1st Edition.

HIV
Prevention Guidelines and Manual:
A Tool For Service Providers Serving African and African Caribbean Communities Living In Canada

By: LLana James - National Project Coordinator,
African and Caribbean HIV/AIDS Community Capacity Building Project

Women's Health in Women's Hands

CACVO
Le conseil des africains et caraïbeens sur le VIH/SIDA en Ontario

ACCHO
African and Caribbean Council on HIV/AIDS in Ontario

HIV Prevention Guidelines and Manual:
A Tool for Service Providers serving African and African Caribbean Communities in Canada

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Dear Reader:

Welcome to the first HIV Prevention Guidelines (HPG) and Manual targeted to service providers working with African and African Caribbean individuals and communities in Canada.

The guidelines have been developed by the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO), formerly known as the HIV Endemic Task Force (HETF). ACCHO was launched in April 2005 with the publication of the Strategy to Address Issues Related to HIV Faced by People in Ontario from Countries where HIV is Endemic. ACCHO's role is to coordinate the response to HIV among African and African Caribbean communities in Ontario, facilitate community development, advocate for resources to address HIV and identify research needs and priorities for African and African Caribbean communities in Ontario.

The HPG and Manual are one component of ACCHO's first major project in its workplan to support the implementation of the Strategy. It demonstrates the commitment, dedication, and hard work of all the people involved in the African and African Caribbean Community HIV/AIDS Capacity Building Project. Our special thanks go to the National Project Coordinator, the Project Partners, the HPG Working Group members who led the development of the guidelines, ACCHO members, and the many external reviewers who took their time to provide input. All of you played a major role in bringing the HPG and Manual to fruition.

We developed the HPG and Manual mainly for service providers and community-based organizations that work with African and African Caribbean communities in Canada to support their efforts in preventing both primary and secondary HIV transmission. The HPG and the ongoing support from ACCHO will help service providers and community organizations develop their capacity to work with African and African Caribbean communities.
Together, let us make the HPG and Manual a community resource that helps us to improve our efforts in HIV prevention, diagnosis, care, treatment and support for individuals and communities.

One love!
Wangari Esther Tharao and Winston Husbands
Co-Chairs, ACCHO
Toronto
July 2006

Dear Reader:

Women's Health in Women's Hands (WHIWH) is a community health centre that provides primary health care and health promotion support to women from an inclusive feminist, pro-choice, anti-oppression, participatory framework. Women are our priority group, particularly those from the Caribbean, Africa, Latin America, and South Asia. Our collaboration with the African and Caribbean Council on HIV/AIDS in Ontario over the past two years has not only been fruitful, it has been crucial for us as a community-based organization that provides services to women from the African and African Caribbean communities.

It has been nine years since WHIWH launched its HIV program. For service providers such as ourselves, who understand that African and African Caribbean communities -- particularly women within these communities -- bear a substantial burden of HIV/AIDS, the HIV Prevention Guidelines and Manual is a long-awaited tool that can only serve to enhance the work that we do. While the statistics and research continue to show that HIV/AIDS is a growing problem in African and African Caribbean communities, African and African Caribbean people have played a limited leadership role in the efforts to deal with the HIV/AIDS epidemic in Canada. ACCHO has rectified this situation through its tireless advocacy, research, and capacity building projects in which we have been a partner. This work has clearly shown us that effective HIV prevention strategies need to engage all members of affected communities in order to provide effective prevention, diagnosis, support, and care.

On behalf of WHIWH, it is a pleasure to offer congratulations to the African and Caribbean Council on HIV/AIDS in Ontario, LLana James as the National Project Coordinator and author of the HIV Prevention Guidelines and Manual, and the volunteers on the development of the first HIV Prevention Guidelines and Manual for Service Providers, specifically geared to the African and African Caribbean communities living in Canada. The tireless efforts of the Council, the staff, and volunteers will not go unnoticed. The Guidelines and Manual will have a positive and resounding impact as we continue our efforts to support our communities in their fight against HIV/AIDS.

Notisha Massaquoi
Acting Executive Director
Women's Health in Women's Hands
Toronto
July 2006

PREFACE

The HIV Prevention Guidelines and Manual are a response to requests from both African and African Caribbean people living in Canada and service providers for resources on HIV prevention among African and African Caribbean communities in Canada. This resource is grounded in a framework of anti-racism, anti-oppression, cultural competence, and harm reduction.

Often, HIV prevention is framed as an issue that can be addressed by focusing solely on individual behaviours, when, in fact, HIV prevention hinges on the determinants of health. Evidence clearly points to the fact that systemic, structural and individual factors converge to create situations and circumstances that facilitate HIV transmission. Systemic and structural issues such as gender inequity, sexism, heterosexism, homophobia and racism limit peoples' ability to make choices that promote and sustain good health.

Whenever HIV prevention work is initiated within and among African and African Caribbean communities living in Canada, it is imperative to look at the whole picture, rather than selectively focusing on the alarming HIV transmission statistics without acknowledging the context in which they occur. Several reports have documented the economic and social disparity affecting African and African Caribbean communities in Canada. Reports such as the Growing Economic Apartheid in Canada: The economic segregation and social marginalisation of racialised groups published by the CSJ Foundation for Research and Education, (2001) and Income of Black Women in Canada (2005) by the Canadian Association of Social Workers document the impact of covert and overt policies and practices that place racilaized communities, in particular African and African Caribbean communities, in situations of chronic marginalization. This marginalization undermines African and African Caribbean communities' ability to secure and maintain the resources and information that would help to limit or prevent the spread of HIV.

The data from several reports highlight that even when immigration, education, and language proficiency are adjusted for, African and African Caribbean immigrants and their children born and/or raised in Canada endure limited opportunities for economic self-sufficiency and often experience subtle and pervasive forms of social isolation and lack of access to services. Yet African and Caribbean people in Canada, often draw on their collective and individual strengths of tenacity, deep-rooted endurance, and commitment to a better tomorrow to overcome challenges.

Meaningful outcomes follow when our tenacity, deep-rooted endurance, and commitment to a better tomorrow are harnessed. Such is the case with the 1st Edition of the HIV Prevention Guidelines and Manual. Ten years ago, a committed, tenacious, and enduring group of people (later named ACCHO) came together with few resources other than their passion to collaborate on a vision. Eventually, through determination, community mobilization and advocacy, ACCHO was able to secure support from all three levels of government for its efforts to address HIV among African and Caribbean communities.

The HIV Prevention Guidelines and Manual are one example of how individuals from the African and African Caribbean communities in Canada have mobilized and continue to chart a course of self-determination in the face of great odds. To sustain and thrive, the infrastructure within and serving African and African Caribbean communities in Canada must be nurtured and strengthened. Effective and sustainable HIV prevention efforts hinge on redressing economic and social disparity. Effective and sustainable HIV prevention requires that the intersections within the lives of the African Diaspora in Canada be factored into prevention strategies. African and African Caribbean people of all walks of life and all generations are invited to take a place of leadership, as well as the responsibility and accountability that accompanies leadership, to ensure that issues related to HIV transmission and prevention are integrated into community-based activism, empowerment and development.

African and African Caribbean communities in Canada are highly diverse. Some people are recent immigrants, some have been in Canada for many generations, and some have come from highly traumatic situations (such as war/civil unrest). African and African Caribbean communities living in Canada are not homogeneous. The diversity within African and African Caribbean communities is also evident in religious and spiritual affiliation, immigration status, sexual orientation/identity, marital and relationship status, cultural norms and values, income and education levels, language, geographic location, and level of participation with other members of African and African Caribbean communities. Organizations working with African and African Caribbean communities in Canada are encouraged to build on the strengths, wisdom, and resilience within our communities and ensure that African and African Caribbean people play lead roles in developing, implementing and evaluating HIV initiatives affecting our communities.

A Snap Shot…

The 2001 Census data reports that approximately 662 200 people of African and African Caribbean birth and/or heritage live in Canada and constitute 2.2% of the Canadian population or 17% of the 'visible minority' population in Canada.

According to Health Canada data, in 2002, there were 3,700 to 5,700 prevalent HIV infections among African and African Caribbean people in Canada, who now account for between 7% and 10% of the Canadian HIV epidemic. The number is growing. For example, between 1985 and 1998, people from African and African Caribbean communities only accounted for 6.7% of new HIV diagnoses; in 2001 and 2002, they accounted for 22% of new diagnoses. HIV prevalence rates are 50 times higher for African and African Caribbean people than in other heterosexual, non-injecting populations. In Canada, rates of HIV infection are increasing faster among African and African Caribbean populations than in any other population. Approximately 40% to 62% of new infections in the African and African Caribbean communities are occurring during residency in Canada. In the African and African Caribbean communities, HIV is primarily transmitted via heterosexual sexual activity. Between 1998 and 2004, 52% of new infections in African and African Caribbean communities occured in women.
We must act now to address the underlying factors that fuel the epidemic by providing appropriate and timely services for African and African Caribbean communities.

The capacity of HIV-specific and other organizations to provide services for the African and Caribbean communities is limited by the:

- Lack of understanding of the nature and diversity among and within African and African Caribbean communities
- Lack of appropriate programs that acknowledge the complex issues (e.g., immigration, gender inequality, economic exclusion, heterosexism and physiological differences in HIV treatment) and the specific and diverse needs of African and African Caribbean people
- Lack of resources
- Lack of infrastructure

We hope that these guidelines and manual will facilitate a concerted effort to limit the spread of HIV in African and Caribbean communities in Canada and encourage action on the complex factors that make African and Caribbean people vulnerable to HIV.

ACKNOWLEDGEMENTS

I would like to take this opportunity to thank everyone who assisted in the research, development and production of the HIV Prevention Guidelines and Manual including but not limited to the members of the HIV Prevention Guidelines and Manual Working Group (Esther Tharao, Robert Remis, Senait Teclom and Clemon George). Thank you Lydia Makoroka for assisting with the research and translating the Guidelines and Manual into french. Thank you to the Community Partners that participated in the two day Workshop: Felicite Murangira, Abai Coker, Alex Adrien, Ron Chaplin, Janice Dayle, Orhan Hassan and Zhaida Uddin. Thank you Felicite Murangira volunteering your time to assist with the translation of this text into french. Thank you to the ACCHO Co Chairs for their support and encouragement. Thank you to all of the ACCHO members who participated in the process and provided valuable feedback.

