born in Connecticut and New Jersey [10].

In 2004, the Black population had a median age of 31.2 years, about 9 years younger than the median age of the non-Hispanic White population (40.1 years). About 8% of Black people were 65 years and over, compared with about 15% of the non-Hispanic White¹⁹ population [10].

Most Black people aged 25 and over (80%) were high school graduates and more than one of every six had a bachelor's degree or more education in 2004. Among the non-Hispanic White population aged 25 and over, about 89% were high school graduates and 30% had a bachelor's degree or more education [10].

In 2004, the unemployment rate among the civilian non-institutional population was 10.4% for the Black or African American population compared to 4.8% for the White population and 4.4% for the Asian population [11].

¹⁷ In the American federal government, the category "Black or African American" refers to people having origins in any of the Black racial groups of Africa. It includes people who indicated their race or races as "Black, African American, or Negro," or wrote in entries such as African American, Afro American, Nigerian, or Haitian. The terms "Black" and "African American" are used by the U.S. Census Bureau.

¹⁸ The Population Reference Bureau informs people from around the world and in the United States about issues related to population, health, and the environment.

¹⁹ The American federal government defines Hispanic or Latino as a person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin regardless of race. Thus, Hispanics may be any race. The terms "Hispanic" and "Latino" are used by the U.S. Census Bureau.

The median income of Black households (\$30,200) in the 12 months prior to being surveyed was lower than non-Hispanic Whites (\$48,800). About 1 of every 4 Black people lived below the poverty level, compared with about 1 of every 10 non-Hispanic Whites [10].

3.2 HIV/AIDS Statistics

HIV Surveillance

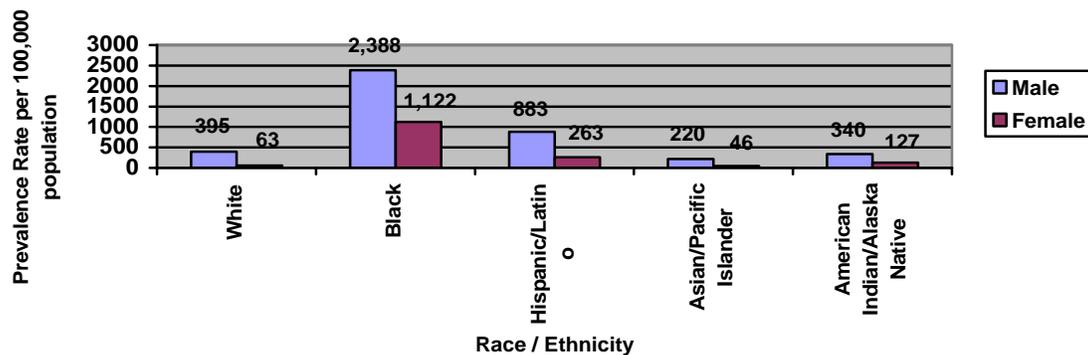
Due to technological advances in HIV surveillance, the Centers for Disease Control and Prevention (CDC) published new estimates of HIV prevalence and incidence in October 2008 [7]. CDC's analysis of this new data reveals that African Americans are among the populations most heavily impacted by HIV infection. The following data summarizes HIV surveillance focusing on gender, age, transmission category and race/ethnicity.

HIV Prevalence

According to CDC, an estimated 1,106,400 people (adults and adolescents) in the U.S. were living with HIV infection at the end of 2006, representing an increase of 11% from 2003. Approximately 21% or one in five people living with HIV in 2006 were unaware of their infection. The majority of people living with HIV in the U.S. continue to be men. In 2006, men comprised three quarters of the people living with HIV (828,000 persons) and women made up one quarter (278,400 persons). Seventy percent of people living with HIV in 2006 were between the ages of 25 and 49 (770,000 persons), 25% were age 50 and over (280,000 persons), and 5% were between the ages of 13 and 24 (56,000 persons). Forty-eight percent (532,000 persons) of all people living with HIV in the U.S. in 2006 were MSM. People infected through high-risk heterosexual contact accounted for 28% of all people living with HIV (305,700 persons). Thirteen percent of men (104,000 persons) and 72% of women (201,700 persons) living with HIV were infected through high-risk heterosexual contact. People infected through injection drug use accounted for 19% of all people living with HIV (204,600). Sixteen percent of men (131,500 persons) and 26% of women (73,100 persons) living with HIV were infected through injection drug use [7].

Race/ethnicity: HIV disproportionately impacts racial/ethnic communities in the U.S. Black people represented nearly half (46% or 510,100 persons) of all people living with HIV in the U.S. in 2006. Whites made up more than one-third of all people living with HIV (35%, or 382,600 persons), while Asian/Pacific Islanders made up approximately 1% and American Indian/Alaska Natives made up less than 1% [7]. Overall, the HIV prevalence rate was greatest among African Americans (1,715 per 100,000 population), Hispanics/Latinos (585 per 100,000) and Whites (224 per 100,000). The prevalence for African American men (2,388 per 100,000) was six times as high as the rate for White men (395 per 100,000). African American women are also severely affected: the prevalence rate for Black women (1,122 per 100,000) was 18 times the rate for White women (63 per 100,000) (Figure 2).

Figure 2: Estimated HIV Prevalence (per 100,000 population) by Race, Ethnicity and Gender, 2006



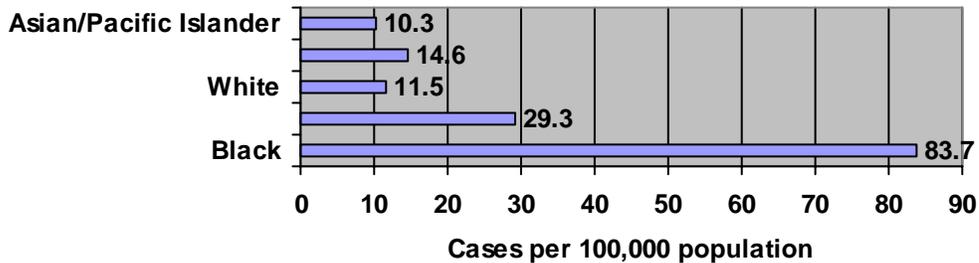
Source: Centers for Disease Control and Prevention, October 2008.

HIV Incidence

According to CDC, the estimated number of new HIV infections among adults and adolescents in the 50 states and the District of Columbia in 2006 was 56,300 at a rate of 22.8 per 100,000 population [5]. In 2006, males accounted for an estimated 73% (41,400 persons) of new HIV infections, and females accounted for an estimated 27% (15,000 persons). The rate of new HIV infections was estimated at 34.3 per 100,000 among males and 11.9 per 100,000 among females. In 2006, persons aged 13–29 accounted for an estimated 34% (19,200 persons) of new HIV infections followed by persons aged 30–39 (17,400 [31%]), aged 40–49 (13,900 [25%]), and persons aged 50 years and older (5,800 [10%]). Although the largest number of new HIV infections occurred in persons aged 13–29 years, the highest rate of new infections was that for persons aged 30–39 years (42.6 per 100,000). Over half of the new HIV infections in 2006 (28,700 [53%]) were among MSM. Persons infected through high-risk heterosexual contact accounted for 31% (16,800 persons) of new HIV infections, IDUs accounted for 12% (6,600 persons), and MSM who were also IDUs accounted for 4% (2,100) [6].

Race/ethnicity: In 2006, African Americans accounted for an estimated 45% (24,900) of new HIV infections, followed by Whites (35% [19,600]), Hispanics/Latinos (17% [9,700]) Asians/Pacific Islanders (2% [1,200]) and American Indians/Alaska Natives (1% [290]). By race/ethnicity, the highest rate of new HIV infections was that for African Americans (83.7 per 100,000) followed by Hispanics/Latinos (29.3 per 100,000), American Indians/Alaska Natives (14.6 per 100,000), Whites (11.5 per 100,000) and Asians/Pacific Islanders (10.3 per 100,000) (Figure 3). By race/ethnicity and gender, the highest rates were those for African American males (115.7 per 100,000) and females (55.7 per 100,000) [6].

Figure 3: Estimated Rates of New Infections by Race/Ethnicity, 2006



Source: Centers for Disease Control and Prevention, August 2008.

AIDS Cases

From 2003 to 2007, the estimated numbers of newly diagnosed AIDS cases have decreased in the United States. The following section outlines AIDS surveillance data based on gender, age, transmission category and race/ethnicity.

In 2007, the estimated rate of AIDS cases in the United States was 11.9 per 100,000 population. From 2003 through 2007, the estimated numbers of newly diagnosed AIDS cases decreased from 40,054 to 37,041. Males accounted for 73% (21.6 per 100,000) of all AIDS cases diagnosed in 2007 among adults and adolescents, while women accounted for 27% (7.5 per 100,000). During the same period, among children, the estimated number of newly diagnosed AIDS cases decreased 62% (less than 13 years of age).

Throughout the 2003 to 2007 period, the number of newly diagnosed AIDS cases:

- decreased among persons between 30 to 44 years
- remained stable among persons aged 45–49 and persons aged 65 years and over
- increased among the 13 to 29 years, and 50 to 64 years.

In 2007, the largest number of new AIDS cases occurred among persons aged 40–44 years, who accounted for 19% of all AIDS cases diagnosed during that year in the 50 states and the District of Columbia.

From 2003 through 2007, among male adults and adolescents, the estimated number of newly diagnosed AIDS cases decreased among IDUs and MSM who were also IDUs. The numbers of males exposed through male-to-male sexual contact and high-risk heterosexual contact remained stable. Among female adults and adolescents, the estimated number of new AIDS cases decreased among IDUs and remained stable among females exposed through high-risk heterosexual contact [5].

Race/ethnicity: From 2003 through 2007, the estimated number of newly diagnosed AIDS cases decreased among African Americans, American Indians/Alaska Natives, and Whites, remained stable among Hispanics/Latinos, and increased among Asians and Native Hawaiians/other Pacific

Islanders. In 2007, rates of AIDS cases were 47.3 per 100,000 in the African American population, followed by 18.3 per 100,000 in the Native Hawaiian/other Pacific Islander population, 15.2 per 100,000 in the Hispanic/Latino population, 6.9 per 100,000 in the American Indian/Alaska Native population, 5.2 per 100,000 in the White population, and 3.6 per 100,000 in the Asian population [5].

