

Ontario HIV/AIDS Strategy for African, Caribbean and Black Communities 2013-2018

CACVO
Conseil des Africains
et Caraïbéens sur le
VIH/sida en Ontario



ACCHO
African and Caribbean
Council on HIV/AIDS
in Ontario

Note about the Cover Graphic

The word cloud on the cover page was created from the qualitative data collected during the focus groups and key informant interviews which informed the development of the *Ontario HIV/AIDS Strategy for African, Caribbean and Black Communities 2013-2018*. A word cloud is a visual representation of text data. The frequency of each word in the source text is shown with font size – the most prominent terms are those which are largest. This word cloud was created using software at <http://www.wordle.net/>.

Acknowledgements

The African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) would like to thank all the individuals, organizations and funders that were involved in the African, Caribbean and Black (ACB) Strategy renewal process. Your energy and ideas were very valuable in shaping the renewed *Ontario HIV/AIDS Strategy for African, Caribbean and Black Communities 2013-2018*. Special thanks to the ACCHO Executive Committee members and ACB Strategy Workers for their input and assistance in the consultation process to develop the renewed ACB Strategy.

We would like to acknowledge the members of the ACCHO Executive Committee who provided guidance and oversight throughout the process:

- Fanta Ongoïba, ACCHO Co-Chair (Africans in Partnership Against AIDS)
- Trevor Gray, ACCHO Co-Chair (PASAN)
- Valérie Pierre-Pierre, ACCHO Director
- Dionne A. Falconer (DA Falconer & Associates Inc.)
- Mercy Gichuki (AIDS Committee of Cambridge, Kitchener, Waterloo and Area)
- Shannon Ryan (Black Coalition for AIDS Prevention)
- Wangari Tharao (Women's Health in Women's Hands Community Health Centre)

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The renewed Strategy was researched and written by San Patten and Associates, Inc., and designed by Phoenixx Creative.

Foreword

On behalf of the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO), I am pleased to present the *Ontario HIV/AIDS Strategy for African, Caribbean and Black Communities 2013-2018*. It replaces the original strategy document entitled *Strategy to Address Issues Related to HIV Faced by People in Ontario from Countries Where HIV is Endemic*, which was launched in 2005.

Like its predecessor, the renewed African, Caribbean and Black (ACB) Strategy was developed relying on extensive consultations with a wide range of stakeholders throughout Ontario, including community members. We heard you and endeavoured to adequately reflect your voices. The new ACB Strategy is more comprehensive, focused and accessible. It can more easily be monitored and evaluated. It also offers many opportunities for action from a diverse range of stakeholders.

We would like to thank everyone who contributed their time and voice to guide the development of this new ACB Strategy. We would also like to thank San Patten and Associates, Inc. for doing a remarkable job of pulling together everyone's contributions into a comprehensive, yet very accessible and concise package. Finally, we would also like to thank the AIDS Bureau, Ontario Ministry of Health and Long-Term Care for its ongoing support in mitigating the impact of HIV/AIDS in Ontario's ACB communities through a coordinated response.

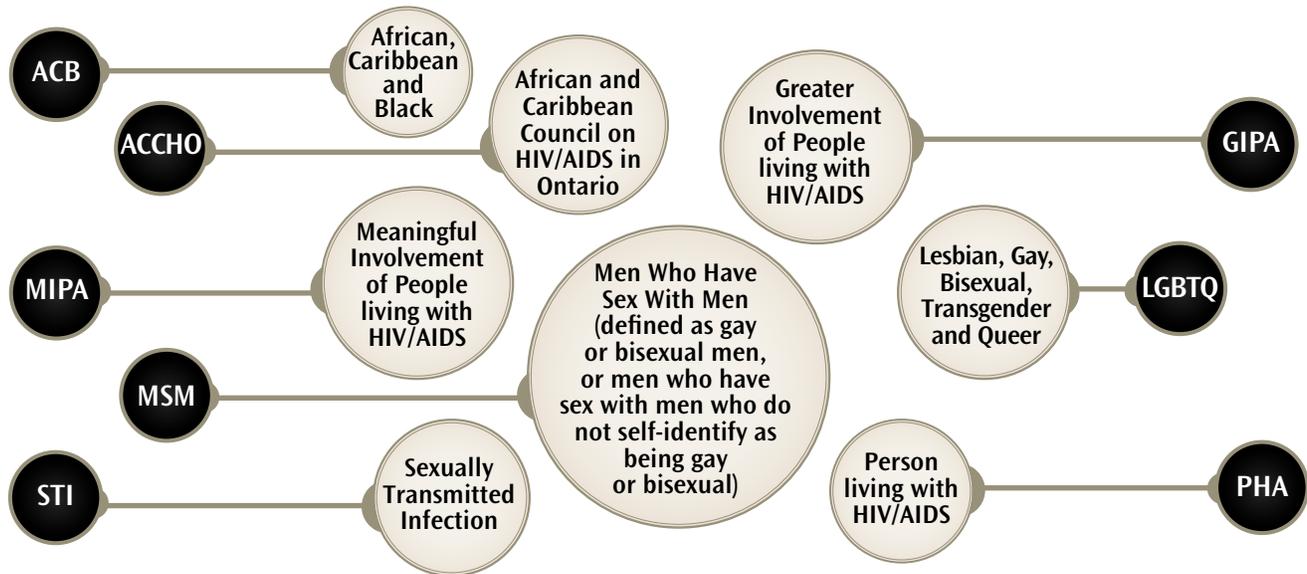
We hope you share our enthusiasm for this new ACB Strategy. We look forward to working with you to strengthen the response to HIV/AIDS in Ontario's African, Caribbean and Black communities. As always, the ACCHO staff is available to support and advise on the practical implementation of the ACB Strategy. We are only a phone call or an email away.