Thank you to all of the reviewers and everyone who provided feedback and insights along the way.. Thank you to the staff and volunteers at Women's Health in Women's Hands Community Health Centre that rolled up their sleeves and assisted with setting up for meetings, photocopying and much needed technical support. To all of the tireless volunteers on this project who stayed late and gave it their all, thank you for your hard work.

LLana James

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PART I

HIV PREVENTION GUIDELINES

A Tool For Service Providers Serving African and African Caribbean Communities Living In Canada

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Service Providers' HIV Prevention Guidelines for African and African Caribbean Communities Living in Canada

CONTENTS

1. HIV TRANSMISSION

Service providers can help African and African Caribbean clients prevent HIV transmission by:

- Explaining how HIV is and is not transmitted, including the factors that contribute to HIV infections
- Explaining that approximately 40% to 50% of people within African and African Caribbean communities in Canada who are infected with HIV (i.e., are HIV-positive) do not know they are infected and have no recognizable symptoms
- Respectfully informing clients that being tested for HIV at regular intervals and practicing safer sex and other harm reduction strategies will reduce HIV transmission between partners and within African and African Caribbean communities in Canada.
- Encouraging clients to be tested and find out their HIV status, instead of assuming they are HIV-negative

HIV cannot be transmitted through:

- Everyday contact with adults or children who have HIV/AIDS
- Shaking hands, hugging, or kissing someone with HIV/AIDS
- Working or playing with someone with HIV/AIDS
- Sharing children's toys (even toys that children put in their mouths)
- Sharing washrooms
- Sharing water fountains, food, dishes, cutlery or clothes
- Changing diapers

1.1 RISK FACTORS FOR HIV TRANSMISSION

HIV is an infectious disease carried in body fluids, such as semen, vaginal fluid, blood, and breast milk. It is primarily spread through blood-to-blood contact and contact between blood and semen or blood and vaginal fluid.

HIV can be transmitted from person to person. For example:

- During vaginal or anal intercourse without a latex or polyurethane condom with a person who is HIV-positive
- During unprotected oral sex with a person who is HIV-positive, when semen, vaginal fluid or menstrual blood can enter the bloodstream through cuts or sores in the mouth, even those that are not visible or noticeable
- When sharing sex toys between people without cleaning or sanitizing them
- When using blood-contaminated needles, syringes, water, cotton filters, straws, or pipes that contain HIV to inject drugs or other substances; often the blood contamination is not visible to the naked eye
- By using needles or ink contaminated with blood that contain HIV for tattooing, skin piercing, scarification rituals, or acupuncture
- Through breastfeeding (i.e., the virus can pass from the mother to her nursing baby).

Although HIV is found in other body fluids, like saliva, mucus, or vomit, it is not present in large enough concentrations to be transmitted through contact with those fluids.

1.2 CO-FACTORS FOR HIV TRANSMISSION

Three co-factors can affect the risk of HIV transmission:

- Viral Load
- Length of Exposure
- Mucosal Immunity

1.2.1 Viral Load

Viral load is a measure of the amount of HIV in the blood. The higher a person's viral load, the higher the risk of transmitting the virus to someone else. A low viral load means less virus and less active disease; a high viral load means more virus and more active disease. Generally, viral load is highest in people during the primary and symptomatic stages of HIV infection. Additionally, viral load is thought to be particularly high in people who are co-infected i.e. with a sexually transmitted infection (STI). When taken as prescribed, highly active antiretroviral therapy (HAART) for HIV can significantly decrease viral load in blood, but the person is still infected; i.e., viral load may be low in the blood, but still high in semen, vaginal fluid and breast milk, and the virus can still be transmitted to others. Having a low or undetectable viral load does not reduce the need for prevention.

1.2.2 Length of Exposure

The risk of HIV transmission increases with the number of times people are exposed and the length of the exposure. After sexual intercourse, semen can remain in the vagina, anus,

and mouth of the receiving partner for a couple of days. This means that, in any single act of penetrative intercourse, the receiving partner has the greater length of exposure.

1.2.3 Health of the Mucosal Membrane (mucosal immunity)

Where the mode of HIV infection involves compromising the mucous membrane, such as penetrative sex, the risk of acquiring HIV through unprotected sex is increased. When the mucosal membrane is broken, inflamed, or infected, risk of HIV transmission is increased because there are more white blood cells present. HIV targets white blood cells in order to infect the cells of a non-infected person. For example, if a woman's vagina or anus is inflamed due to an STI, yeast infection, or if she has abrasions or tears resulting from vigorous or violent sexual intercourse, her risk of acquiring HIV may increase by three to fifty times.

To maintain healthy mucous membrane:

- Young women (i.e., under age 18) should limit pre-ejaculate and semen from coating the vagina and cervix to prevent damage to cells before they have fully matured and acquired natural mucosal resilience.
- The mouth, vagina, and anus should be treated with care and permitted to heal completely after a yeast infection, sexually transmitted infection (STI), sores, tears, cankers, dental work, herpes outbreak, or cuts (including damage from sexual violence, child birth, abortions, and miscarriages)
- Individuals should limit friction, tearing, and drying of the mucous membrane by avoiding douches, enemas, and un-lubricated sex and by using condoms consistently
- Service providers should inform clients who are uncircumcised that they may be at increased risk of STI infections, including HIV, and emphasize the importance of preventive practices (e.g., condoms, HIV testing, limiting the number of sexual partners and meticulous hygiene practices) to both uncircumcised and circumcised men

Factors that lead to inflammation or infection of mucosal membrane include:

- Age/Stage of physical development. The cells in the vagina do not fully mature and acquire natural mucosal resilience until about age 18. Until that time, young women are highly vulnerable to HIV infection and other infections.

- Unprotected penetrative vaginal or anal intercourse when the vagina or anus is dry. This can occur when the vagina or anus is not sufficiently lubricated, during forced intercourse/rape, consensual sex or when a woman or a man is not lubricated with water-based lubricant during anal intercourse, or when a woman or man uses herbs, soaps, cleansers, and other astringents to dry out natural lubricants with the intention of tightening the vagina and/or anus.

(Factors that lead to inflammation or infection of mucosal membrane include: cont)

- The presence of sexually transmitted infection (STI). The presence of STIs substantially increases the risk of HIV transmission. The presence of STIs often creates points of entry for the virus by causing ulceration or inflammation of the genital and/or anal tract. The risk appears to be greatest with genital ulcerative disease (GUD), especially Hemophilus ducreyi (the bacteria that causes chancroid), herpes viruses (usually HSV-2), and syphilis. The receiving partner is at higher risk of acquiring sexually transmitted diseases, including HIV, than the penetrative partner (WHO 2000). For example, if a penetrative partner has a gonorrhoea infection, there is a 70% chance that the receiving partner will acquire the infection from a one-time exposure; if the receiving partner has gonorrhoea, there is a 30% risk for the penetrative partner from a one-time exposure. When HIV and gonorrhoea infection are present the risk of HIV transmission and infection are markedly increased.

- The use of irritating substances. Using spermicides, douching with perfumed soaps, or using enemas that include ingredients such as herbs, soaps, cleansers, and other astringents can irritate the vagina or anus.

- Female genital mutilation (FGM). FGM includes all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious, or other non-therapeutic reasons. Women who have undergone FGM, particularly types III and IV [see 2.3.10.2 genital mutilation], are especially vulnerable to HIV infection because of the complications and consequences of the procedure.

- Menstrual cycle. The amount of HIV in an HIV-positive woman's genital fluids (i.e., viral load) fluctuates during her menstrual cycle. The viral load is often greatest during active menstruation and lowest immediately following menses. Sex during menstruation appears to increase the risk of both transmitting and acquiring HIV infection; this may be due to the higher concentration of HIV in the blood and the opening of the cervix during menses.

- Male circumcision. Studies are currently ongoing with respect to whether male circumcision (i.e., the surgical removal of the foreskin that covers the glands or head of the penis) may reduce the risk of HIV infection. Limited research has cited lower rates of HIV transmission among men who are circumcised when circumcision is performed with sterile instruments in a clinical setting.

(Factors that lead to inflammation or infection of mucosal membrane include: cont)

Service providers should inform clients that circumcision performed with sterile equipment might reduce STI transmission. However, service providers must continue to caution uncircumcised and circumcised men that effective HIV prevention, such as consistent condom use, limiting the number of sexual partners and routine HIV testing, is required to reduce exposure to HIV and the risk of HIV transmission.

2. CONTEXT OF HIV TRANSMISSION IN EVERYDAY LIFE

This section provides information about African and African Caribbean people that may affect both HIV prevention and treatment. It should help service providers share information about HIV transmission and prevention more effectively with African and African Caribbean people.

2.1 THE HIV EPIDEMIC IN AFRICAN AND AFRICAN CARIBBEAN COMMUNITIES

In Canada, epidemiologic data show that heterosexual sex is the primary mode of HIV transmission among African and African Caribbean people living in Canada.

Data suggests that African and African Caribbean people living in Canada usually underestimate their past and present exposure to HIV and do not know their HIV status. The overwhelming majority believes it is unlikely that they are at any risk of contracting HIV. As a result, a small segment of the population is unwittingly transmitting HIV.

While the main risk factor for African and African Caribbean people is unprotected 'heterosexual' intercourse, individuals in the community may also have other forms of unprotected sex or use shared injection drug equipment or share crack pipes. To avoid stereotyping or making unfounded assumptions, HIV education should include non-judgmental accurate information about various types of unprotected sex i.e. oral, vaginal and anal, as well as unsafe injection drug use and crack pipe use.

2.2 A FRAMEWORK FOR HIV PREVENTION IN THE AFRICAN AND AFRICAN CARIBBEAN COMMUNITY

These guidelines advocate an approach to HIV prevention within the African and African Caribbean community that incorporates the following key health and social concepts:

- A Population Health/Determinants of Health Approach
- An Anti-racist, Anti-oppression Framework
- Harm Reduction Approach

When working with African and African Caribbean communities in Canada, service providers are expected to integrate these concepts into all aspects of their work and use them as a framework for service delivery, policy development, procedures, program and project implementation.

In addition, service providers should consult with well-informed members of the African and African Caribbean communities who are trained and knowledgeable about HIV transmission

and prevention in Canada and who can help provide a context for and interpret the concepts presented before delivering HIV prevention services to individuals or to the community at large.