3.3 Risk Factors and Barriers to Prevention

According to CDC, the African American population as a whole is more likely to experience challenges associated with risk factors for HIV infection that include the following:

1. **"Socioeconomic issues** and other social and structural influences affect the rates of HIV infection among Blacks. In 1999, nearly 1 in 4 Blacks were living in poverty. Studies have found an association between higher AIDS incidence and lower income. The socioeconomic problems associated with poverty, including limited access to high-quality health care, housing, and HIV prevention education, may directly or indirectly increase the risk factors for HIV infection." (CDC, *HIV/AIDS among African Americans*, p. 3)
2. **Gender:** "Black women are most likely to be infected with HIV as a result of sex with men who are infected with HIV. They may not be aware of their male partners' possible risk factors for HIV infection, such as unprotected sex with multiple partners, bisexuality, or injection drug use." (CDC, *HIV/AIDS among Women*, p. 3). Furthermore, lack of HIV knowledge, lower perception of risk, drug or alcohol use, different interpretations of safer sex and relationship dynamics may contribute to the disproportionate number of Black women who are affected by HIV infection (*HIV/AIDS among Women*, p. 2-3). A woman is significantly more likely than a man to contract HIV infection during vaginal intercourse. (CDC, *HIV/AIDS among Women*, p.4).
3. **Sexual Risk Factors:** Sexual contact is the main risk factor for Black men. Male-to-male sexual contact was the primary risk factor for 48% of Black men with HIV/AIDS at the end of 2005, and high-risk heterosexual contact was the primary risk factor for 22% of Black men." (CDC, *HIV/AIDS among African Americans*, p. 3)
4. **Lack of Awareness of HIV Serostatus:** "Not knowing one's HIV serostatus is risky for Black men and women. In a recent study of MSM in 5 cities participating in CDC's National HIV Behavioral Surveillance System, 46% of the Black MSM were HIV-positive, compared with 21% of the White MSM and 17% of the Hispanic MSM. The study also showed that of participating Black MSM who tested positive for HIV, 67% were unaware of their infection; of participating Hispanic MSM who tested positive for HIV, 48% were unaware of their infection; and of participating White MSM who tested positive for HIV, 18% were unaware of their infection." (CDC, *HIV/AIDS among African Americans*, p. 3)
5. **Sexually Transmitted Diseases:** "The highest rates of sexually transmitted diseases (STDs) are those for Blacks. In 2005, Blacks were about 18 times as likely as Whites to have gonorrhoea and about 5 times as likely to have syphilis. Partly because of physical changes caused by STDs, including genital lesions that can serve as an entry point for HIV, the presence of certain STDs can increase one's chances of contracting HIV infection

- 3- to 5-fold. Similarly, a person who has both HIV infection and certain STDs has a greater chance of spreading HIV to others." (CDC, *HIV/AIDS among African Americans*, p. 3)
6. **"Homophobia** and stigma can cause some Black MSM to identify themselves as heterosexual or not to disclose their sexual orientation. Indeed, Black MSM are more likely than other MSM not to identify themselves as gay. The absence of self-identification or the absence of disclosure presents challenges to prevention programs. However, data suggest that these men are not at greater risk for HIV infection than are Black MSM who identify themselves as gay. The findings of these studies do not mean that Black MSM who do not identify themselves as gay or who do not disclose their sexual orientation do not engage in risky behaviours, but the findings do suggest that these men are not engaging in higher levels of risky behaviour than are other Black MSM." (CDC, *HIV/AIDS among African Americans* p. 3)
 7. **Substance Use:** "Injection drug use is the second leading cause of HIV infection both for Black men and women. In addition to being at risk from sharing needles, casual and chronic substance users are more likely to engage in high-risk behaviours, such as unprotected sex, when they are under the influence of drugs or alcohol. (CDC, *HIV/AIDS among African Americans*, p. 3)
 8. **Operationalization' of the term African American:** According to researchers presenting at the 128th annual meeting of the American Public Health Association (APHA), "Culture can influence the ways in which a person seeks and uses health care. It provides the context by which an individual evaluates his or her symptoms, chooses a health care professional, and selects a health care setting. We have largely ignored the impact of culture on the health status of U.S. born and foreign-born Blacks. We have operationalized the term Black or African American in a way that obscures cultural differences among people of African descent living in the U.S. While we know that people of African descent living in the U.S. are composed of many different ethnic backgrounds (e.g., persons from the Caribbean and African countries), we have not systematically examined these differences using national data. Therefore, foreign born and U.S. Blacks appear to use different criteria when seeking and using health care." (Bryant, 2000).

3.4 Selected HIV Prevention Programs/Projects

This section describes CDC's national response to HIV/AIDS within the African American population and local projects aimed at HIV prevention among African-born communities:

In response to the HIV/AIDS epidemic facing the Black population in the U.S., CDC joined ranks with public health, African American leaders and communities to develop the *Heightened National Response to the HIV/AIDS Crisis among African Americans* (2008) with the following objectives:

- expanding the reach of prevention services through helping communities to implement effective programs for women, youth and Black MSM;
- increasing opportunities for diagnosing and treating HIV through launching the HIV Testing Initiative (\$35 million to health departments to increase HIV testing primarily for African

- Americans unaware of their HIV status); and piloting the 'Take Charge. Take the Test' campaign to increase HIV testing for African American women at risk for HIV;
- developing new, effective prevention interventions: CDC held a research consultation to address intervention strategies for HIV/AIDS prevention with African Americans In 2007. Also, CDC has research projects underway for: African American women, Heterosexual Black men, Black gay and bisexual men and incarcerated individuals (i.e., *Brothers y Hermanos, Women's Study*);
- mobilizing African American communities to ACT! Against AIDS: Awareness: This is a project to break the silence around HIV/AIDS among friends, family, and co-workers via awareness raising, communication and testing [2].

Furthermore, CDC also;

- disseminates scientifically-based HIV prevention interventions targeted or adapted for sub-groups of the African American population;
- supports research to create new interventions for African Americans and to test interventions that have proven successful with other populations for use with African Americans; and
- funds agencies through ADAPT (Adopting and Demonstrating the Adaptation of Prevention Techniques) to adapt and evaluate effective interventions for use in communities of color [2].

For example, **The Women's Collective** in Washington, D.C. combined a CDC intervention, *SISTA* (Sisters Informing Sisters on Topics about AIDS), with their own unique curriculum that incorporates the needs and issues of intergenerational African American women – to develop the *SisterAct Institute*. The SisterAct Institute engages urban, at-risk African American women ages 12+ in cross generational HIV/AIDS prevention education sessions. The sessions establish and/or increase effective communication about women's sexual health within the African American community. A number of topics are addressed including age, gender, culture, and language, particularly as they relate to HIV/AIDS prevention in order to decrease the risks for HIV disease overall. They also provide women with the opportunity to know their serostatus. To summarize, The SisterAct Institute educates and empowers, promotes intergenerational African American women's perspectives and solutions, encourages women to speak of their experience across the life-span of sexuality, and reaches women where they are.

With regards to the foreign-born Black population in the U.S., it appears that there are a limited number of HIV prevention programs that focus solely on African and Caribbean Diaspora communities. Examples of these programs include the following:

- The Ethiopian Community Development Council worked with a CDC technical adviser to adapt an evidence-based HIV prevention intervention, **Real AIDS Prevention Project (RAPP)** – a community mobilization program designed to reduce risk for HIV and unintended pregnancy among heterosexually active women (and their male partners) in high risk communities by increasing condom use – for African-born populations in Arlington, VA. RAPP is based on the trans-theoretical model of behaviour change, which states that people move through a series of stages in the process of changing their behaviour. The program is supported by theories of social learning and diffusion of

innovation, which suggest that people are more likely to adopt new behaviours that have already been accepted by others who are similar to them and whom they respect. The RAPP intervention relies on a set of peer-led integrated activities which include outreach (engaging community members in one-on-one discussion to deliver information and resources regarding HIV prevention), small groups ('safe sex parties' for organized community groups) and community mobilization (recruitment of local businesses to support the project's activities).

- **Sub-Saharan African Youth & Family Services of Minnesota (SAYFSM)** provides culturally and linguistically appropriate HIV/AIDS education, health and social services to African populations in St. Paul. SAYFSM's Education and Outreach Service informs African communities about HIV prevention, presenting at community events, churches, and schools. SAYFSM also develops culturally and linguistically appropriate HIV-educational materials and provides free HIV counselling, testing, and referral (including case management and care advocacy services). To meet the needs of refugees, SAYFSM provides orientation to new arrivals from Africa in partnership with three of Minnesota's volunteer resettlement agencies. Furthermore, SAYFSM facilitates a spiritual and emotional HIV support group and women's self-sufficiency program.

See Appendix C for detailed project overviews and Section 5 for a summary of the strengths and obstacles of these HIV prevention interventions.

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4.0 HIV/AIDS and African and Caribbean Diaspora Communities Living in the United Kingdom

4.1 Demographic Profile

Over ninety percent of the Black people living in the UK are of African or Caribbean descent. This section describes some of the key social demographic characteristics of African and Caribbean communities living in the UK based on 2001 data from the Office of National Statistics (ONS).

According to the ONS 2001 Census, there were an estimated 1,148,738 Black people in the UK, representing 2.0% of the total population. In 2001, 42.2% of the Black population was of African descent and 49.3% was of Caribbean descent. Overall, the Black African and Black Caribbean populations accounted for 1.8% of the total population in the UK [7]. Among the Black African population, Nigerian (Yoruba and Ibo) and Ghanaian (Ashanti, Fanti, Ga and Ewe) communities formed the two largest populations. Significant numbers of Black African people have arrived from Somalia, Uganda, Ethiopia, Zimbabwe and the Democratic Republic of Congo in recent years, seeking asylum [6].

Around three quarters (78%) of the Black African population and 61% of the Black Caribbean population live in London. Black African people comprise more than 10% of the population of Southwark, Newham, Lambeth and Hackney. There are also large Somali communities in London and Manchester, and Cardiff has the oldest and largest British-born Somali population in the UK [6].

Minority ethnic groups in the UK have a younger age structure than the White population. Among the Black African community, 30% were under the age of 16, over 60% were 16 to 64 years and 2% were aged 65 years and over. In 2001/02, about 20% of the Black Caribbean community was under age 16, over 60% were 16 to 64 years and 9% were aged 65 or over. This compared with 19% under the age of 16, over 60% between 16 to 64 years and 16% aged 65 or over among the White population [7].

In 2001/02, people from some minority ethnic groups in the UK were more likely to have degrees (or equivalent) than White people. Those most likely to have degrees were Chinese, Indian, Black African and 'Other Asian'²⁰ communities. Black Caribbean men were the least likely to have degrees [7].

In 2001/02, men and women from minority ethnic groups had higher unemployment rates than White people. Young Black African men, Pakistani, Black Caribbean, and those belonging to the Mixed²¹ group also had the highest rates of unemployment ranging from 25% to 31%. The comparable unemployment rate for young White men was 12%. Although the Black African

²⁰ Other Asians fall under the ethnic group of Asian or Asian British (Indian, Pakistani, Bangladeshi, Other Asian background, All Asian groups).

²¹ Mixed refers to persons who self-identify as White and Black Caribbean, White and Black African, White and Asian or other mixed background.

population is often highly qualified academically, they experienced high levels of unemployment. In 2001/2, around one in seven Black African men was unemployed (15%) compared with 5% of White British men [7].

People from minority ethnic groups were more likely than White people to live in low-income households²² in 2000/01. A substantial proportion (49%) of Black Non-Caribbean households also lived on low incomes after housing costs²³ had been deducted. However, the risk of low-income for this group was much less pronounced in comparison with other ethnic groups if income before housing costs is used [7].

4.2 HIV/AIDS Statistics

HIV Surveillance

The Health Protection Agency's (HPA) 2008 report on HIV in the UK recommended that HIV interventions be strengthened in order to better meet the needs of populations with high risk HIV acquisition such as the Black African heterosexual population. Based on HPA data, the following section describes HIV surveillance in the UK regarding gender, age, transmission category and race/ethnicity.

HIV Prevalence

According to the HPA, there were an estimated 77,400 people living with HIV in the UK at the end of 2007, equivalent to 127 persons per 100,000 population. Among the 73,300 persons aged 15 to 59 years living with HIV, 28% were unaware of their infection. The majority of people living with HIV in the UK are men. Among men, the rate of persons living with HIV was 170 per 100,000 compared to 84 per 100,000 for women in 2007. The estimated number of adults (15 to 59 years) living with diagnosed HIV in the UK in 2007 was 22,950 among MSM, followed by heterosexual women born in Africa (13,250), heterosexual men born in Africa (6,300), heterosexual women born elsewhere (including the UK) (4,600), heterosexual men born elsewhere (including the UK) (3,750), IDU men (1,200) and IDU women (550) [1]. The majority of Black African and Black Caribbean populations diagnosed with HIV were reported as acquiring their infection heterosexually. Among men, the estimated number of new HIV diagnoses acquired through sex between men was 5% among the Black African population, 51% among the Black Caribbean population, and 84% among the White population. A number of studies, however, have consistently reported a higher prevalence of HIV among Black and ethnic minority men who have sex with men [2].

Race/ethnicity: In England the diagnosed prevalence of HIV was 3.7% among the Black African population, nearly 10 times higher than among the Black Caribbean population (0.4%) and over 40 times that among the White population (0.09%) (See Table 1). It was estimated that of all Black African people living with HIV in the UK in 2006, 36% of men and 23% of women had not been diagnosed with HIV and were thus unaware of their infection [2].

²² Low-income household is defined as having less than 60% of the median equivalized disposable income.

²³ Income before & after housing costs: These 2 measures are used in the Households Below Average Income (HBAI) data & each has imperfections as a guide to differences in, & changes to, living standards.

Table 1: Percentage of Ethnic Groups Living with Diagnosed HIV in England, 2007

	Black African	Black Caribbean	White
Number of individuals aged 15 to 59 living with diagnosed HIV	18,719	1,538	24,368
Population aged 15 to 59 (2006 estimates)	500,600	395,800	27,058,700
Percentage aged 15 to 59 living with diagnosed HIV	3.7%	0.4%	0.09%

Source: Health Protection Agency, November 2008.

HIV Incidence

The estimated number of new HIV infections among the adult populations in the UK in 2007 was 7,734, equivalent to 16 new diagnoses per 100,000 men and 9 per 100,000 women. In 2007, men accounted for an estimated 63% (4,887 persons) of new HIV infections and females accounted for an estimated 37% (2,846 persons), representing a continuation of the high levels seen in the previous four years [1].

The number of new HIV diagnoses in young people (aged 16 to 24) in the UK remains relatively low compared to older age groups. In 2007, 702 young people were diagnosed with HIV, representing 11% of all new HIV diagnoses (10 per 100,000). Nearly all young people diagnosed with HIV in 2007 were infected through either heterosexual contact (48%), of which the largest group were Black-African people who have probably been infected abroad; or sex between men (48%), of whom the majority were White and have probably been infected in the UK. Young MSM remain the group of young people most at risk of acquiring HIV in the UK [3].

After adjusting for missing information, over half (55% [4,260 persons]) of new HIV infections in 2007 were acquired through heterosexual contact (1,690 men and 2,570 women), representing a decline from a peak of approximately 4,850 persons in 2004 [1]. After adjusting for missing information, 41% (3,160) of new infections in 2007 were acquired through sex between men, representing an increase from previous years. The estimated numbers of diagnoses of HIV infection acquired through injecting drug use (180 in 2007) and mother-to-child transmission (110 in 2007) have remained low over the past five years. The majority (63%) of children diagnosed in the UK in 2007 were born abroad and infected through mother-to-child transmission [1].

Race/ethnicity: Of all new HIV diagnoses where ethnicity was reported in 2007, 35% (2,691 persons) was among the Black African population and three percent (189 persons) was among the Black Caribbean population. Of the HIV diagnoses in 2007, the majority of the Black African (94%) and Black Caribbean (70%) populations reported heterosexual contact as their probable route of infection. The Black African population, in particular, accounted for 69% of all new diagnoses among heterosexuals, of whom two-thirds were women [2]. Among the Black African population, the number of HIV diagnoses reported in 2007 represents a continuing decline since the peak of 3,976 diagnoses reported in 2003 [2].

AIDS Cases

AIDS is diagnosed when an HIV-infected person's immune system becomes severely compromised (measured by CD4 cell count) and/or the person becomes ill with an opportunistic infection. As part of the HPA's Centre for Infections HIV and STI Department, the CD4 Surveillance Scheme monitors national trends in immunosuppression of HIV-infected adults (aged 15 and above). To estimate the proportion of patients at high risk of opportunistic infection each year (average CD4 counts each year below 200 cells/mm³), the average of all CD4 counts each patient had per year was calculated, and patients with an average CD4 count less than 200 cells/mm³ were considered to be at high risk in that year. Overall, in the UK, the proportion of HIV-infected adults at risk of opportunistic infection each year decreased further in 2007 from previous years. This section is based on counts reported to the CD4 Surveillance Scheme that are linked to records of HIV-infected adults held in the HIV diagnosis database [4]:

- "Importantly, since 2000, the median CD4 count at HIV diagnosis of women detected through antenatal screening has been consistently higher than among other women (even after adjusting for age at diagnosis) and heterosexual men. This indicates that the recommendation of testing during pregnancy provides an opportunity for women to be diagnosed earlier in the course of their infection reducing their risk of developing opportunistic infections and potential early death. However, it is worth noting that the median CD4 count of women diagnosed via antenatal screening remains lower than that of men who have sex with men due to the relatively large number of women from abroad who are likely to have acquired their infection some years prior to arrival in the UK." (HPA, 2008, p. 16)
- "For counts linked in 2007, 16% (1,600) of male heterosexuals had average counts per year less than 200 cells/mm³, compared to 16% (200) of injecting drug users, 11% (1,900) female heterosexuals, and 6% (1,500) of MSM. Overall, there was a gradual increase in the median CD4 cell counts of newly diagnosed MSM, heterosexual women, and heterosexual men between 1998 and 2007. These data indicate that individuals are increasingly being diagnosed earlier in the course of infection." (HPA, 2008, p. 15)
- "In the UK in 2007, an estimated 31% of adults (aged 15 or more) were diagnosed late and 8% had AIDS at the time of HIV diagnosis. The proportion of adults diagnosed late was lowest among MSM (19% with a low CD4 count and 6% with AIDS) and increased through heterosexual women (36% and 10%), IDUs (30% and 13%) and heterosexual men (42% and 14%) respectively. Late diagnosis also increased with age." (HPA, 2008, p. 18)

Race/ethnicity: The number of new AIDS cases diagnosed among the Black African population (276) in 2007 has declined from the peak reported in 2003 (550). However, "for Black African and Caribbean communities, HIV continues to cause serious illness and death due to late diagnosis. The proportion of Black African and Caribbean adults (aged 15 and over) diagnosed late has fallen slowly in the last 10 years from 50% in 1998 to 41% in 2007. Black African and Caribbean adults

diagnosed late were ten times more likely to die within a year of their HIV diagnosis than those with higher CD4 counts (4.5% compared to 0.48%).” (HPA, 2008, p. 20).

4.3 Risk Factors and Barriers to Prevention

The web-based article, *African Communities residing in the UK and HIV*, highlights some of the ongoing challenges that HIV-positive (and negative) African communities face such as poverty, immigration status, poor living conditions, and limited access to training, skills and job opportunities [6]. These difficulties, along with the following factors, present barriers to HIV prevention and treatment:

1. “Difficulties in meeting these **basic needs** clearly lead to reduced quality of life. They have significant and ongoing difficulties associated with anxiety and depression, their ability to sleep, their self-confidence and their personal relationships.”²⁴
2. “Despite a relatively long history of the epidemic in sub-Saharan Africa, **HIV remains significantly stigmatised** among African communities in the UK and globally. The disclosure of an HIV-positive identity often leads to the withdrawal of vital community support. Thus, African people with HIV in the UK are less able to disclose to and draw support from their family and expatriate communities. Sigma Research found that 15% of African people living with HIV had not disclosed their status to their partners and only a third of respondents had disclosed their HIV status to their children or their families.”²⁵
3. “**Social exclusion** is undoubtedly exacerbated by factors associated with migration. It is likely that a significant proportion of African people with HIV in the UK are (or have been in the past) refugees or asylum seekers, a group already significantly socially excluded. Exclusion associated with being HIV positive may be significantly compounded by pre-existing social exclusion and social need associated with being an African refugee or asylum seeker.”²⁶
4. “**The policy of dispersing asylum seekers** away from large urban environments often means that those living with HIV are moved away from specialist HIV treatment and care centres as well as being moved to a setting where support and contact within expatriate groups is unlikely. Home Office²⁷ changes to immigration policy and the 2005 decision by the Law Lords²⁸ also mean that a person with HIV who is on treatment will be unlikely to be

²⁴ NAM. (2009). *African Communities residing in the UK and HIV*. Retrieved on March 19, 2009 from <http://www.aidsmap.com/cms1008878.asp>

²⁵ Ibid.

²⁶ Ibid.

²⁷ The Home Office is the lead government department for immigration and passports, drugs policy, counter-terrorism and police in the UK.