2.2.1 Population Health/Determinants of Health Approach

Population health refers to the health of a population globally, which is influenced by a number of factors including social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services. As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course. It identifies systemic variations in their patterns of occurrence, and applies the resulting knowledge to develop and implement policies and actions to improve the health and well-being of those populations. (Population Health Template, p. 11. Health Canada).

The most widely accepted definition of health promotion is "the process of enabling people to increase control over, and to improve, their health" (Ottawa Charter for Health Promotion, 1986). The American Journal of Health Promotion (AJHP) offers a similar yet expanded definition of health promotion.

> "Health promotion is the science and art of helping people change their lifestyle to move toward a state of optimal health. Optimal health is defined as a balance of physical, emotional, social, spiritual and intellectual health. Lifestyle change can be facilitated through a combination of efforts to enhance awareness, change behaviour and create environments that support good health practices. Of the three, supportive environments will probably have the greatest impact in producing lasting change." (American Journal of Health Promotion, 1989, 3, 3, 5)[1]

The full spectrum of factors and their interactions known to influence and contribute to health are referred to as the determinants of health. They include:

- Income and social status
- Social support networks
- Education, employment/working conditions
- Social environments
- Physical environments
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender
- Culture

[1]Website, January 2006, Ontario Health Promotion Resource System, http://www.ohprs.ca/hp101/mod1/module1d.htm

The social determinants of health are the conditions that influence the health of individuals and communities. These determinants also establish the extent to which a person possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment. Reducing the number of new HIV infections and improving the health and well-being of those already infected with HIV depends on changing the social determinants that place people at risk for HIV infection.

The social determinants of health include, but are not limited to:

- Income inequality
- Social inclusion and exclusion
- Employment and job security
- Working conditions
- Contribution of the social economy
- Early childhood care
- Education
- Food security
- Housing

Source: http://www.phac-aspc.gc.ca/ph-sp/phdd/overview_implications/01_overview.html,Public Health Agency of Canada

Other social determinants that can influence health are:

- **Poverty**
- **Gender orientation**
- **Income and job security**
- **Early childhood experiences**
- **Abuse**
- **Alcohol or substance misuse**
- **Discrimination**
- **Lack of caring and supportive family and friends**
- **Access to health services**
- **Lack of respect for social and cultural diversity and equality**

Source: http://www.hlth.gov.bc.ca/hiv/determinants.html, Government of British Columbia Ministry of Health

2.2.2 Anti-Racist and Anti-Oppression Framework

Racism manifests as systems, institutions, decisions, policies and individual actions that subordinate a racialized individual/group advertently and inadvertently, which includes the oppressive role of colonization in structuring relations between racialized groups and non-racialized groups.

In general, anti-racism refers to actions, measures, and mechanisms designed by the state, institutions, organizations, groups, and individuals to counteract racism. (Henry, Francis et al.2004.) An anti-racist framework helps service providers identify and address issues of racism. It refers to forms of thought and/or practice that seek to confront, eradicate, and/or ameliorate racism. Anti-racism implies the ability to identify a phenomenon – racism – and to redress systemic and structural policies and practices within organizations and by service providers. (Bonnet Alistair, 2000.)

An anti-oppression framework acknowledges the necessity of allies and the limitations and boundaries required when working with allies. An anti-oppression framework involves an analysis of the effects of class demarcation, power, privilege, the absence and presence of civil liberties, internalized and external classism, caste systems, gender oppression, heterosexism, homophobia, and transphobia within society for the purpose of eradicating the associated burdens imposed upon oppressed and marginalized individuals and groups. An anti-oppression framework places responsibility with those who wield or influence power to enact change, facilitate equity and simultaneously supports oppressed and marginalized individuals and groups to mobilize and build their capacity for self determination.

2.2.3 Harm Reduction

Harm reduction is "a public health concept of lowering the health consequences resulting from certain behaviours" (www.druglibrary.org). Characteristics of a harm reduction approach include:

- Adopting a pragmatic attitude toward sex and drug use
- Acknowledging that people take risks and that stigmatizing behaviour(s) increase(s) the probability that individuals will avoid accessing and processing information as well as supportive resources necessary to reduce risk
- Creating a safe place where people can explore their ambivalence about personal behaviours and learn about ways to make their behaviour less risky
- Measuring success in terms of improving personal quality of life and community well-being

- Recognizing the personal and social destruction and tragedy associated with drug misuse/abuse and unprotected sex, while understanding the forces that fuel those behaviours
- Recognizing that change can be a slow process that involves attention to everyday needs such as health care, shelter, and food that support an individual's progress toward health.

Harm reduction involves assessing a person's risk factors. For individuals to be able to better assess their own risk factors, they need HIV prevention education and a safe source of information, i.e., a non-judgmental environment (Hemphill Mary L., 2005.).

Sexual health education is part of a harm reduction strategy and an essential part of personal health and healthy living. The goals of sexual health education as outlined in the Canadian Guidelines for Sexual Health Education are:

- To help people achieve positive outcomes (e.g., self-esteem, respect for self and others, non-exploitive sexual relations, rewarding sexual relationships, the joy of desired parenthood)
- To avoid negative outcomes (e.g., unintended pregnancy, HIV/STIs, sexual coercion, sexual dysfunction). Effective sexual health education should be age-appropriate, acknowledge the role of culture, ethnicity, and spirituality without reinforcing oppressive ideology or actions [see 2.2.2], and respect individual choices.

Effective sexual health education:

- Recognizes the interplay among personal desires, the needs and rights of others, and the requirements and expectations of society
- Focuses on the self-worth and dignity of the individual
- Helps individuals to become more sensitive and aware of the impact of their behaviour on others (i.e., sexual health is an interactive process that requires respect for self and others)
- Integrates the positive, life-enhancing and rewarding aspects of human sexuality while also seeking to reduce and prevent sexual health problems
- Is based on a life-span approach that provides information, motivational support, and skill-building opportunities relevant to people at different ages and stages in their lives
- Is structured so that changes in behaviour and attitudes happen as a result of informed individual choice and are not forced upon the individual
- Does not discriminate on the basis of race, ethnicity, gender, sexual orientation, religious background, or disability
- Provides accurate information to reduce discrimination based on race, ethnicity, gender, sexual orientation, religious background, and disability

- Encourages critical thinking about gender-role stereotyping, recognizing the importance of gender-related issues in society, the increasing variety of choices available to individuals, and the need for better understanding and communication to bring about positive social change
- Recognizes and responds to the specific sexual health education needs of particular groups, such as adults, seniors, people who are physically or developmentally challenged, children and adults who have experienced sexual abuse and marginalized populations such as aboriginal people, people of the African Diaspora, immigrants, gay, lesbian, bisexual and transgendered people, as well as youth, street involved youth, homeless and precariously housed people.
- Provides sexual health education within the context of the individual's moral beliefs, ethnicity, sexual orientation, religious backgrounds, and other characteristics.

Studies indicate that both unemployment and lower socio-economic status are associated with poorer health. For this reason, efforts to promote sexual health and reduce risks should be reinforced by a social environment that seeks to enhance education and employment opportunities and reduce socio-economic marginalization. (Canadian Guidelines for Sexual Health Education, 2005)

Harm Reduction Strategies

Reduce risks related to sexual transmission of HIV by:

- **Knowing your HIV status**
- **Reducing the number of sexual partners**
- **Increasing condom use**
- **Reducing frequency of 'higher risk' behaviours**
- **Minimizing or eliminating drug misuse/abuse**
- **Keeping medical appointments**
- **Reducing other health risks**

Reduce risks associated with injection drug use by:

- **Using a needle/syringe exchange**
- **Cleaning needles with bleach**
- **Being on methadone treatment**
- **Shifting to drug taking methods that do not involve injecting or use of broken or shared crack pipes**

Reduce risks associated with other substance use (including alcohol) by:

- **Reducing the frequency of use**
- **Being knowledgeable about and avoiding drug interactions**
- **Staying hydrated**
- **Keeping medical appointments**
- **Not driving or doing other tasks that put you or others at risk**
- **Maintaining good nutrition**

2.3 KEY FACTORS IN HIV PREVENTION FOR AFRICAN AND AFRICAN CARIBBEAN COMMUNITIES

For African and African Caribbean communities in Canada, issues related to patriarchy/power imbalances, gender, same-sex relationships, racialization, and social-economic exclusion manifest in specific ways that often differ from other communities. Because of the diversity within the African Diaspora 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.

This section describes key factors that affect HIV prevention in the African and African Caribbean communities in Canada. Information for this section has been obtained from several studies conducted with African and African Caribbean communities living in Canada. [see Sources]

2.3.1 HIV Related Stigma, Discrimination and Denial

Stigma operates at a number of levels in societies and individual lives. For example:

- Stigma affects attitudes about sexuality in the country of origin and cultures (i.e., sexual practices, notions of morality and promiscuity, orientation, poverty).
- In Canada, racialization affects African and African Caribbean people; e.g., social and economic exclusion, discrimination and the extent that service providers or their affiliated agencies fail to provide a level of care appropriate for African and African Caribbean people. All of this is compounded by stigmatization specifically related to HIV.

Religion plays an important role in the lives of many African and African Caribbean people. Some religious adherents overtly or covertly believe that they cannot acquire and/or transmit HIV infection simply because they are 'saved', 'believers', protected by a deity/divine power, 'born again', or have converted/recommitted to a religion or spiritual path. Scientific evidence and the millions of people living with HIV infection worldwide who are religious adherents demonstrate that those beliefs on their own do not prevent HIV from spreading.

Religious beliefs have also affected many people's responses to HIV/AIDS. For example, HIV is perceived by some as a punishment, dividing the world into those who deserve assistance and those who do not. These attitudes and beliefs can directly affect a service provider's ability to talk to individuals and communities about HIV prevention methods (e.g., condom use, negotiating safer sex). Training is often required to help service providers address these issues, as well as identify how their own perceptions and personal beliefs as a service provider can help and/or hinder HIV prevention work with African and African Caribbean individuals and

communities. Training of this nature will reduce incidents of racism and misunderstandings that are often "invisible" to service providers.

Theories about where HIV originated and spread among human populations have unjustly stereotyped African people (and, by extension, African Caribbean communities) as being at the epicenter of the pandemic. Attention focused on Africa is doubled-edged; while it has led to more action to help eradicate HIV in Africa, it has also stigmatized African and African Caribbean people.

HIV-related stigma, discrimination, and denial often have a negative impact on health including social support networks (e.g., a person may be afraid to take an HIV test in case someone finds out and judges them as engaging in "immoral" behaviour), employment and/or working conditions (e.g., a person may think that not knowing their HIV status will help them avoid discrimination in the workplace), personal health practices, and coping skills.

The service provider's role is to:

- Stop the perpetuation of HIV-related stigma, discrimination, and denial whenever possible
- Be aware of how stigmatization may keep both service providers and members of the African and African Caribbean communities from identifying and acting on opportunities for HIV prevention and diagnosis
- Correct and challenge expressions of HIV-related stigma among colleagues, as well as during service provision to African and African Caribbean individuals and communities
- Remain mindful of the fact that stigma, discrimination, and denial are barriers to implementing HIV prevention

Stigma is a term applied widely to any condition, attribute, trait, or behaviour that marks an individual or community as culturally unacceptable or inferior. Stigma is linked to notions of shame and disgrace.

HIV-related stigma has implications not only for HIV-positive people, but also for their families and communities as a whole because stigma "spreads" from the stigmatized person to his or her close connections. In Canada, the fear of stigmatization for the whole community, as opposed to personal stigma, has been identified as a deterrent for HIV testing.

(Tharao, Esther., Massaquoi, Notisha., Telcom, Senait. 2005)

2.3.2 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 (e.g., underemployment, social and economic exclusion). Racism plays a key role in African and African Caribbean people denying HIV as a problem and distancing themselves from HIV prevention interventions.

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.

Service providers can play a constructive role in reducing racism by:

- Participating in training that helps them to identify and address racism and other forms of discrimination.
- Making structural and systemic changes in their organizations and intervening to reduce racism in all aspects of the agency's service provision (i.e., day-to-day service provision, agency aesthetic, and hiring practices).
- Advocating for training and a hospitable and welcoming atmosphere in their agencies.

Service providers who participate in anti-racist, anti-oppression training often report feeling challenged and, at times, overwhelmed initially. However, they also report that they often work through the challenges and, in so doing, become more confident as they apply anti-racist, anti-oppression principles to their day-to-day work.

2.3.3 Women, Gender and Equity

The increasing prevalence of HIV/AIDS in women in Canada is the result of a complex mix of biological factors (e.g., structure and maturity of the reproductive system, length of exposure to HIV) and social factors (e.g., gender inequities).

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 (even when they know their partner is having sex 'outside' of the relationship) for fear of being perceived as too sexually knowledgeable, aggressive, or promiscuous.

A woman's capacity to negotiate safer sex is complicated by one or more of the following factors:

- Her male partner may be the main income-earner and the only person who speaks one of Canada's official languages.
- Immigration requirements may limit her ability to access social benefits.
- Women who are sponsored by their husbands cannot access social benefits unless they are willing to openly declare and document their relationship issues for immigration officials. This can be very difficult for women if they believe that their actions may have a negative impact on their children and their ability to stay in Canada.
- Some women, particularly African women who do not speak either of Canada's official languages, may depend on their family to provide translation and interpretation. This may limit their autonomy and their ability to receive information about HIV prevention (when members of the family translate for women, they have control over the information the women receive).
- Husbands/partner may withhold legal documents, passports and other travel documents, thereby limiting a woman's ability to leave an unsafe situation.

Because of gendered cultural norms, many African and African Caribbean women believe they would jeopardize their longterm relationships if they ask a male partner to use a condom. Many women are not prepared to risk their relationship if they believe they are at low/no risk for acquiring HIV infection. For many African and African Caribbean men, negotiating safer sex practices is not a priority and/or is perceived as the primary responsibility of the woman (Silent Voices of the HIV Epidemic, 2004).

When working with African and African Caribbean women, service providers should:

- Understand that gender inequities affect racialized women in very specific ways and require specific types of problem solving
- Recognize that gender-based inequality affects a woman's ability to negotiate safer sex, even when a woman is able to negotiate other aspects of her life readily
- Provide information on options for HIV prevention
- Discuss strategies that individual women can use to protect themselves, their children and their relationships with a male partner

2.3.4 Sexual Violence

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, particularly if the perpetrator is a member of the immediate or extended family or part of the larger African and African Caribbean community.

Forced sex, rape, childhood sexual abuse and incest may directly lead to infection, while fear of sexual and physical violence limits women's ability to negotiate condom use. 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.

Girls, young women, and lesbian, gay, bisexual, transgendered, queer people (LGBITQ) and people living with disabilities are often targeted for physical and sexual victimization. Although boys and men also experience sexual violence, it is important to acknowledge that girls and women are disproportionately affected by sexual and physical violence, regardless of their country of origin, culture, social class, religion, or ethnic group. 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). Research findings also indicate that sexual abuse in childhood may place survivors at risk for physical and sexual abuse in adulthood, which may limit their ability to negotiate safer sex and or identify their right to protect their body. The impact of sexual violence must be recognized in designing practical primary and secondary HIV prevention activities such as outreach programs and HIV testing campaigns.

Service providers have a valuable role to play in:

- Helping survivors of violence access free and/or affordable therapy by skilled therapists
- Helping survivors access support resources such as support groups, shelters, etc
- Providing training/workshops to women, men, and youth about negotiating physical and sexual health with oneself and partners

"Violence against women" means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such coercion or arbitrary deprivation of liberty, whether occurring in public or in private, life.
Violence against women shall be understood to encompass, but not be limited to, the following:

- **Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practice harmful to women, non-spousal violence and violence related to exploitation;**
- **Physical, sexual and psychological violence occurring within the general community, including rape, incest, childhood sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;**
- **Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.**

Declaration on the Elimination of Violence against Women, the United Nations in 1993

2.3.5 Heterosexism and Homophobia

In the early days of the HIV epidemic, HIV was labeled as a 'gay disease' due to limited knowledge and erroneous media coverage. Decades later, many people still hold on to and share this misinformation. **LGBITQ** (Lesbian, Gay, Bisexual, Intersexed, Transgendered and Queer) people are often subjected to heterosexist and homophobic attitudes. Heterosexist and homophobic attitudes are often used to scapegoat gay men, bisexual men and women, lesbians, transgendered, intersexed and queer people, as well as heterosexual men and women who do not openly acknowledge same-sex sexual relationships that they engage in. Furthermore, heterosexist and homophobic attitudes stigmatize people who do not fall within a heterosexist worldview. These attitudes often result in blaming various population groups for HIV, avoiding responsibility for participating in HIV prevention, and derailing HIV prevention efforts [see 2.3.3].

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 create an environment which prevents African and African Caribbean men from discussing HIV prevention methods, particularly if they have sex with other men.

Service providers have a valuable role to play in:

- Stopping the perpetuation of homophobia and heterosexism whenever it arises as well as facilitating advocacy for changes that will reduce and eliminate homophobia and heterosexism
- Being aware of how heterosexism and homophobia hinder service providers and African and African Caribbean individuals and communities from identifying and acting on opportunities for HIV prevention and diagnosis
- Correcting and challenging heterosexism and homophobia in policies, practices, and daily interactions, i.e., among colleagues and/or during service provision with African and African Caribbean individuals and communities
- Providing HIV prevention information in a non-biased manner that supports people who may or may not engage in penis to vagina sexual intercourse with timely or pertinent information that assists them in selecting and implementing appropriate HIV prevention methods

2.3.6 Attitudes Towards Health and Well-Being

Service providers must be aware that African and African Caribbean people living in Canada have belief systems about health that are based on prior experiences in their countries of origin. These beliefs, which are maintained by their cultural community and often remain intact for generations, are often quite different from European/Western attitudes to health care. This affects how African and African Caribbean people perceive HIV and whether they see it as a treatable chronic illness. There may be a tendency on the part of service providers to see the low rate of HIV testing within African Diaspora as resistance or to characterize communities as "hard to serve" populations; however, choices about health care and HIV prevention may be driven by different perceptions of health and well-being, as well as pragmatism.

For many African and African Caribbean people, it is very important to remain self-sufficient and productive. Anything that challenges an individual's sense of self-sufficiency may be perceived as a threat, and this perceived threat can fuel denial about HIV or the need for HIV prevention methods. 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 (e.g., lack of access, social exclusion) – 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 such as providing sexual health education to children/youth, and behaviour change that appears to challenge their views about the "proper" role of women and men, heterosexism and homophobia, HIV prevention in common-law or marital relationships (i.e., using condoms and testing in long-term relationships), challenging

gender inequality, and acknowledging the dangers of heterosexism and homophobia.

2.3.7 Attitudes Towards Sex: Sex as a Taboo Subject

Although the media sometimes portrays African and African Caribbean women and men as highly sexualized and promiscuous, 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.

When service providers are trying to introduce the topic of sexual/reproductive health with members of the African and African Caribbean community, they should:

- Be innovative, but respectful
- Consider using a body systems approach rather than a generic approach. For example, during an annual check-up, a primary care provider could discuss vaginal, anal and penile health, as well as mucosal immunity. The primary care provider could also highlight the usefulness of annual HIV testing and condom usage to ensure long-term health and monitor impediments to mucosal immunity.
- Community health providers such as counsellors, health promoters and mental health counsellors can also use this technique to discuss HIV prevention methods and related sensitive topics deemed taboo.

2.3.8 Multiple Sex Partners

By tradition and custom men in many different cultures are "permitted" to have many sexual partners. Generally, women are not "permitted" to do the same.

Polygamy (i.e., one husband, many wives), a predominantly patriarchal practice, occurs in African and African Caribbean communities. Migration to Canada, where polygamy is illegal, may have reduced the number of African men entering into official polygamous relationships, but it has not eliminated the practice altogether. Men who had more than one wife before coming to Canada feel a moral and economic obligation to the women and children from these relationships and cannot justify abandoning them. 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. Partners may be women, men, or transgendered.

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 are "clean" (i.e., do not have HIV or other STIs), and they choose partners who they assume are also uninfected.

When working with men in the African and African Caribbean community, service providers should:

- Never assume that men are exclusively either heterosexual or gay
- Discuss the risks associated with uprotected sex with multiple sex partners
- Discuss the full range of HIV prevention options without bias and provide information they can use to protect themselves and their partners
- Reinforce that relationship status does not protect against HIV
- Explain that, in heterosexual relationships, men are twice as likely to transmit HIV and other STIs to their female partners than vice versa (in addition, the risk is always greater for the receiving partner, whether it is a female, male, or transgendered person)
- Highlight that men can play a unique and valuable role in HIV prevention in their communities by educating themselves and other men
- Listen carefully to the their objections to HIV testing and prevention and help them overcome the barriers (recognizing that this is an ongoing process)
- Encourage them to select and use HIV prevention methods (e.g., using condoms, reducing the number of partners, engaging in non-penetrative sex), even if they are in long-term relationships, in order to protect current and future partners, from any risks associated with sexual activity outside the relationship
- Help them develop a contingency plan in case they engage in sexual behaviour outside their primary relationship
- Recommend regular HIV and other STI testing (e.g., once a year and when partner(s) are changed or added).