²⁸ The Law Lords are full-time judges who carry out the judicial work of the House of Lords: the highest court of appeal in the UK.

granted leave to remain on medical grounds under humanitarian protection provisions. If that person is granted discretionary leave to remain it will only be for three years.”²⁹

5. “In addition to this, changes made to the **provision of National Health Service (NHS) services for overseas visitors** impose strict limitations on access to hospital care for non-residents and those whose asylum applications have failed. Broadly speaking, this means that while short-term visitors, including students, and failed asylum seekers will be allowed to access HIV testing and other STI screening, long-term treatment for infection will not be provided unless it is paid for privately or via the Accident and Emergency Department.”³⁰

Overall, this article maintains that the current social, legal and policy environment in the UK is not geared towards maximizing the health of HIV+ African peoples [6].

4.4 Selected HIV Prevention/Projects

The following section describes the UK’s national strategy to address HIV highlighting the National African HIV Prevention Programme (NAHIP) and community-based HIV prevention projects aimed at African and/or Caribbean populations.

In 2001, the Department of Health (DH) published *The National Strategy for Sexual Health and HIV*, which detailed a 10-year plan to address sexual health issues and modernize sexual health services in the UK. The key objectives of the strategy were to:

- reduce transmission of HIV and STIs;
- reduce prevalence of undiagnosed HIV and STIs;
- reduce unintended pregnancy rates;
- improve health and social care for people living with HIV;
- reduce the stigma associated with HIV and STIs [5].

One of the strategy’s major commitments is geared towards supporting the DH-funded NAHIP. NAHIP, managed by the African HIV Policy Network (AHPN)³¹, works largely with African-led organisations to identify the HIV health promotion needs of African communities, and support the implementation of work through a range of partners across England [5]. In 2004, a number of organizations (including NAHIP and AHPN) and individuals with expertise in health promotion and HIV prevention work with African communities collaborated on *Doing it well* – an evidence-based good practice guide for choosing and implementing community-based HIV prevention interventions with African communities in the UK [9].

²⁹ NAM. (2009). *African Communities residing in the UK and HIV*. Retrieved on March 19, 2009 from <http://www.aidsmap.com/cms1008878.asp>

³⁰ Ibid.

³¹ The AHPN is an alliance of African community-based organizations and their supporters working for fair policies for people living with HIV/AIDS in the UK, providing training, support, research and information. The AHPN is the only African organization in the UK whose work is dedicated to policy, advocacy and representation at national level. Its major focus is on HIV and the sexual health of Africans in the UK.

The Knowledge, the Will and the Power – a new plan of action for sexual HIV prevention interventions targeting Africans living in England developed by NAHIP partner organizations and Sigma Research, identifies obstacles to HIV prevention and focuses on how to overcome them in order to achieve change. NAHIP also works through national health promotion campaigns such as the African HIV testing campaign to encourage earlier testing, and through provision of local training and technical support for work with African communities [4]. Most recently, NAHIP, in consultation with its Implementing Partners (IP)³², has developed a series of web-based online videos, *Kobana's Stories*, which raise awareness of how HIV and sexually transmitted infections (STIs) can impact Black African families. Viewers watch as character Kobana discusses HIV and STI related issues with his wife, son, daughter and mistress [8].

The following are other community-based examples of HIV prevention projects conducted by NAHIP Implementing Partners:

- The Ethiopian Community Centre in the UK's (ECCUK) **Pan African and Caribbean Sexual Health Project (PACSH)** provides Primary and Secondary HIV prevention programmes to African and Caribbean populations living in Enfield and Haringey. The Primary HIV Prevention Programme provides condom information, resource distribution and promotes HIV awareness and testing. PACSH raises awareness around HIV and HIV testing through workshops and seminars that focus on gender, MSM, youth, faith groups, francophone communities and countries where HIV is emerging as issues. The Secondary HIV Prevention Programme is aimed at empowering persons living with HIV to stay well and prevent HIV transmission as well as addressing other issues such as immigration, housing, welfare benefits, debt, education, training and business start-up. This programme includes a community support and services for newly diagnosed pregnant women. See Appendix C for detailed project overview.
- **The Monya Project** (African MSM Sexual Health Project) aims to support African MSM to face the challenges that HIV, homophobia, immigration etc. can present. The core elements of the Monya Project include: outreach (to distribute information and resources at Black gay clubs in East London), a peer support group (to discuss topics such as relationships, compromise), social activities and an HIV/AIDS helpline

See Appendix D for detailed project overviews and Section 5 for a summary of the strengths and obstacles of these HIV prevention interventions.

4.5 References

³² Implementing Partners (IP) work in partnership to help identify needs and implement work on behalf of NAHIP. IP partners are established service providers and community based organizations.

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5.0 ANALYSIS

The following table highlight the main strengths and obstacles of the HIV prevention projects noted in this report as identified by the organizations responsible for implementation:

Table 2: Strengths and Obstacles of Selected HIV Prevention Programs/Projects in Canada, the U.S. and the U.K.

Strengths	Obstacles
<p>Community Involvement</p> <ul style="list-style-type: none"> - Community members are involved in most, if not all aspects of HIV prevention (i.e., peer education, evaluation, fundraising, sponsorship), which serves to build community action around HIV/AIDS. <p>Peer-led HIV Prevention Interventions</p> <ul style="list-style-type: none"> - Peer volunteers/outreach workers are recruited specifically from African & Caribbean communities and as such, share common values etc. as populations to be engaged. This cultural connection allows peers to gain access quickly to African and Caribbean Diaspora populations and build rapport. - Training curriculum for peer-led interventions and other educational materials are developed in collaboration with community members and local and/or national health organizations to ensure accuracy of HIV/AIDS data and cultural appropriateness. All curricula are user-friendly and easy for peers to deliver. - Being a peer creates a stepping stone for future employment as peers become skilled in HIV education, outreach etc., and are exposed to a variety of community-based organizations. - To assist with retention, peers are provided with an honorarium or hired on as casual staff. 	<p>Attitudes, Beliefs</p> <ul style="list-style-type: none"> - Homophobia and heterosexism - HIV-related stigma, fear, discrimination and denial, by religious communities in particular - Myths and misinformation about HIV/AIDS (i.e., forks and toilet seats spread HIV; sex with a virgin will cure HIV). - Attitudes towards health and well-being: perception that HIV is no longer an issue, the community is well informed about HIV and has been tested - Attitudes towards sex (sex as a taboo) <p>Environmental Pressures</p> <ul style="list-style-type: none"> - Socioeconomic concerns take priority over health issues - Fear of deportation - African and Caribbean populations are transient when they initially immigrate as they try to reunify with family members and find gainful employment. This transience makes it difficult to locate and access health services in general. - Lack of legislation to protect populations who are HIV+ and without legal immigration status. <p>Organizational Issues</p> <ul style="list-style-type: none"> - Recruitment of volunteers with appropriate language skills - Lack of youth-focused HIV prevention interventions

<p>HIV/AIDS Service Delivery</p> <ul style="list-style-type: none"> - Community-based organizations develop faith-based, age and gender-specific HIV prevention interventions that respect the current stage of change of community members. - Community-based organizations offer culturally and linguistically appropriate HIV information, resources and services (HIV testing, referral, media campaigns, service provider training etc.) in a variety of formats (individual, group, web-based), as well as programs that address other issues of importance to African & Caribbean Diaspora communities (transportation, immigration and settlement services). - Staff at community-based organizations and/or peers gradually engages community members in discussion regarding HIV/AIDS issues in non-intrusive, informal settings where African & Caribbean communities already congregate. - Community-based organizations develop expertise in identifying and developing strategies in addressing HIV infection. <p>Partnership/Collaboration</p> <ul style="list-style-type: none"> - Collaboration with other community-based organizations who work with African and Caribbean populations - Recruitment of small business, local schools and media representatives to sponsor and advertise HIV prevention interventions. - Funders can connect service providers doing similar or complimentary HIV prevention work. 	<ul style="list-style-type: none"> - Lack of organization capacity to write grant proposals - Limited funding for: building organizational capacity, compensating peer outreach workers/volunteers, translating materials in appropriate languages, assisting HIV+ individuals with the cost of treatment. - Mainstream HIV prevention interventions are geared predominantly towards native born Black populations, and therefore may not be culturally-appropriate for African and Caribbean-born communities.
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6.0 RECOMMENDATIONS

Based on the strengths and obstacles identified in Section 5.0, the following is a list of recommendations for organizations planning to or currently engaged in HIV prevention among African and Caribbean Diaspora communities.

1. Community Involvement

Involve the African and Caribbean community members in all aspects of HIV prevention to build community action and ownership around HIV/AIDS issues. Opportunities for community involvement can include: peer education, evaluation, sponsorship, fundraising and sitting on a project advisory panel.

2. Peer-led HIV Prevention Interventions:

Develop/adapt and implement peer-led HIV prevention interventions that draw upon African and Caribbean populations to gradually engage community members in discussion about HIV/AIDS issues. Effective peer workers are:

- trained in HIV/AIDS, outreach and resources prior to engaging the community;
- engage their community in non-intrusive, informal settings such as barbershops, community centres, places of worship;
- draw upon cultural commonalities to build rapport and trust with community members;
- allow participants to build comfort around HIV-related issues;
- paid an honorarium or paid as casual staff to assist with retention and build confidence;
- encouraged to explore job opportunities that may arise from participating as a peer;
- participate in all aspects of an organization's HIV prevention interventions: one-on-one intervention, group discussions, community events, recruitment of participants and other volunteers, evaluation.

3. Approaches to Service Delivery

- In collaboration with community members, local and/or national health organizations, develop culturally and linguistically appropriate, faith-based, age and/or gender-specific HIV prevention interventions that respect the current 'stage of change' of community members. Create an environment where participants can gradually discuss myths, stigma, fears and attitudes
- Offer culturally and linguistically appropriate HIV information, resources and services (HIV testing, referral, media campaigns, service provider training etc.) in a variety of formats (individual, group, web-based), as well as programs that address other issues of importance to African & Caribbean Diaspora communities (transportation, immigration and settlement services).
- Collaborate with other organizations working to develop, implement, evaluate and support HIV prevention among African and Caribbean populations, including small businesses, schools and media who can assist with sponsorship and fundraising.

4. Strategic Directions

- Identify and engage local, national and international funding bodies.
- Advocate for a national strategy for HIV/AIDS prevention among African and Caribbean Diaspora communities; for surveillance that tracks HIV/AIDS among African and Caribbean Diaspora populations; and to all levels of government regarding the issues that face African and Caribbean Diaspora communities such as poverty, immigration policy and deportation.