How the information is presented is just as important as what is shared. For example, explaining mucous membrane immunity provides opportunities to openly discuss anal, vaginal, and oral sex, as well as ways to prevent HIV transmission.

2.3.9 Immigration and Migration

Many members of the African and African Caribbean communities perceive the risk of exposure to HIV in Canada as negligible to highly unlikely. This belief may lead people to be complacent or to resist HIV prevention campaigns and interventions. 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.

Some African and African Caribbean people who have lived in Canada for some time may return home to find a long-term partner and the couple may not learn their own or each other's HIV status until they are in the midst of the immigration process or being tested during pregnancy.

The immigration process itself may contribute to risk of HIV transmission for some people. It is quite common for one member of a family to come to Canada first, get established, and then send for the other. This means that partners may be separated for a year or more. When they are apart, they may be involved in sexual relationships that could put them at risk.

For many African and African Caribbean women, migration has disrupted many aspects of their lives. Changes in gender roles can lead to conflicts within the relationship. This means that people whose marriages break down and who find themselves single may start dating with little preparation for negotiating safer sex and limited knowledge about HIV/AIDS or other STIs (Tharao, Esther., Massaquoi, Notisha., Telcom, Senait. 2005).

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.

To help members of the African and African Caribbean community address issues related to immigration and migration, service providers should:

- Share their knowledge and information and educate both men and women about HIV prevention and safer sex options
- Reinforce that HIV transmission is not specific to a geographic location but it is transmitted through unprotected sex and sharing of drug equipment
- Provide information about HIV infections rates in Canada to help people understand the importance of protecting themselves and others
- Help couples who are separated to acknowledge the risk of HIV transmission during the time they were apart and encourage them to practice safer sex when they are first reunited and to test for HIV prior to engaging in unprotected sex with one another
- Encourage clients to be tested for HIV, particularly if they are making decisions about marriage or finding a life-long partner

- Highlight the risks associated with sexual tourism and encourage people to always practice safer sex with all partners
- Remind clients that the risk for HIV does not go away when they travel or go on vacation
- Provide basic information about legal and ethical requirements for disclosure
- Refer people to services that can provide education, care, and support

2.3.10 Cultural and Personal Hygiene Practices

Some cultural and personal hygiene practices may put members of the African and African Caribbean community at risk for exposure to HIV and have an impact on the type of information and support they need.

2.3.10.1 Male Circumcision

Male circumcision is a common practice in many African cultures. Male circumcision is often practiced within a traditional setting, meaning it is often performed as a rite of passage. 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.

2.3.10.2 Female Genital Mutilation

Female genital mutilation (FGM) refers to the partial or complete removal of the female external genitalia for reasons other than medical therapeutic purposes. It is practiced by followers of all religious beliefs and traditional adherents.

A traditional practitioner usually performs FGM with an instrument and without anesthetic. The risk for HIV transmission is particularly high if multiple female genital mutilations are being done with the same instrument that is rarely sterilized. Among the more affluent, FGM may be performed in a health care facility by qualified health personnel. The age at which female genital mutilation is performed varies from area to area. It is performed on females ranging from infants who are a few days old to adolescents and mature women. The World Health Organization is opposed to all the types of female genital mutilation, whether it is medicalized or traditional.

There are many African women who have undergone the FGM procedure who now live in Canada. Those who have undergone FGM, particularly type III (infibulations), are at increased risk of HIV infection. The procedure (i.e., the entire clitoris, labia minora and majora are removed and the two sides are sewn together leaving only a small opening for urination) often results in physical trauma to the vaginal lining during sexual intercourse (e.g., abrasions, tearing, bleeding), which increases the risk of the woman acquiring HIV or other STIs.

2.3.10.3 Vaginal Cleansing/Douching

Vaginal cleansing is also a common practice among African women. It is used to dry out vaginal secretions for "dry sex" or to tighten the vaginal lining to increase friction and male pleasure during intercourse. A number of African men indicate that they would not have sex with a woman who has not dried out her vagina to remove all that "messy" stuff.

Douching is a method of maintaining personal vaginal hygiene that is a common practice among many African Caribbean women. It is also common among young women who use douching to conceal sexual activities.

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 and need to be part of any risk assessment activities.

Service providers working with African Caribbean and African women, girls, and young women as well as men should:

- Be educated about cultural practices that may contribute to HIV transmission
- Be knowledgeable about the co-factors for HIV transmission (e.g., mucosal immunity, sexual health)
- Inform and assist women, men, transgendered people, and youth about key biological factors that need to be addressed in assessing risk of exposure to HIV infection and developing their HIV prevention plan.

Four types of female genital mutilation are practiced today:

- **Type I: Excision of the prepuce, with or without excision of part or all of the clitoris**
- **Type II: Excision of the clitoris with partial or total excision of the labia minora**
- **Type III: Excision of part or all of the external genitalia and stitching/ narrowing of the vaginal opening (infibulation)**
- **Type IV: Pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above.**

World Health Organisation

3. HIV PREVENTION RECOMMENDATIONS

3.1 GENERAL RECOMMENDATIONS

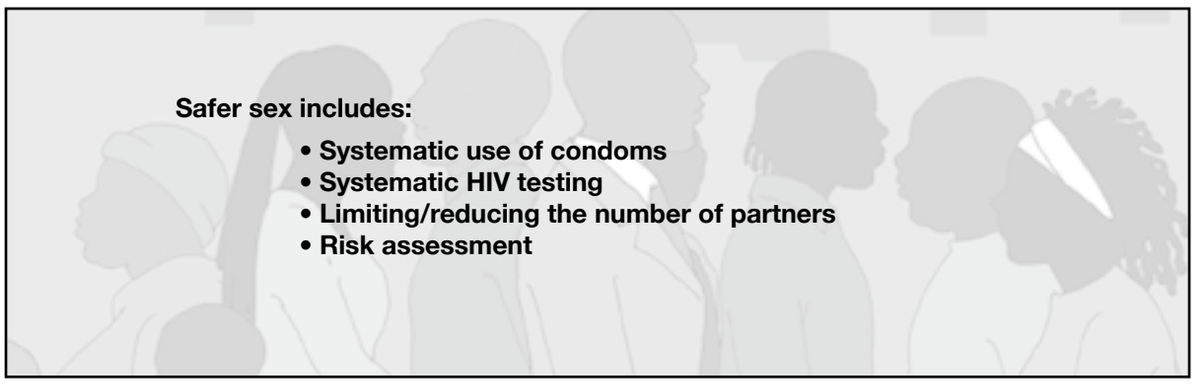
Promoting safer sex is a primary component of any comprehensive effective HIV prevention program. There are many systemic, structural, and personal reasons why attitudes and behaviours that contribute to the spread of HIV remain entrenched including lack of resources, social environment, economic constraints, and gender inequity. Deep-seated psychological factors can also inhibit adoption of systematic use of the male and/or female condom.

In African and African Caribbean communities, specific practices, such as scarification and FGM, increase the risk of HIV transmission. These practices must be addressed within the context of HIV prevention.

Some social and sexual behaviour patterns, such as polygamy or functional polygamy, may also pose a particular challenge in terms of developing strategies and practices that can reduce risk.

To address these issues, service providers and their agencies should:

- Develop culturally appropriate and well-timed community-based social marketing and messaging campaigns
- Offer culturally appropriate, anti-racist, non-oppressive, gender sensitive counselling in a variety of service settings
- Develop outreach programs designed for, by and with African and African Caribbean communities.



3.2 OVERCOMING BARRIERS TO HIV PREVENTION IN AFRICAN AND AFRICAN CARIBBEAN COMMUNITIES

There are a number of barriers to HIV prevention within African and African Caribbean communities, including:

- Misconceptions about who is at risk for HIV: One common misconception is that only gay men (particularly white gay men), sex trade workers, and persons who inject drugs are at risk for HIV transmission. Some people believe only people who are 'immoral', have many sex partners, or sell sex for money are at risk.
- Concern about the impact of HIV testing on immigration status (for people who are not already landed immigrants).
- Stigma from family, friends and community around being tested or receiving a HIV-positive test result.
- The possible impact of taking an HIV test on employment, housing and financial security
- Denial: people may suspect that they are HIV-positive based on past exposures but may be psychologically unready to cope with a HIV-positive test result because of concerns about their ability to deal with the impact of a HIV-positive diagnosis especially in the context of other important issues (e.g., settlement).

Because of these barriers, very few sexually active African and African Caribbean people have taken an HIV test.

To overcome these barriers, service providers should:

- Reinforce that everyone, regardless of marital status, religious denomination, sexual orientation, gender or economic status, is at risk for HIV and should take an HIV test and practice safer sex and drug use.
- Provide information on how HIV is and is not transmitted, including the modes of transmission and ways to prevent HIV transmission that reflect the diversity in partnering/coupling practices, gender expression, sexual orientation, socio-cultural and religious practices.
- Actively promote HIV testing and educate people about their testing choices.
- Offer voluntary HIV testing and counselling to all persons from African and Caribbean countries in the context of other health services (e.g., walk-in clinics, reproductive health centres, counselling/therapy), acknowledging and respecting the person's right to refuse. Voluntary testing and counselling must be sensitive to people's psychological as well as medical needs.
- Explain that all HIV testing requires consent and pre-and post-test counselling and information on any opt-in and opt-out programs and how they are administered.

- Address the myth that an HIV test is "routinely" done (e.g., whenever a blood test is done during routine examination, during pregnancy related testing during immigration-related medical exams).
- Ensure service providers, particularly health providers, are educated about confidentiality and record-keeping, including the implications of violating confidentiality (e.g., impact on workers compensation if disclosure of HIV status was not relevant to a claim submission). Physicians/service providers may be opening themselves to potential litigation or professional review [see the Canadian HIV/AIDS Legal Network for more information].
- Provide access to HIV testing for women in the context of contraception and reproductive health services.
- Encourage African and African Caribbean men to play a key role in preventing the spread of HIV by being willing to negotiate healthy sexual relationships, using condoms consistently and testing for HIV at regular intervals.