7.0 CONCLUSION

While African and Caribbean Diaspora communities comprise less than 8% of all Black populations in Canada, the United States and the United Kingdom, these populations are over-represented in terms of HIV prevalence, incidence and AIDS cases. African and Caribbean communities in these countries are also more likely to experience challenges that place them at higher risk for HIV infection. These challenges are numerous and include: socioeconomic issues, HIV-related stigma, discrimination and denial, immigration and migration, racism, sexism, sexual and physical violence, heterosexism and homophobia, sexual risk factors, social exclusion, attitudes towards sex, health and well-being, lack of awareness of HIV serostatus, operationalization of terms like African American, and cultural and personal hygiene practices. Each of these countries has developed a national initiative to address HIV/AIDS that include efforts focused on people from countries where HIV is endemic or native-born Black populations. However, only the UK has created a plan of action specific to African Diaspora populations that identifies obstacles to HIV prevention, and focuses on how to overcome these barriers in order to achieve change.

At the local level, community-based organizations in each of these countries have implemented peer-led HIV prevention interventions that engage community members in informal, non-intrusive settings. These interventions have been largely successful at involving the broader community in HIV prevention, building rapport, and developing culturally and linguistically appropriate tools. In terms of obstacles, these community-based organizations are faced with budget cuts while simultaneously attempting to address stigma, discrimination and fear regarding HIV/AIDS along with systemic issues such as immigration. Given the action plan developed in the UK, it will be important to learn from this resource. In doing so, other African and Caribbean Diaspora communities can create new strategies in reducing HIV transmission and enhanced quality of life for people living with HIV/AIDS.

Appendix A: HIV-Endemic Country List, 2007

Caribbean and Central/South America:

Anguilla	Haiti
Antigua and Barbuda	Honduras
Bahamas	Jamaica
Barbados	Martinique
Bermuda	Montserrat
British Virgin Islands	Netherlands Antilles
Cayman Islands	St. Lucia
Dominica	St. Kitts and Nevis
Dominican Republic	St. Vincent and the Grenadines
French Guiana	Suriname
Grenada	Trinidad and Tobago
Guadeloupe	Turks and Caicos Islands
Guyana	U.S. Virgin Islands

Asia (recent additions):

Cambodia
Myanmar/Burma
Thailand

Africa:

Angola	Lesotho
Benin	Liberia
Botswana	Malawi
Burkina Faso	Mali
Burundi	Mozambique
Cameroon	Namibia
Cape Verde	Niger
Central African Republic	Nigeria
Chad	Rwanda
Congo	Senegal
Djibouti	Sierra Leone
Equatorial Guinea	Somalia
Eritrea	South Africa
Ethiopia	Sudan
Gabon	Swaziland
Gambia	Tanzania
Ghana	Togo
Guinea	Uganda
Guinea-Bissau	Zaire
Ivory Coast	Zambia
Kenya	Zimbabwe

Appendix B: Canadian-based HIV Prevention Programs/Projects

<i>Assisting Women with AIDS-related Education (AWARE)</i>	
East York East Toronto Family Resources (EYET) <i>Toronto, ON, Canada</i>	
<p>Project Overview</p> <p>EYET provides formal and informal family support services for families. Their family support and early child development programs include:</p> <ul style="list-style-type: none"> - formal and informal parenting support programs for families at Ontario Early Years Centres - parenting support, and school readiness for children - education and support for pregnant women in Canada - Prenatal Nutrition Programs - child care for junior kindergarten and kindergarten students - support for parents and children with special needs - Supporting families who do not speak English, and assisting our programs and partner staff, through our Cultural Linguistic Workers who represent over 25 languages - linking participants to other key services in the community - volunteer opportunities <p>The AWARE project provides outreach and support to culturally diverse women in the East York area of Toronto and promotes HIV/AIDS awareness and provides choices in relation to healthy lifestyles and community action. Peer Outreach Workers deliver information and facilitate workshops within existing family resource programs and Ontario Early Years Centres regarding women's reproductive health, HIV/AIDS and related topics, as well as providing referrals and information on existing community programs. This project is funded by the City of Toronto, AIDS Community Investment Program.</p> <p>Core Elements</p> <p>Recruitment and Training of Peer Outreach Workers: Peer Outreach Workers are recruited from other organizations (partner agencies, their staff and clients, local colleges and universities), that work with women from diverse communities. The Peer Outreach Workers must be reflective of the community. They are hired on as part of EYET's staff and receive training in HIV/AIDS and outreach from Toronto Public Health and other partner agencies.</p> <p>Outreach: On a regular basis, Peer Outreach Workers engage and deliver information to women where they consistently congregate: family resource programs, community programs, pre-natal groups, young mothers groups, Ontario Early Years Centres. The Peer Outreach Workers build rapport with women, and then on a one-to-one basis discuss issues regarding women's sexual health.</p> <p>Group Workshops: Participants attend these workshops based on the relationships that the Peer Outreach Workers have built with them. Discussion topics include HIV/AIDS awareness, sexually transmitted diseases/infections, contraception options, women and youth sexual health. EYET and partner organizations (i.e., Black Coalition on AIDS Prevention, Toronto Public Health) present at these workshops.</p>	<p>Project Materials</p> <ul style="list-style-type: none"> - Pamphlets about AWARE with info about when they'll be in the community - HIV/AIDS, STI pamphlets from Toronto Public Health that are translated into appropriate languages - HIV/AIDS 101 training by Toronto Public Health - Online links to information about sexual health issues <p>Evaluation</p> <ul style="list-style-type: none"> - Peer outreach workers log the number of women spoken to, age range, ethnic origin, languages spoken and any success stories. - During workshops, AWARE tracks: number of attendees, how participants felt after the training via a pre and post assessment, and what was the most important thing they learned. Evaluation tools are currently not translated but the Peer Outreach Workers are present to assist with comprehension of evaluation. If partner agencies are involved in workshop, their staff (who represents diverse backgrounds) also assists with comprehension. - If a Peer Outreach Worker gets a job with another organization based on the work they've done with AWARE, this is included as a success in the overall program evaluation. - Manager observes Peer Outreach Workers and groups then facilitates debrief with staff to discuss challenges, successes etc. - The venues where Peer Outreach Workers do outreach and one-to-one discussion also provide feedback about how the AWARE project is received by participants. - Individuals/organizations that present during group workshops also provide feedback about questions asked by participants, how participants responded to content etc. <p>More Information</p> <p>Michelle Adams, Manager for Outreach & Community Services East York East Toronto Family Resources 947 Queen Street East Toronto, ON M4M 1J9 Tel.: 416-686-3390 Ext 9987 Fax: 416-686-8282 michelleadams@eyetfrp.ca</p>
<p>References</p> <p>East York East Toronto Family Resources. (2009). <i>AWARE</i>. Retrieved on March 17, 2009 from http://www.eyetfrp.ca/programs/aware.cfm</p>	

Operation Hairspray

Somerset West Community Health Centre (CHC)

Ottawa, ON, Canada

Project Overview

Somerset West CHC is a non-profit, community-governed organization that provides primary health care, health promotion and community development services, using interdisciplinary teams of health providers. These teams include physicians, nurse practitioners, dietitians, health promoters, counsellors and others. Somerset West CHC is sponsored and managed by an incorporated non-profit community board made up of members of our community.

Operation Hairspray is delivered through a partnership between the Somerset West Community Health Centre and Ottawa Public Health. It is an innovative peer-led health promotion initiative, which seeks to engage African and Caribbean hairdressers and barbers as a channel to reach people from countries where HIV is endemic.

Project Objectives:

- To increase community capacity/awareness to respond;
- To increase access / reduce barriers to health;
- To evaluate the use of Hairstylists and Barbers, as Peer Volunteers in health promotion, as a channel to engage the African and Caribbean communities in Ottawa;
- To provide HIV/AIDS prevention information.

Core Elements

Phase I:

- **Recruitment of Project Advisory Group** consisting of at least one community member and at least one hairdresser/barber from the African or Caribbean communities, public health representatives, and an academic researcher in the field of HIV/AIDS, who monitor the development, implementation and evaluation of the initiative.
- **Recruitment of Hairdressers and Barbers** who provide services to the African and Caribbean communities in Ottawa. These volunteers will become peer educators.
- **Training:** Through this training, participants acquire 1) the knowledge and the skills needed to integrate STI and HIV/AIDS prevention education within their practice and 2) the ability to recognize opportune moments to share this information within client conversations.
- **Implementation**

Phase II of the project is meant to go beyond barber shops and hair salons to engage clothing stores, restaurant and Caribbean grocery stores. Steps of this phase include those noted in Phase I as well as an evaluation component

Somerset West CHC is also engaged in a campaign called Braids for AIDS which provides HIV education while individuals have their hair braided. Fees go towards condoms and resources that are best suited to the community's needs.

Project Materials

- HIV Prevention Guidelines and Manual (African & Caribbean Council on HIV/AIDS in Ontario-ACCHO)
- Understanding and Challenging HIV Stigma: Toolkit for Action (International HIV/AIDS Alliance, Academy for Educational Development, International Center for Research on Women)
- Questionnaire to assess impact of project on the community
- Condoms, HIV/AIDS pamphlets, STI booklets
- ACCHO Strategy booklet

Evaluation

Evaluation of the project will be implemented in Phase II of the project.

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References

African & Caribbean Council on HIV/AIDS in Ontario. (2009). *Resources*. Retrieved on March 23, 2009 from <http://www.accho.ca/index.aspx?page=resources>

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Somerset West Community Health Centre. (2009). *Program Guide*. Retrieved on March 17, 2009 from <http://www.swchc.on.ca/index.php>

One Night Your Choice

Black Coalition of AIDS Prevention (Black CAP)

Toronto, ON, Canada

Project Overview

Black CAP is an organization that works to reduce HIV/AIDS in Toronto's Black, African and Caribbean communities and enhance the quality of life of Black people living with or affected by HIV/AIDS. HIV/AIDS is spreading quickly in Toronto's Black communities. Black, African and Caribbean people currently account for more than one quarter of all new HIV infections in Toronto compared to one-tenth in the early nineties. Issues of HIV related stigma and discrimination, homophobia, anti-Black racism, immigration, poverty, and barriers to social inclusion also continue to make Black CAP's work harder.

In 2006, Black CAP conducted a research study to examine which population among Toronto's Black communities needed urgent attention with regards to HIV prevention. From the 36 interviews and literature review that were conducted, it became clear that young Black women, between the ages of 15 and 29 required a focused HIV prevention initiative. This study, *"Who Feels It Knows: Challenges of HIV Prevention for Young Black Women in Toronto"* revealed the issues that young Black women in Toronto were facing within their lives, and how they impacted their ability to practice adequate HIV prevention. Among the number of sexually transmitted infections (STIs) being documented in Toronto, women, especially young women between 15-29 years, are recording a large percentage of cases.

Core Elements

Phase 1: After the research study was completed, Black CAP convened a Youth Advisory Committee (YAC) consisting of 8 Black women, and 4 Black men between the ages of 15 and 29. The YAC affirmed the recommendations put forward in the report and over a series of meetings with Black CAP, jointly developed the plan for the *One Night Your Choice* media campaign. The main goal of this campaign (includes posters, postcards, a website and online forum) was to reveal to young Black women how they are at risk for HIV within their lives through innovative messaging. Throughout the development of the campaign, the YAC critiqued the tools developed to ensure the look, feel and messaging reflected the lives of young Black women in Toronto.

Phase 2: After the launch of the media campaign, Black CAP began facilitating women's only sexual health workshops for established youth groups across Toronto. The curriculum included HIV/AIDS, STIs, relationships and homophobia. Youth who have been infected or affected by HIV/AIDS were encouraged to attend these workshops.

Phase 3: Black CAP's research study also identified that women who have sex with women (WSW) required a focused HIV prevention initiative. As such, an advisory committee of service providers and community members (Black CAP Women's Health in Women's Hands Community Health Centre, Planned Parenthood Toronto, Rainbow Health Coalition and young WSW) are currently in the process of developing tools to educate young Black WSW how they are at risk for HIV. These tools (a postcard and poster) will be launched at 2009 Pride events in Toronto and in the future at other events where Black WSW congregate.

Project Materials

- Report: *"Who Feels It Knows: Challenges of HIV Prevention for Young Black Women in Toronto"* (<http://onenightyourchoice.com/downloads/whofeels.pdf>)
- Seven posters and six postcards titled: *HIV/AIDS lasts longer than 9 months; It's just you and me no; I was born with HIV/AIDS; What else isn't he telling you; Trust me baby I'll pull out;* and *Not your panties?*
- A locally relevant sexual health resource: *"What Momma Didn't Tell You: A Guide to HIV/AIDS & Sexual Health for young Black women in Toronto"*
- One Night Your Choice website (www.onenightyourchoice.com) that includes locally-based resources and an online forum for youth to discuss issues.

Evaluation

Overall, the media campaign has received positive feedback from individuals and organizations who have e-mailed feedback to Black CAP and its partners.

With regards to the women's only workshops, youth are invited to complete an evaluation after each session. So far, youth have indicated that the topics discussed are relevant to their lives.

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References

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The THINK campaign, Get the Low Down website and Many Men, Many Voices

Black Coalition of AIDS Prevention (Black CAP)

Toronto, ON, Canada

Project Overview

Black CAP is an organization that works to reduce HIV/AIDS in Toronto's Black, African and Caribbean communities and enhance the quality of life of Black people living with or affected by HIV/AIDS. HIV/AIDS is spreading quickly in Toronto's Black communities. Black, African and Caribbean people currently account for more than one quarter of all new HIV infections in Toronto compared to one-tenth in the early nineties. Issues of HIV related stigma and discrimination, homophobia, anti-Black racism, immigration, poverty, and barriers to social inclusion also continue to make Black CAP's work harder.

In 2006, the Ontario Ministry of Health and Long-Term Care's AIDS Bureau granted funds to a number of HIV prevention strategies in the province. Black CAP was chosen to develop a targeted HIV prevention program for Black men who have sex with other men (BMSM) in Toronto. Black CAP's process to identify needs and service limitations for gay, bisexual and straight BMSM included the development of a program recommendations report entitled *Visibly Hidden: Rethinking BMSM and HIV Prevention*. Based on the recommendations outlined in the report, it was decided that a new and innovative campaign was needed that targeted not only Black men, but more specifically young BMSM in Toronto. It was recognized that young BMSM are uniquely located and vulnerable, and that their experience with racism, ageism and homophobia influence choices which leave them at risk for HIV/AIDS and other sexually transmitted infections (STIs). The creation of the THINK print advertisement campaign and the Get the Low Down resource website was the first step in Black CAP's innovative new sexual health campaign for the gay/bisexual black youth community in Toronto. The second phase of the project implemented the delivery of a life skills intervention group based on the Many Men, Many Voices (3MV) program for young BMSM.

Core Elements

THINK campaign and Get the Low Down resource website: The main goal of this multi-media campaign was to reveal to young BMSM how they are at risk for HIV within their lives through innovative messaging. The media tools consist of a postcard series on topics such as safe sex in bathhouses, being HIV positive, sexual roles, myths, sex while on vacation and relationships. Each of the postcards links young BMSM to the Get the Low Down website where they can access information about HIV, STIs, condoms, testing, being HIV positive, as well as an online forum where youth can ask questions of experts. The website also includes two resource guides that Black CAP developed for gay, lesbian, bisexual, transgender, queer and questioning Black youth and their parents: *Dealing with Being Different*. Black CAP is in the process of starting a chapter of PFLAG for families of colour in Toronto. Given that young BMSMs' social networks extend outside of Toronto, the website also provides a link to the YouTube program, ADTV with Derek Briggs (<http://www.youtube.com/watch?v=BzBIRb9pghc>).

Many Men, Many Voices (3MV): Developed by Diffusion of Effective Behavioural Interventions (DEBI) in the United States, 3MV is a group-level intervention program designed to prevent HIV and sexually transmitted diseases among Black men who have sex with men (MSM) who may or may not identify themselves as gay.

The intervention addresses factors that influence the behavior of Black MSM: cultural, social, and religious norms; interactions between HIV and other sexually transmitted diseases; sexual relationship dynamics; and the social influences that racism and homophobia have on HIV risk behaviors. The MSM HIV Prevention Coordinator at Black CAP is the first person in Canada to be trained in the delivery of this model and has subsequently re-formatted the intervention to suit the needs of young BMSM in Toronto (i.e., three-day retreat instead of 7 sessions of 2 to 3 hours; inclusion of techniques to impact the core beliefs of Black MSM through hypnosis; participation of adult BMSM as mentors).

Project Materials

- Report: Visibly Hidden: Rethinking BMSM and HIV prevention, http://www.getthelowdown.ca/visibly_hidden_report.pdf
- Get the Low Down website (includes postcard stories), <http://www.getthelowdown.ca/home.html>
- Dealing with Being Different: A Resource Guide for gay, lesbian, bisexual, transgender, queer and questioning Black youth, <http://www.getthelowdown.ca/differentsmall.pdf>
- Dealing with Being Different: A Resource Guide for Parents of gay, lesbian, bisexual, transgender, queer and questioning Black youth, <http://www.getthelowdown.ca/differentsmall.pdf>
- 3MV curriculum: <http://www.effectiveinterventions.org/go/intervention/s/many-men-many-voices>

Evaluation

Thus far, the 3MV project has conducted a pre-evaluation with participants followed by a qualitative interview. Black CAP intends to run the program again in the future and allow for more time to discuss topics of importance to participants such as coming out, experiences of violence and what the future holds for a BMSM.

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References

Black Coalition for AIDS Prevention. *Get the Low Down*. Retrieved on July 6, 2009 from <http://www.getthelowdown.ca/home.html>

Diffusion of Effective Behavioral Interventions. (2009). *Many Men, Many Voices*. Retrieved on February 27, 2009 from <http://www.effectiveinterventions.org/go/interventions/many-men-many-voices>

Roots of Risk

Black Coalition of AIDS Prevention (Black CAP)

Toronto, ON, Canada

Project Overview

Black CAP is an organization that works to reduce HIV/AIDS in Toronto's Black, African and Caribbean communities and enhance the quality of life of Black people living with or affected by HIV/AIDS. HIV/AIDS is spreading quickly in Toronto's Black communities. Black, African and Caribbean people currently account for more than one quarter of all new HIV infections in Toronto compared to one-tenth in the early nineties. Issues of HIV related stigma and discrimination, homophobia, anti-Black racism, immigration, poverty, and barriers to social inclusion also continue to make Black CAP's work harder.

Roots of Risk is a community level HIV prevention campaign that uses a mix of evidence-informed approaches to provide information and support to Black youth living in Toronto. The Roots of Risk project uses a combination of the POL (popular opinion leader) model, creative social marketing methods, and youth engagement opportunities to deliver prevention education programming to straight, gay, bi, lesbian and trans Black youth at heightened risk for HIV. The Roots of Risk project leverages the social networks of youth in Toronto and uses personal and social relationships to transfer important information related to risk reduction. The project is also focused on the promotion of two Black CAP's previously developed HIV prevention campaigns through popular media.

Program Objectives:

- To increase access to sexual health information for Black youth at heightened risk of HIV infection – build knowledge and increase recognition of risk, stigma reduction and prevention
- To engage youth in knowledge transfer activities and empower youth to play an active role in reducing growing rates of HIV/AIDS & STIs
- To leverage the social networks of youth in Toronto to disseminate information
- To promote related HIV prevention campaigns using popular media
- Increase leadership opportunities in high poverty neighbourhoods in Toronto for at-risk youth

Core Elements

Launched in September 2008, the Roots of Risk project:

- Works with 32 youth to act as popular opinion leaders (POLs) in their communities and provides youth with the means to distribute resources and information through the technologies they use to communicate with their peers (cell phone, text messages, email, IM, facebook, myspace, etc.). Black CAP (along with community partners such as Toronto Public Health) trains POLs in HIV 101, sexual health, barrier methods and communication methods for effective outreach.

- Distributes weekly sexual health and relationship messages to thousands of youth in Toronto which reduces their risk for HIV; creates traffic to two of Black CAP's websites for youth (onenightyourchoice.com and getthelowdown.ca); answers questions their peers have about HIV and sexual health in person and over the phone, distributes condoms, and promotes HIV testing sites in their local communities.
- Promotes the Think! and OneNightYourChoice campaigns in a range of media – including TTC, print ads, a youth Zine and at other events.

The Roots of Risk program also works to support POLs in connecting sexual health and relationship messages with other issues of importance to Black youth living such as employment, housing, substance use and taboos around sexuality and sexual orientation in African and Caribbean communities.

Project Materials

- Black CAP's HIV 101 and community outreach training
- T-shirts, knapsacks

Evaluation

At present, the POLs have completed a pre-assessment to ascertain how often to youth engage in discussion around sexual health, their knowledge around types of sexual activity, HIV and sexual health clinics in Toronto etc. The program will be evaluated again towards the middle and end of the initiative to measure the impact of the POLs and the sexual health messages.

More Information

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References

Black Coalition for AIDS Prevention. *Roots of Risk*. Retrieved on July 6, 2009 from http://www.black-cap.com/index.php?option=com_content&view=article&id=34&Itemid=44

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Keep it Alive Campaign

African and Caribbean Council on HIV/AIDS in Ontario (ACCHO)
Toronto, ON, Canada

Project Overview

The African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) is made up of organizations and individuals committed to HIV prevention, education, advocacy, research, treatment, care and support for African and Caribbean communities in Ontario. The goal of ACCHO is to reduce the incidence of HIV among African and Caribbean people in Ontario and to improve the quality of life for those infected and affected by HIV/AIDS. ACCHO's goals include:

- Coordinate strategy development, implementation, revision/renewal, and monitoring and evaluation;
- Develop and synthesize knowledge and policy, and set priorities to support the implementation of the Strategy and the vision of ACCHO;
- Support the work of agencies in implementing the Strategy; and
- Develop and maintain the effectiveness and relevance of ACCHO through initiatives such as organizational development, and ongoing monitoring and evaluation of ACCHO's membership and activities.