Components of Pre-Test Counseling

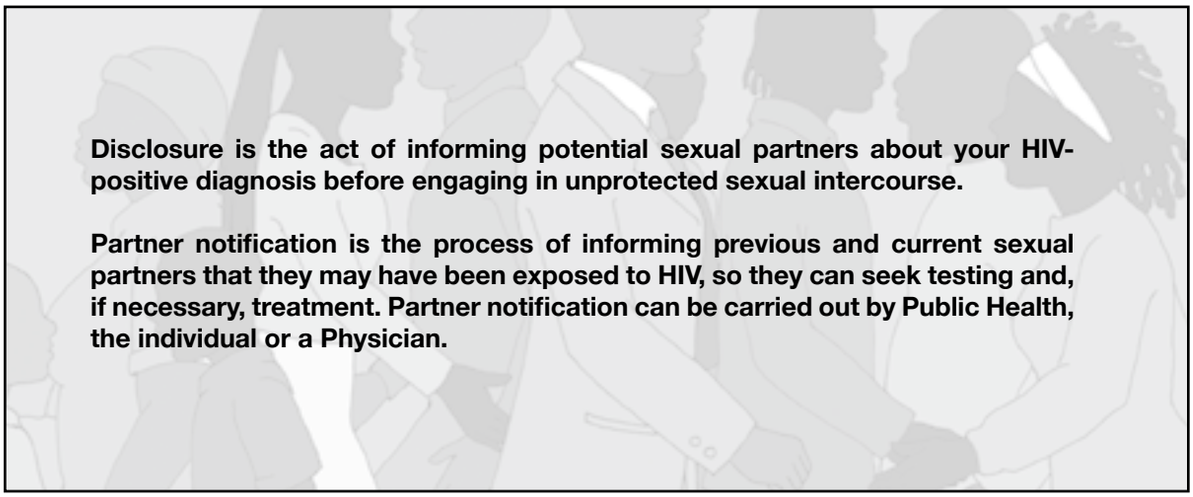
- **Assessing the person's risk of HIV infection**
- **Determining whether the person might be in the window period**
- **Providing information about how HIV is acquired**
- **Identifying risk related activities and ways to avoid or reduce risk**
- **Discussing HIV testing options available in the region and their differences**
- **Discussing record-keeping for each testing option and access to those records by other health-care professionals**
- **Discussing the advantages and disadvantages of HIV testing**
- **Determining the timing of testing and the post-test visit if the person chooses to proceed with the HIV test**

Note: Some provinces and territories have 'opt-in' HIV testing programs while others have 'opt-out' HIV testing programs. Consult a physician, health care provider or Public Health to determine what type of HIV testing program is used.

Pre- and post-test HIV counseling are integral parts of HIV testing. If counselling is skipped or done poorly, HIV testing becomes much less effective as an education/prevention tool.

To ensure that agencies are able to provide effective pre- and post-test counseling to members of the African and African Caribbean communities, staff should be educated about the unique needs of the community and be able to provide relevant information that will help clients assess their vulnerability and identify effective prevention strategies. Agencies should also recruit people from the African and African Caribbean community, including those who are HIV-positive, to provide advice and to assist in educating staff and developing outreach and prevention/education programs.

As noted above, members of the African and African Caribbean community should be offered voluntary HIV testing and counseling and understand the different testing options available to them (e.g., anonymous, non-nominal, nominal) [see Service Providers 2.2 HIV Testing Options.]



Disclosure is the act of informing potential sexual partners about your HIV-positive diagnosis before engaging in unprotected sexual intercourse.

Partner notification is the process of informing previous and current sexual partners that they may have been exposed to HIV, so they can seek testing and, if necessary, treatment. Partner notification can be carried out by Public Health, the individual or a Physician.

3.2.2 Client Assessment

An effective client assessment is a key element of HIV pre-test counseling. During the assessment, the service provider gathers information that will help the client understand the factors in his/her life that are contributing to HIV risk. The purpose of client assessment is NOT to screen out individuals who want an HIV test or have reservations; rather it is an opportunity to respectfully help people identify unconscious, non-visible, and visible risk or vulnerability to HIV exposure and transmission [see Service Providers Manual 3-3.1 Risk Assessment].

To ensure that African and African Caribbean people are able to benefit from HIV testing and counseling, service providers should:

- Explain HIV transmission [see 1-1.23], including the fact that HIV is an infectious disease that is primarily spread through direct blood-to-blood contact and contact between blood and semen or vaginal fluid (often during unprotected anal, vaginal or oral sex, injection or non-injection drug use) and that 40% to 50% of people who are HIV-positive do not know they are infected and have no recognizable symptoms.
- Assess the client's knowledge and skills in HIV risk reduction, including an assessment of the client's attitudes towards practising safer sex and injection drug use and discuss any barriers that may prevent such practices.
- Provide information in a respectful manner about safer sex, safer injecting practices, and other measures known to reduce the risk of HIV transmission.
- Provide education about HIV-related stigma.
- Provide the tools necessary for safer sex and injecting practices (including male and female condoms, lubricant, new needles/syringes and other injecting equipment, such as alcohol swabs, mixers and safer crack use kits) and clear instructions for use.
- Advise people who engage in unprotected sex, in particular penetrative sex where pre-ejaculate, semen, menstrual blood and/or vaginal fluids are present, to be retested for HIV regularly (i.e., at least once per year or every time a sexual partner is added or changed– whichever occurs first).
- Explain the implications and benefits of HIV testing for the immigration process and for travel.
- Offer access to both short and long-term counselling to reduce related stressors.
- Refer African and African Caribbean people who are newly diagnosed with HIV to resources that can provide support and help them understand issues related to disclosure.

3.2.3 Legal Issues, Disclosure and Partner Notification

When people are diagnosed with HIV, service providers should discuss disclosure and partner notification with them. From a legal and ethical perspective, sexual partners must be able to provide full consent when engaging in sexual intercourse. In the eyes of the legal system, full consent means that the person agreeing to sex is making an 'informed' decision. A person living with HIV must disclose 'relevant information' such as his/her HIV status before unprotected sex occurs for a person(s) to be able to give consent [see the Supreme Court of Canada's decision in R v Cuerrier].

Disclosure

Disclosure gives each partner in a relationship (e.g., serodiscordant couples: one person is HIV-positive, the other is HIV-negative) the opportunity to implement practices to reduce the risk of HIV transmission. Disclosure is also important when both partners are HIV-positive in order to prevent superinfection with more than one strain of HIV.

Barriers to African and African Caribbean people with HIV disclosing their status include:

- The possible impact on immigration status (if they are not already landed immigrants)
- Stigma from family, friends and community
- The possible impact on employment, housing, and financial security
- Fear of abuse and/or loss of confidentiality

To help clients deal with issues of disclosure, service providers should:

- Discuss the ethical responsibilities of individuals in society to protect one another from infection with HIV and other infectious diseases
- Explain the legal requirement of people living with HIV/AIDS to disclose their HIV status to people who are at "significant risk of serious bodily harm" (i.e., someone they may have unprotected sex with)
- Explain that activities that have a "significant risk of serious bodily harm" include unprotected anal and vaginal intercourse, the sharing of needles, syringes etc. and using crack pipes that have not been cleaned.
- Encourage clients who are HIV-positive to disclose their HIV status to potential sexual partners, particularly if unprotected sex may occur
- Help clients determine to whom and when disclosure should occur (particularly as it pertains to legal responsibility)

Disclosure in Prisons

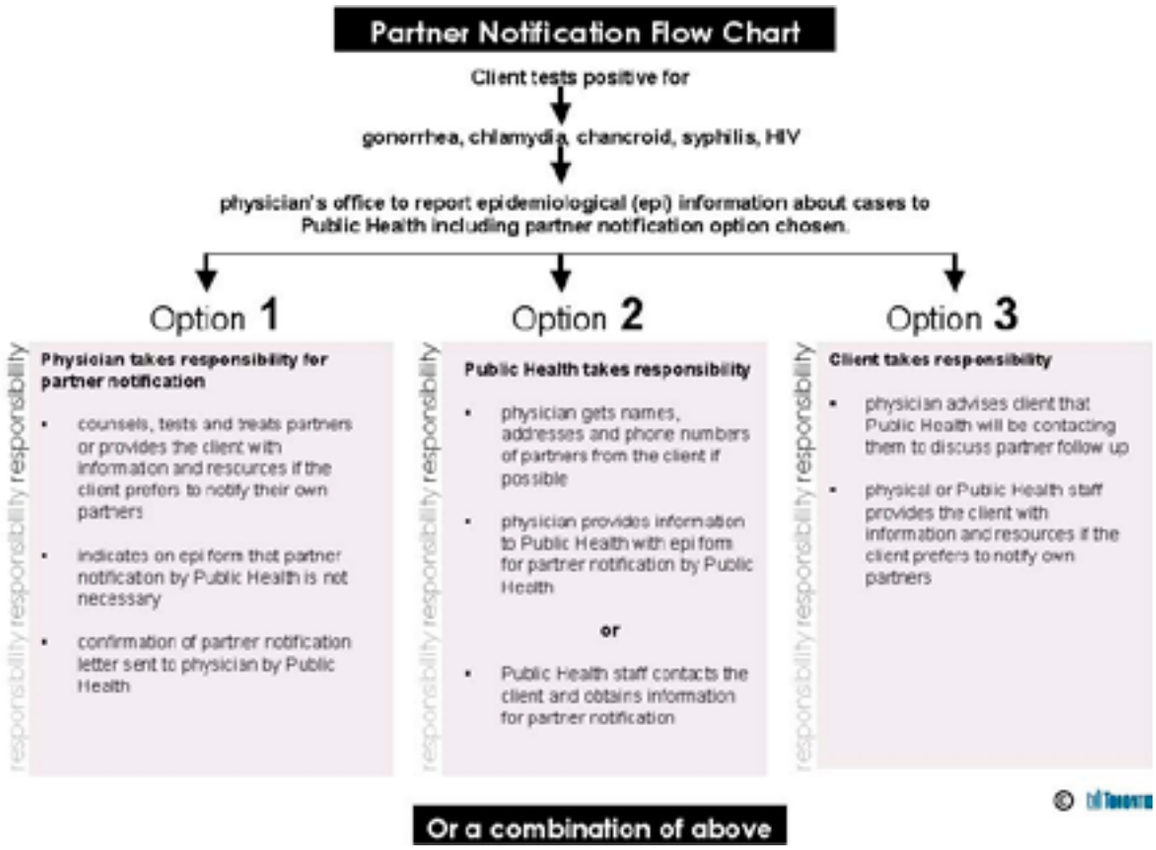
Inmates have the same rights to confidentiality of information obtained by a health professional as the general population. Practices for managing health care records in prisons must conform wherever practical to the standards of health care professionals in the community. A prisoner's health care records must not be included in his or her institutional file. Information about a prisoner's health, i.e. HIV status, must not be released to supervisory or agency staff without the inmate's consent.
As is the case in the general community, if it is believed that the prisoner's actions may constitute a danger to themselves or others, health care staff is authorized to disclose medical information that is pertinent to the issue without consent.