Keep it alive is an initiative of the [ACCHO](#) that was developed by and for African and Caribbean people in Ontario to raise awareness about HIV/AIDS among African and Caribbean communities in Ontario. The campaign encourages adults and youth from Africa and the Caribbean to fight against HIV/AIDS stigma, to know their HIV status by getting tested, and to practice safer sex. The campaign is part of the Strategy on HIV/AIDS for African and Caribbean communities in Ontario. This Strategy is a framework to help African and Caribbean communities and organizations respond to HIV/AIDS. The Strategy is also a guide for communities and governments to work together to prevent the spread of HIV.

Core Elements

Media Campaign: Launched in 2006, the *Keep it Alive* campaign targets specific populations within African and Caribbean communities (youth, families, francophone and same sex) through different types of media (print, radio, music and TV). ACCHO invited community members to submit a written or video excerpt of them explaining how they would initiate a conversation about HIV/AIDS with an important person in their life. ACCHO and media organization, Top Drawer Creative, then supported the selected finalists to be the spokesperson for the campaign. The campaign was disseminated across southern Ontario, depicting healthy images of Black people with messaging relevant to each sub-population.

Website: Each component of the *Keep it Alive* media campaign would lead community members to the website, www.preventaids.ca where they could access detailed information about HIV i.e., how it is acquired, prevention and anonymous testing. Furthermore, the website has tools for service providers working with African and Caribbean populations around HIV prevention: HIV Prevention Guidelines and Manual and an educational video.

Strategy Workers: The Ontario Ministry of Health and Long-Term Care's AIDS Bureau, funds positions in various organizations that work with African and Caribbean communities across Ontario (i.e., Ottawa, Kitchener, Niagara Region) to support the implementation of the Strategy on HIV/AIDS for African and Caribbean communities in Ontario. Six times per year, ACCHO facilitates joint meetings of these Strategy Workers to share learnings, synchronize their work and discuss challenges.

Project Materials

- Strategy on HIV/AIDS for African and Caribbean communities in Ontario: http://www.accho.ca/pdf/ACCHO_strategy_ENGLISH_Dec2003.pdf
- HIV Prevention Guidelines and Manual: <http://www.accho.ca/index.aspx?page=resources>
- Website: www.preventaids.ca
- Print, TV, music and radio ads (available on the website above)

Evaluation

ACCHO has already completed a process evaluation of *Keep it alive*, and will shortly implement an outcome evaluation. The key findings of the evaluation will determine the next steps for the campaign.

During the campaign, ACCHO, Top Drawer Creative and partner organizations received e-mail comments regarding the commercials and posters. Overall, people were impressed by the healthy images of Black people in the media. Others expressed concern that the campaign was implemented by the provincial government. ACCHO and its partners followed up with these concerns, indicating that the campaign was developed by and for African and Caribbean communities in Ontario.

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References

African and Caribbean Council on HIV/AIDS in Ontario. *Keep it Alive Campaign*. Retrieved on June 30, 2009 from http://www.preventaids.ca/photowall.asp?init_topic=7

African and Caribbean Council on HIV/AIDS in Ontario. *Resources*. Retrieved on June 30, 2009 from <http://www.accho.ca/index.aspx?page=resources&lang=en>

Appendix C: US-based HIV Prevention Programs/Projects

**SisterAct Institute: Intergenerational Approaches to
HIV Prevention among Women across the Lifespan**

**The Women's Collective
Washington, DC, US**

Project Overview

The SisterAct Institute is an intergenerational approach to HIV/AIDS prevention education with women across the lifespan. The SisterAct Institute engages urban, at-risk African American women ages 12+ in a cross generational HIV/AIDS prevention education sessions that establish and/or increase effective communication about sexual health; provide women opportunities to know their serostatus; and address the age, gender, cultural, spiritual, and language specific needs of our community regarding women's sexual health, particularly as it pertains to HIV/AIDS prevention in order to decrease their risks for HIV disease overall. The SisterAct Institute educates and empowers, promotes intergenerational African American women's perspectives and solutions, encourages women to speak of their experience across the life-span of sexuality, and reaches women "where they are."

Core Elements

SisterAct is a 10 session group level intervention that combines the Centers for Disease Control and Prevention's (CDC) effective intervention Sisters Informing Sisters on Topics about AIDS (SISTA) with TWC's own unique curriculum that incorporates the needs and issues of intergenerational African American women. The SisterAct curriculum increases knowledge of HIV disease among cross generations of African American girls and women; increases knowledge sharing about HIV transmission, prevention and care, and other sexual and women's health topics with the ultimate goal of reducing HIV infection among this cross section of women. SisterAct reinforces this goal by distributing resources about related health resources and facilitating access to services including HIV counseling, testing and referral services.

Project Materials

- Resources from the CDC's effective interventions , SISTA

Evaluation

SisterAct

- They have an on-staff evaluator who liaises with an external evaluator to develop tools, reports, statistics etc.
- Pre and post tests are administered to participants as well as interviews, group observation and post-session participant feedback forms
- The project has yielded significant, positive change regarding increased knowledge.
- Behavioural change is harder to assess as program duration is not that long. They did, however see incremental change: increased willingness to take condoms home

Between us girls

- Still collecting data and will be better able to capture behavioural change
- Increased knowledge has already occurred

More Information

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References

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Education and Outreach

Sub-Saharan African Youth and Family Services in Minnesota (SAYFSM) St. Paul, Minnesota, US

Program Overview

SAYFSM provides culturally and linguistically appropriate HIV/AIDS education and social services to Africans in Minnesota.

SAYFSM Education and Outreach Service educates the community about HIV prevention (i.e., condom use), presenting at community events, churches, and schools. It develops culturally and linguistically appropriate HIV-educational materials and provides HIV counselling, testing, and referral at outreach events, at the SAYFSM office, or at places of an individual's choosing. To meet the needs of refugees, SAYFSM provides orientation to new arrivals from Africa in partnership with Lutheran Social Service, Minnesota Council of Churches, and World Relief, three of Minnesota's volunteer resettlement agencies.

Core Elements

- **Spiritual and Emotional Support Group:** SAYFSM facilitates an HIV support group that meets twice a month. Participants and their families receive wellness education and emotional support.
- **Case Management and Care Advocacy:** SAYFSM provides an array of services to meet the many needs of clients.
- **Women's Self-Sufficiency Program:** Participants attend sewing classes and receive monthly wellness education.
- **Free HIV/AIDS Testing**
- **Education and Outreach:** SAYFSM educates the community and new refugees about HIV prevention

Project Materials

- HIV/AIDS 101 handouts
- Condoms
- HIV prevention group curriculum

More Information

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RAPP (Real AIDS Prevention Project)

Ethiopian Community Development Council (ECDC)
Arlington, VA, US

Project Overview

Through offices across the United States, ECDC conducts educational and social service programs that help newcomers resettle in their new communities and acculturate; recover from past trauma; gain personal independence and economic self-sufficiency; and quickly become able participants and productive, contributing members of American society. In responding to the health care concerns and needs of the African newcomer community, ECDC has sought to design an approach that combines direct services with culturally sensitive health promotion and health education.

ECDC has over 19 years of experience in providing a variety of health-related services, including: familiarizing newcomers with the roles and services of area healthcare providers and how to access healthcare services; holding cultural competency training sessions for area service providers; providing translation and interpretation services to area health departments; translating health materials into languages spoken by refugee newcomers; conducting a Health Needs Assessment Survey of African-Born Residents in the Washington, D.C., Metropolitan area; conducting HIV testing, HIV/AIDS peer education along with group and individual outreach interventions; educating newcomers about the harmful effects of smoking and environmental smoke; advocating for clean indoor air policies; and increasing newcomers' knowledge about preventive health and health screenings.

RAPP is a CDC-funded, community mobilization program designed to reduce risk for HIV and unintended pregnancy among heterosexually active women (and their male partners) in high-risk communities by increasing condom use. RAPP is based on the trans-theoretical model of behaviour change, which states that people move through a series of stages in the process of changing their behaviour. The program also is supported by theories of social learning and diffusion of innovation, which suggest that people are more likely to adopt new behaviours that have already been accepted by others who are similar to them and whom they respect. The RAPP intervention relies on a set of peer-led integrated activities:

Core Elements

Core elements are intervention components that must be maintained without alteration to ensure program effectiveness. The core elements of RAPP include:

- **Outreach:** Peer volunteers contact their neighbours on the street, at businesses and community organizations, and in residential areas. During brief, one-on-one encounters, they deliver informational brochures, referrals, and condoms. They may also engage in longer discussions in which they determine the woman's stage of change and motivate her with stage-appropriate messages and "role model" stories (project-produced brochures containing stories of community women in different stages of readiness to use condoms and describing their experiences and decisions). Peer volunteers are trained in HIV prevention, condom use demonstration and receive an honorarium for their work.

- **Small groups:** Peer network leaders supplement street outreach by conducting small group activities, such as safer sex parties and presentations to organized community groups. Sessions are based on participant's stage of readiness to change, and conducted at times and in settings that are convenient to participants (i.e., evenings, weekends, community centres). The peer networkers also represent the project in community activities. Participants are referred to HIV testing clinics upon request.

- **Community mobilization:** Peer networkers recruit businesses to provide in-kind services for project activities and to participate in a media campaign. The businesses display posters and distribute "role model" stories and brochures and newsletters containing information on HIV prevention, women's health and well-being, and referral sources.

Project Materials

Replicating Effective Programs (REP) is a CDC-initiated project that identifies HIV/AIDS prevention interventions with demonstrated evidence of effectiveness. REP supports the original researchers in developing a user-friendly package of materials designed for prevention providers. RAPP is one of the REP interventions. The RAPP intervention package was developed by researchers and representatives from the health department, community-based HIV prevention organizations (CBOs), and public housing communities. The package has been field tested in two public housing communities by non-research staff. Package contents include:

- Overview of program for agency and community leaders
- Training manual for agency staff and peer network volunteers from the community
- Video introducing the program and demonstrating each of its components
- Materials for reproduction, such as training modules, tracking forms, and "role model" stories
- ECDC has translated educational materials are prepared into the language of the communities they serve (i.e., French, Somali, Amharic, English)

Evaluation

RAPP is evaluated by CDC on a regular basis. Data regarding number of individuals reached through activities is tracked in CDC's database. Organizationally, ECDC conducts pre and post evaluation to assess changes in participant behaviour.

More information

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Appendix D: UK-based HIV Prevention Programs/Projects

National African HIV Prevention Programme (NAHIP)	
African HIV Policy Network <i>London, UK</i>	
<p>Project Overview</p> <p>The African HIV Policy Network (AHPN) is an alliance of African community-based organisations and their supporters working for fair policies for people living with HIV/AIDS in the UK, providing training, support, research and information. The AHPN is the only African organisation in the UK whose work is dedicated to policy, advocacy and representation at national level. Its major focus is on HIV and the sexual health of Africans in the UK.</p> <p>Funded by the Department of Health, NAHIP came under the management of the AHPN in October 2001. NAHIP's mission is to enable Africans to access appropriate information and services to help them to make informed sexual health decisions, to fight stigma and influence change with the aim of reducing the incidence of HIV among African communities in England. NAHIP embraces the objectives proposed by the African Framework for African HIV prevention work to:</p> <ul style="list-style-type: none"> - Work in partnership at all levels to promote a comprehensive response to the HIV prevention needs of African communities in England; - Help reduce HIV-related stigma and discrimination; - Respond to the different HIV prevention needs of different African populations in England. - Facilitate continuous improvements to HIV prevention services through the work of its Research Team <p>Core Elements</p> <ol style="list-style-type: none"> 1. NAHIP Partnership: NAHIP partners provide a range of HIV services, some specifically targeted at Africans, others targeted more widely but including services to Africans. Implementing Partners (IP) work in partnership to help identify needs and implement work on behalf of NAHIP. IP partners are established service providers and community based organisations. There are currently 19 members of the NAHIP Implementing Partnership such as: Black Health Agency, Ethiopian Community Centre UK, NAZ Project London, Pan Afrique Community, Terrence Higgins Trust, Uganda AIDS Action Fund, West African Networking Initiatives, Positively Women, The Crescent Support Group. IP partners are trained by NAHIP to conduct HIV prevention services among the communities that they serve. They meet quarterly to discuss issues impacting community, provide advice 2. Research: BASS Line 2007 is a research report that outlines the findings of an HIV prevention needs assessment carried out by Sigma Research among Africans in England. They have also developed a tool (Knowledge, Will, Power) to assist organizations with doing HIV prevention in African communities, from grant writing 3. Campaigns: <ul style="list-style-type: none"> - African HIV Testing: The testing campaign was developed to encourage African people to think about the benefits of testing as part of good sexual health 	<ul style="list-style-type: none"> - Beyond Condoms: Seeks to encourage debates within communities not only of condom use but also on other safer sex practices that reduce the spread of HIV and promote the building of a safer sex culture. - Do it Right – Africans Making Healthy Choices: Gender-focused campaign with online videos that raise awareness of how HIV and STIs can affect families - http://www.doitright.uk.com/kobana/ <p>4. Training: The NAHIP African Community Workers' Training aims to enhance knowledge, understanding and develop skills that community based HIV service providers working with African communities need to deliver successful and effective HIV prevention interventions in community settings. In addition the training programme will build skills for using research-based knowledge and written NAHIP health education resources. NAHIP has also developed a Christian and Muslim toolkit for faith leaders/organizations to conduct HIV prevention among worshippers. Faith leaders were involved in the development of this tool.</p> <p>Project Materials</p> <ul style="list-style-type: none"> - Do it Right poster, booklet, folding card, helpline care, website - Beyond Condoms leaflets, posters (in Amharic, English, French and Portuguese for youth, women, men and faith communities) - African HIV Testing posters, wallet cards, leaflets in French and Amharic - BASS Line 2007 Survey Report <p>Evaluation</p> <ul style="list-style-type: none"> - The University College of London evaluates all of NAHIP's work to ensure that the programme is meeting the needs of the target population. An evaluation report is issued on an annual basis. - Overall, the feedback is positive: HIV prevention messages are reaching the African community, clearly demonstrating that the Implementing Partners are doing lots of work - Evaluation has revealed that more work needs to be done with youth. NAHIP will be applying for additional funding to accomplish this. - Evaluation also demonstrated that HIV testing is needed within the African community. As such, NAHIP will be re-launching their African HIV Testing campaign <p>More Information</p> <p>Mariama Kamara, Office Manager NAHIP and AHPN New City Cloisters, 196 Old Street London EC1V 9FR Telephone 020 7017 8910 Mariama.kamara@ahpn.org</p>
<p>References</p> <p>African HIV Policy Network. (2009). <i>About Us</i>. Retrieved on March 23, 2009 from http://www.ahpn.org/</p> <p>National African HIV Prevention Programme. (2009). <i>About Us</i>. Retrieved on March 6, 2009 from http://www.nahip.org.uk/</p>	

Pan African and Caribbean Sexual Health Project (PACSH)

The Ethiopian Community Centre in the UK (ECCUK)
Tottenham, London, UK

Project Overview

ECCUK provides services on health and health related matters for Ethiopians and other African Ethnic backgrounds community members. ECCUK is a partner with African HIV Policy Network (AHPN), and a lead organisation in North Central London for National African HIV Prevention Programme (NAHIP).

In addition to health related services specific to Ethiopians, ECCUK coordinates and provides HIV prevention services for the Horn of Africa Community members residing in Enfield and Haringey. The services of ECCUK have been expanded to Pan African and Caribbean communities since 2005 and have covered the wider issues of Primary and Secondary HIV prevention. The PACSH project has successfully supported well over 48 different nationalities via direct support to HIV positive people and primary prevention.

Core Elements

PACSH project provides information, advice and guidance on sexual health in general through two main programmes:

1. Primary HIV Prevention Programme:

- **Condom Information and Resource Distribution Programme:** The overall aim of condom and information resources distribution is to reduce HIV transmission, spread and reduce new HIV infections, through raising basic awareness and knowledge. It is also aimed at contributing to the reduction in the spread of HIV and STIs through improved access to and availability of condoms (male and female) and through increased and effective use of condoms.
- **HIV Awareness and Test Promotion:** The overall aim of HIV Awareness and HIV Testing is to reduce HIV transmission, spread and reduce new HIV infections, through raising basic awareness and knowledge. It is also aimed at reframing participants' thinking about their sexual behaviour through a combination of behavioural interventions and information that focus on the benefits of HIV and STI testing services. This work stream is designed to reduce a reliance on written information and connect service users to other services, such as, the *Love Safely Partnership* Project – which offers structured follow up to improve personal knowledge about HIV and its transmission; and encourages longer term safer sex practice. The aim of HIV Awareness and Test Promotion is accomplished mainly by running workshops and seminars that includes, gender specific work, work targeting African Muslims and Black majority churches, work targeting communities where HIV is emerging as an issue, for example, the Horn of Africa and West Africa; Dominican Republic, Haiti, Barbados, Jamaica, Bahamas, Trinidad and Tobago, work addressing the specific needs of people under 25 years of age, work targeting francophone communities and work engaging African and Caribbean men who have sex with men.

2. Secondary HIV Prevention Programme

The main aim of the Secondary HIV Prevention Programme is to provide practical and emotional support to people who are affected or infected by HIV. ECCUK also helps them to address other issues such as immigration, housing, welfare benefits, money and debt, education and training and business start up support:

- **Community Support Service:** This service includes: providing information, advice and guidance and emotional support to HIV positive people and people who are leaving hospital after an episode of care to provide a single contact point for community based emotional support; signposting to other services; access to training and volunteering opportunities; support with accessing primary health care and emergency health care; support to access financial help, and where appropriate access to immigration and other specialist advice services; support around disclosure of their HIV status; relationship support and support to establish and sustain safer sex with their partners, including distribution of free condoms.
- **Newly Diagnosed Pregnant Women Support Service:** The aim of this service is to support the newly diagnosed pregnant women and also those who have recently delivered their babies who are receiving Treatment and Care at the North Middlesex Hospital. It is also aimed at reducing stigma and discrimination surrounding HIV and improving the health and well being of African and Caribbean people living with HIV. It will also help African and Caribbean people to be educated about HIV with access to clear, accurate and credible information and quality services.

Other PASCH services include the Chlamydia Screening Programme.

Project Materials

- Leaflets and condoms provided at no charge by the appropriate Primary Care Trust

Evaluation

- ECCUK programs are evaluated on an ongoing basis

More Information

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References

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The Monya Project: The African MSM Sexual Health Project

Naz Project London (NPL)
London, UK

Project Overview

NPL aims to educate and empower communities to face the challenges of sexual health and the AIDS pandemic, and to mobilise the support networks that exist for people living with HIV/AIDS. NPL also provides training services to voluntary, community and statutory organisations as well as a wide range of free resources.

The African MSM Sexual Health Project (also known as the Monya Project) is an NPL and Newham Primary Care Trust (PCT) initiative. Monya means strength in Swahili. This project is focused on African men who have sex with men in Newham. African MSM living in London are faced with a number of problems including HIV, immigration, education and employment, isolation, fear and hate crimes. The project aims to enable African MSM to confront the challenges that HIV, sexual health and homophobia can present. Facing these issues requires not just the strength of African MSM, but also of their friends, family and loved ones to bring an end to the stigmatisation.

The project emerged as a result of a call from organizations serving African LGBT populations who noted a lack of HIV prevention programs for African MSM. This population experienced discrimination both in their communities and the health care system. NPL started the Monya Project in 2007 with funds from the national trust system in East London (this project is not delivered across the UK).

Core Elements

Services provided:

- Outreach: Conducted at 2 Black gay clubs in East London where NPL distributes leaflet, condoms and provides information
- Peer support group: The support group discusses topics such as: relationships, compromise, taking control, immigration etc. Topics are based on the needs of the current participant group. They identify myths and debunk them, often inviting speakers to provide expert information. Through these conversations, NPL highlight sexual patterns that put participants at risk. They are very cautious about discussing HIV because participants are very scared. They do not condemn participants for risky behaviour, and encourage them to make healthy choices. Participants are also encouraged to be tested and NPL provides referrals to the genitourinary medicine (GUM) clinics.
- Social activities
- HIV/AIDS information and helpline

Project Materials

- Leaflets regarding HIV/AIDS
- Condoms

Evaluation

- The project is evaluated on a monthly basis and a yearly report is prepared for the Newham PCT
- Past evaluation has revealed that the concerns of African MSM go beyond sexual health: issues such as immigration, fear of deportation and isolation are issues of most importance to this population. As such, these are consistent topics for discussion within the support groups. Furthermore, NPL assists service users with acquiring the appropriate immigration documentation.
- The evaluation process also revealed that the project needs to include a treatment component because some clients tested positive.

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Note: The UK will be having its first conference on African MSM in the near future.

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