Lines, Rick. (2002)

Partner Notification

Partner notification involves tracing the sexual partners/contacts of a person who tests positive for HIV to let them know that they may have been exposed and advising them to be tested. In some provinces, partner notification is required by law. Partner notification is particularly important in HIV prevention because many people who are HIV-positive do not know they are infected and may be unknowingly spreading the virus. It also encourages more people to be tested and to avoid donating blood until they know their status. Partner notification helps people access HIV treatments as early as possible.

When done well, partners can be notified without revealing the identity of the HIV-positive person. As the following diagram illustrates, partner notification can be done by the HIV-positive person, by his/her health care provider, or by the public health department.



For members of the African and African Caribbean community, there are a number of barriers to partner notification including:

- Fear of stigma, abuse, or violence from partners
- For women, gender inequity which can result in the woman being abandoned by a partner on whom she is financially or socially dependent
- Distrust of the health care system and an unwillingness to provide information that will allow public health authorities or physicians to notify past sexual partners
- Problems contacting partners (i.e., some may live outside Canada where public health systems are weak and there is no system in place to find and notify partners)
- An inability to accurately recall all sexual partners
- Lack of time and resources to do effective and sensitive partner notification

To help clients understand and participate in partner notification, service providers should:

- Develop an approach to partner notification that is culturally sensitive, and reflects the unique needs of the African and African Caribbean communities
- Identify and address barriers to partner notification by helping people navigate the system, mitigate negative impacts where possible (e.g., immigration/
- sponsorship problems, sexual and physical violence) by providing individual counselling and/or relationship counselling where issues of abandonment, shaming and threat of divorce are present

4. POPULATION SPECIFIC GUIDELINES

African and African Caribbean communities are highly diverse. Subgroups within the community will have different needs and require culturally sensitive information and support to meet their needs. To be effective, service providers will require education and training on the needs of each subgroup and on appropriate prevention strategies.

This section highlights the unique HIV prevention needs of individuals and groups within the African and African Caribbean community.

4.1 HETEROSEXUAL WOMEN AND MEN

Epidemiologic data has identified unprotected sex among heterosexuals (regardless of religious affiliation/practice or marital status) as the primary route of HIV transmission among African and African Caribbean people living in Canada. Pregnancy is a marker for unprotected sex and a risk factor in mother-to-child transmission. Therefore, all sexually active individuals considering conceiving or parenting a child should be aware of the risks, as well as strategies, to prevent HIV transmission (e.g., HIV testing, safer sex, choice of contraception). HIV prevention must be integrated into family planning. In the African and African Caribbean community, having children is often considered one way of fulfilling obligations to one another, family, and community. For serodiscordant couples, preventing HIV transmission, practicing safer sex, and family planning may require different strategies during the span of their relationship(s).

Receiving information and education from culturally competent, well-trained service providers in a service user friendly atmosphere can support both partners, reduce risk of transmission, and help serodiscordant couples make informed decisions about options on how to prevent HIV transmission when conceiving or birthing a child(ren).

Many African and African Caribbean women who become pregnant are at some risk of HIV infection if they have engaged in unprotected sexual intercourse. Women are at high risk of HIV infection and transmission because they:

- Are often not aware of their own or their partners' HIV status
- May lack information about reproductive health and HIV transmission
- May doubt or deny their risk, and not be committed to practicing safer sex
- Have not practiced safer sex (i.e., pregnancy is an indicator of unprotected sex)
- Have partners who take little responsibility for practicing safer sex
- May not have been able to negotiate HIV prevention with their partners
- May be survivors of rape, sexual abuse or forced sex

Because of gender inequity and its effect on quality of life, women with HIV are often diagnosed late, which affects their health and may increase the risk of mother-to-child transmission.

Service providers often face challenges when trying to integrate HIV prevention into contraceptive selection and family planning, including:

- Most African and African Caribbean peoples' knowledge about HIV and risk of transmission is heavily influenced by HIV-related stigma and denial that may limit effective self assessment.
- Many African and African Caribbean people do not have accurate information or receive counselling about exposure to and transmission of HIV which hinders informed decision making.
- Many African and African Caribbean people have limited information about the spectrum of HIV prevention options and the role of safer sex, HIV testing, family planning, diagnosis, and treatment.
- Some African and African Caribbean people, particularly some women, trust their partner and/or healthcare providers to do the best for them and their unborn children and may not adequately advocate for HIV-related services on their own behalf.

To help clients integrate safer sex and family planning, service providers should:

- Ensure staff is knowledgeable about risk factors for HIV transmission such as homophobia, gender based inequity, and lack of consistent condom use.
- Ensure staff is able to help people make informed choices about safer sex practices and contraceptive methods based on each individual's desire, timing, choice regarding conception, sexual expression and identity, gender expression, systemic and individual vulnerability, culture, and ability to negotiate safer sex and contraception.
- Develop outreach programs to reach women in the community.
- Integrate HIV/AIDS education across sectors (e.g., during visits with a physician, therapist, shelter and crisis workers without "over-policing" women's health).
- Inform HIV-positive women/men and their partners of the different options available to them that can help prevent mother-to-child HIV transmission.
- Refer African and African Caribbean people who test negative and are at an increased risk for HIV transmission to services specifically designed to meet their diverse needs and encourage them to participate in small group activities that will allow women/men to enhance their health and discuss strategies to prevent HIV (e.g., the 10-week program "Women's Health and Well Being: Experiences of African and African Caribbean Woman Living in Canada").
- Encourage clients who continue to participate in activities that put them at risk (e.g., unprotected sexual intercourse) to be tested at regular intervals.

- Advise women who have been victims of forced sex or rape to take a HIV test and/or refer these women to a free and/or affordable therapist, counsellor or support groups since taking a HIV test may cause issues related to rape and sexual abuse or involuntary sex to arise and/or overwhelm the client.

4.2 HIV-POSITIVE PREGNANT WOMEN

Mother-to-child (MTC) transmission of HIV can occur in the uterus before labour and delivery (i.e., intrauterine), during labour and delivery (i.e., intrapartum), and after delivery through breast milk (i.e., postpartum). Without intervention, between 25% and 35% of babies born to HIV-positive women will be infected – about one-third of them through breastfeeding.

Since 1994, effective prophylaxis (i.e., antiretroviral therapy) have been available that can reduce MTC transmission of HIV to almost zero. To take advantage of these treatments or other options (e.g., therapeutic abortion, avoiding breastfeeding), pregnant women need to know their HIV status. Almost all HIV-positive pregnant women who are newly diagnosed in pregnancy either opt to take prophylaxis as prescribed or opt for a therapeutic abortion. All provinces and territories in Canada offer HIV testing to pregnant women and women planning a pregnancy.

Voluntary HIV testing respects a woman's autonomy and allows meaningful exercise of individual liberty. Consequently, pre- and post-test counseling is required, and a woman's decision must not be unduly pressured or compelled, either by persons or circumstances (Hoffmaster and Scherecker).

Despite the widespread availability of HIV testing, researchers estimated that about 15% to 25% of HIV-positive pregnant women remain undiagnosed. Reasons why women are not tested include:

- Not being offered the test by their physicians (often physicians mistakenly assume some women are not at risk)
- Fear of the impact on their immigration status
- Fear of stigma from family, friends, and community
- Possible impact on employment, housing, and financial security
- The negative influence of partners who may threaten violence
- Concern about their ability to deal with the impact of a positive test result amid other important problems related to pregnancy, such as settlement and other issues

The Canadian Medical Association (CMA) has clinical guidelines for the prevention of mother-to-child transmission, which are summarized here. The full-length guidelines and supporting evidence are available online at www.cmaj.ca.

During labour and delivery, the risk for transmission can be reduced by:

- Performing a caesarean section before onset of labour, which can reduce the risk of infection up to fourfold because it minimizes the exposure of the child to maternal body fluids
- Avoiding invasive procedures, such as fetal scalp pH, artificial rupture of membrane, and routine episiotomy
- Minimizing instrumental delivery and lacerations
- Making efforts to prevent postpartum haemorrhage
- Adhering strictly to infection prevention precautions
- Reducing the risk of MTC through interventions related to breastfeeding. Decisions about whether and how to breastfeed can be complicated. Replacement feeding with formula eliminates the risk of transmitting HIV through breast milk.

To assist African and African Caribbean people in the prevention of mother-to-child HIV transmission, service providers should:

- Encourage women and their partners to be tested for HIV (often, pregnant women are tested for HIV while their partner is not, which places both mother and child at further risk for HIV infection)
- Refer women to centres dedicated to the care of persons of African and African Caribbean heritage, where they may receive support and advice about HIV testing in pregnancy and, if desired, undergo HIV testing
- Explain the benefits of treatment to women who test HIV-positive
- Recommend an HIV test if the mother or father have tested HIV-positive
- If a child experiences unexplained recurring or chronic illness explain the benefits and drawbacks of HIV testing to the attending guardian or parents
- Help HIV-positive women access infant formula so they can avoid breastfeeding [Contact your local public health unit for information on infant formula programs]

Sample Maternal HIV Testing Policy

"The Ministry of Health in conjunction with the physicians and midwives of Ontario will make voluntary HIV testing available to all pregnant women and women planning a pregnancy, either as part of routine prenatal screening or through current HIV testing programs. Women should be counseled about the benefits and risks of HIV antibody testing and must give their informed consent before their physician or midwife orders the test".

Ontario Ministry of Health and Long-Term Care, 1998

4.3 GAY MEN, BISEXUAL MEN AND MEN WHO HAVE SEX WITH MEN

Men who have sex with men (MSM), bisexual men, and gay men are at increased risk for HIV infection if they engage in unprotected sex (vaginal or anal sex without the use of a condom). The practice of grouping MSM, bisexual, and gay men together for epidemiological purposes poses problems for HIV prevention because these groups of men differ in their sexual identity and their perception of risk for HIV. Each group has different perceptions and needs that must be addressed specifically if HIV prevention programs are to be effective.

For example, heterosexual African and African Caribbean men who have sex with men face a number of issues including:

- Internalized homophobia
- Fear of violence if their MSM behaviours become known
- Denial: they may not acknowledge they are having sex with men
- Lack of education about HIV transmission
- Perception that sex with other men is not sex but an issue of dominance
- Perception that only gay-identified men are at risk of HIV and have to practice safer sex
- Risk of infecting partner(s) - male and/or female

African and African Caribbean men who self-identify as gay or bisexual face similar issues as well as:

- Cultural taboos against male-to-male sexuality
- Physical violence
- Homophobia from society as a whole
- Internalized homophobia
- Isolation, stigma, and discrimination from African and African Caribbean communities

To support African and African Caribbean gay men, bisexual men, men who have sex with men, service providers should:

- Seek advice and leadership from bisexual and gay men in the African and African Caribbean community to help develop effective programs and services
- Recognize that MSM are not easily identifiable and will often present as heterosexual or be perceived as heterosexual
- Focus on cofactors for HIV transmission, such as mucosal membrane health (mucosal immunity -- see Cofactors for HIV transmission) and penile and rectal health, rather than directly discussing sexual identity -- unless the service provider has developed a rapport with the client

- Provide relevant accurate information about mucosal membrane health (mucosal immunity), reproductive, penile, and rectal health and wellness, as well as HIV /STI prevention to all men
- Recommend that all sexually active men be voluntarily tested for HIV at regular intervals
- Inform all men that the transmission of HIV in African and African Caribbean communities will decrease if men develop and implement an HIV prevention plan (i.e., use condoms consistently)
- Discuss the merits of using condoms for all men regardless of perceived heterosexuality and marital status
- Advise male clients to carry condoms and check their expiration date
- Discuss and demonstrate proper condom usage
- Inform men that only non-petroleum lubricant can be used with condoms
- Encourage men to experiment with different brands of condoms to determine the best size and fit
- Advise men to negotiate condom use with all sexual partners prior to engaging in foreplay
- Advise men who use martial status to downplay the need for condom use to take an HIV test and use condoms systematically until both partners test HIV negative and have no exposure to HIV
- Create a supportive environment that will help African and African Caribbean men who are having sex with men (who are in denial) deal with their denial and take responsibility for protecting their own and their partners' health
- Connect men who self-identify as gay or bisexual with organizations that serve African and African Caribbean gay men and/or bisexual men

4.4 LESBIANS, BISEXUAL WOMEN AND WOMEN WHO HAVE SEX WITH WOMEN

Bisexual women and lesbians are at risk of exposure to HIV and have distinct issues and needs. For example, bisexual women face issues such as:

- Cultural taboos against bisexuality
- Homophobia and sexism, including internalized homophobia
- Fear of violence/fear for personal safety if bisexual behaviours are recognized by community
- Denial: bisexual women may not acknowledge their bisexual activity
- Lack of education about risks of HIV transmission

Lesbian women face issues related to:

- Cultural taboos against female-to-female sexuality
- Physical violence
- Isolation, stigma, and discrimination from African and African Caribbean communities

To provide support for bisexual and lesbian women, service providers should:

- Seek advice and leadership from bisexual and lesbian African and African Caribbean women who can help develop effective programs and services
- Recognize that bisexual women may present themselves or be perceived as either heterosexual or lesbian
- Discuss all aspects of sexual and reproductive health, including rectal health, with all women
- Educate women about the co-factors that increase their risk for HIV infection (e.g., mucosal immunity, menses)
- Remind women that practices used to avoid pregnancy (e.g., birth control pill, withdrawal) will not protect them from HIV or other STIs
- Encourage all sexually active women to be tested for HIV at regular intervals
- Encourage the consistent use of condoms and dental dams
- Create a supportive environment that educates bisexual and lesbian African and African Caribbean women that low risk is not the same as no risk and that practicing HIV prevention consistently will decrease the risk of exposure to and transmission of HIV

4.5 TRANSGENDERED PEOPLE

HIV prevention efforts in the African and African Caribbean community often ignore or deny the needs of transgendered people, despite the fact that they are also at risk of acquiring HIV. Transgendered African and African Caribbean people face a number of unique issues including:

- Effects of racism, sexism, heterosexism, homophobia, transphobia, including internalized transphobia, and classism on access to employment, housing, healthcare, and social and economic inclusion
- Lack of access to affordable and accessible gender reassignment surgery or other surgeries
- Lack of access to unused needles that are the proper size for hormone injections etc.
- Lack of access to services and well-trained primary and allied health care providers who are knowledgeable about transgendered health and wellness

To support transgendered African and African Caribbean people, service providers should:

- Seek advice and leadership from transgendered (male to female and female to male, non-transitioning (no hormones or surgery)) African and African Caribbean people to help develop effective programs and services

- Ensure that service providers enroll in anti-racist, anti-oppression training that includes information about transgendered issues specific to African and African Caribbean people; content developed and delivered by a transgendered African and African Caribbean person(s) may be most effective (if the environment is hostile or otherwise unsuitable it is important to strategize around it, i.e., have the topic delivered by someone else until such time as it is 'safe' to do otherwise)
- Recognize that it is a transgendered person's right to define themself
- Be well informed about and share information with transgendered men and women about respective reproductive health issues, relevant safer sex options, and HIV prevention injection options
- Refer transgendered clients to support services where they will not be subject to stigmatization, transphobia, or homophobia; where such supports do not exist advocacy is required
- Recommend voluntary HIV testing
- Refer newly diagnosed transgendered people to centers that are transpositive and have dedicated culturally sensitive programs to meet their needs (i.e., support and treatment, referrals and counselling to reduce the risk of secondary HIV transmission)
- Empower HIV-positive transgendered African and African Caribbean people by providing information on the risks associated with re-infection and strategies to protect themselves and their partners

4.6 YOUTH

African and African Caribbean youth face specific barriers to HIV prevention, including:

- Feeling invincible and not appreciating the real risk of HIV
- Lack of risk assessment, decision making, and negotiation skills
- Age and stage of life, which often means they are experimenting sexually and are not yet at ease with sexual issues
- Engaging in "unplanned" sexual activity and feelings of guilt and denial about being sexually active
- Misplaced trust, assumptions, and wishful thinking (e.g., "she is a good girl/he's a nice guy; she/he couldn't be HIV-positive")
- Reluctance, particularly on the part of young women, to suggest or insist on condom use for fear of being perceived as too experienced
- Unwillingness, particularly by young men, to use condoms (i.e., because of perception that condoms are not macho, cause less pleasure, possible loss of erection)

To meet the needs of African and African Caribbean youth, service providers should:

- Seek advice and leadership from African and African Caribbean youth to help develop effective programs and services, including programs for lesbian, gay, bisexual, intersexed, transgendered and queer (LGBITQ) youth
- Recruit youth to help deliver programs
- Provide holistic, non-stigmatizing, non-judgemental primary HIV preventive interventions (i.e., safer sex, safer drug use) in settings where youth gather (e.g., schools, community organizations, youth clubs, community media, religious settings)
- Support youth in developing their skills to reach out and help themselves and peers in their community
- Encourage sexually active youth to be tested for HIV at regular intervals (e.g., when changing or adding a sexual partner, including when returning to a former partner)
- Refer newly diagnosed youth to centres that have dedicated programs to meet their needs; where such supports do not exist, advocacy is required
- Provide a safe environment for LGBITQ youth to help them stay safe and avoid victimization, gay bashing/queer bashing, and stigmatization
- Provide appropriate culturally sensitive services for youth living with visible and non-visible disabilities
- Develop HIV prevention interventions that facilitate dialogue and communication between youth and caregivers (i.e., parents and guardians)
- Encourage caregivers, parents, and guardians to have age-appropriate discussions with children and youth that support healthy attitudes towards sex and sexuality and disease prevention (i.e., non-judgemental, non-stigmatizing, and non-oppressive language)
- Encourage new immigrants and first generation caregivers, parents, and guardians to attend workshops and seminars independently and with their children and youth to talk about HIV prevention, diagnosis, care and related issues

4.7 PRISONERS

Barriers and Challenges

Recent reports on police services across Canada and the criminal justice system have confirmed that African and African Caribbean communities experience racism and racial profiling.

Many African and African Caribbean youth, men and women in prisons are members of social groups within African and African Caribbean communities that experience further marginalization based on gender, class and other factors.

Systemic Issues

> *'The HIV/AIDS crisis is devastating Canadian prisoners. Inmates are becoming infected with HIV during their incarceration because they do not have the information and resources to protect themselves. Once they are HIV-positive, their lives are often endangered by a lack of access both to doctors specializing in HIV/AIDS and to approved treatments and alternative therapies. Prisoners with HIV/AIDS are often mistreated. For example, they are often forced into isolation and their confidentiality is routinely violated because both guards and fellow prisoners are under the false impression that they need to know who is HIV-positive in order to take appropriate precautions.*
>
> *Whether a person living with HIV/AIDS (PHA) lives in prison or in the outside community, their care, treatment, and support needs are the same. However, within the prison system, various prison policies and practices contribute to the creation of environments that can make PHAs in prison more vulnerable to health decline than many PHAs in the community.*
>
> *Despite its mandate of care, and Charter obligations to do so in theory, in practice correctional systems across Canada limit – or even deny – HIV-positive prisoners access to a standard of care commensurate with that available in the community. As a result, imprisoned PHAs are generally forced to live in conditions that increase their vulnerability to medical neglect, opportunistic infections, needless suffering, and untimely death.' (Lines., Rick 2002)*

To support African and African Caribbean people who are prisoners, service providers should:

- Provide accurate information about HIV transmission and strategies to prevent infection to people prior to being incarcerated and upon release
- Ensure HIV prevention information is accessible to all prisoners (i.e., check language, literacy level)
- Advocate for incarcerated people to have easy access to condoms, dental dams, and lubricants
- Help people being discharged from prison connect with HIV prevention, diagnosis, and support from service providers committed to anti-racism and anti-oppression in the community that work respectfully and effectively with people who have experienced incarceration