Valérie Pierre-Pierre
Director
ACCHO

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Acronyms



Introduction

This document provides the strategic vision and areas of action for addressing HIV/AIDS and related issues amongst African, Caribbean and Black (ACB) communities in Ontario. This Strategy, developed from June 2012 to May 2013, is a renewal of the first *Strategy to Address Issues Related to HIV Faced by People in Ontario from Countries Where HIV is Endemic*¹ (the ACB Strategy) which was launched in 2005. The renewed ACB Strategy, which we are now calling the *Ontario HIV/AIDS Strategy for African, Caribbean and Black Communities 2013-2018*, was developed through a comprehensive process of document review, stakeholder consultation and community validation. The purpose of this Strategy is to guide a coordinated set of actions to address HIV issues within ACB communities in Ontario. This Strategy does not, however, provide detailed direction on program development or service delivery. Specific objectives, activities and outcome indicators will be developed by organizations according to their local realities and how they see their role within the broad strategic action areas.

Our Starting Point

In 2003, the HIV Endemic Task Force developed the *Strategy to Address Issues Related to HIV Faced by People in Ontario from Countries Where HIV is Endemic* (ACB Strategy). The ACB Strategy was the first comprehensive plan developed to promote a timely and coordinated response to issues related to HIV faced by people from ACB communities in Ontario. Since the launch of the ACB Strategy in 2005, various stakeholders working under its guidance contributed towards the goal of reducing the incidence of HIV among ACB people in Ontario and improving the quality of life for those living with and affected by HIV/AIDS. The ACB Strategy, the first of its kind in Canada, was the springboard for ground breaking, innovative and necessary responses.

In 2010-2011, ACCHO set out to formally evaluate the ACB Strategy in order to assess its implementation and impact in Ontario, and to identify lessons learned and recommendations for the future. There was consensus that the ACB Strategy should continue. The evaluation concluded that in order to build on the achievements of the ACB Strategy, there will need to be continued funding, resources and staff dedicated to its ongoing implementation, enhanced by the execution of the recommendations and opportunities identified in the formal evaluation.

The implementation of the ACB Strategy was supported by key activities, processes and structures that involved the AIDS Bureau of the Ontario Ministry of Health and Long-Term Care (the AIDS Bureau), the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO), 12 ACB Strategy Workers² funded specifically to implement the ACB Strategy, and other partners and collaborators working with ACB communities. The roles of each stakeholder crystallized to include an oversight and monitoring role for the AIDS Bureau; a coordinating and implementation role for ACCHO; and a range of implementation roles related to prevention, support, capacity building, advocacy and research for the Funded Agencies, partners and collaborators.



The coordination of and reporting on achievements of the ACB Strategy occurred within ACCHO through regular reporting at ACCHO Council meetings including provincial scans/activity summaries of ACB Strategy Workers and other Council members, identification of success indicators, priority setting exercises and workplan updates.

The three objectives of the first ACB Strategy were:

1. To coordinate the work of agencies, institutions and policy makers working with and for ACB people regarding prevention, education, health promotion, care and support.
2. To facilitate community development in response to HIV/AIDS challenges.
3. To identify research needs priorities and opportunities to inform the response to HIV/AIDS in ACB communities in Ontario.

¹ <http://www.accho.ca/en/AboutUs/TheStrategy.aspx>

² “Strategy Worker” is an in-house harmonized term used only by ACCHO to identify the designated positions funded by the AIDS Bureau to support the implementation of the ACB Strategy. The official title given to this position varies across Funded Agencies. The ACB Strategy Workers are based in 11 Funded Agencies – 10 AIDS service organizations and one community health centre. These are: Africans in Partnership Against AIDS; AIDS Committee of Cambridge, Kitchener, Waterloo and Area; AIDS Committee of Durham Region; AIDS Committee of Ottawa; AIDS Committee of Windsor; AIDS Niagara; Black Coalition for AIDS Prevention; Peel HIV/AIDS Network; The AIDS Network (Hamilton); Regional HIV/AIDS Connection; and Somerset West Community Health Centre.

Our Purpose

The purpose of the renewed ACB Strategy remains unchanged from the original Strategy, as it was deemed by stakeholders to still be relevant and appropriate. The ultimate desired outcome of the renewed ACB Strategy is to reduce the incidence of HIV among ACB people in Ontario, and to improve the quality of life for those living with and affected by HIV/AIDS. With this goal in mind, the renewed ACB Strategy aims to provide a framework for the response to HIV/AIDS in ACB communities in Ontario in the areas of prevention, education, policy, health promotion, care, support and research by:

1. Guiding the work of agencies, institutions and policy makers working with and for ACB people regarding prevention, education, policy, health promotion, care and support.
2. Promoting community development in response to HIV/AIDS challenges.
3. Identifying research needs, priorities and opportunities to inform the response to HIV/AIDS in ACB communities in Ontario.



Our Renewal Process

The renewed ACB Strategy was developed over a period of eleven months from June 2012 to May 2013 with in-depth input from a wide variety of stakeholders. The renewal of the ACB Strategy was undertaken by an independent consultant, under guidance and supervision of the ACCHO Director and Executive Committee. The following is a summary of the sources of input provided during the development of the renewed ACB Strategy:

Sources of Input

17 DOCUMENTS

Document Review: including the original ACB Strategy, the ACB Strategy evaluation report, project and evaluation reports from program initiatives under the ACB Strategy, research articles and reports relating to ACB communities in Ontario, and other Ontario HIV strategies.

18 KEY INFORMANTS

Key Informant Interviews: individual interviews with experts from community-based organizations, provincial and federal government, and universities.

104 RESPONDENTS

Online Survey: validation and prioritization survey conducted with community and religious leaders, educators, students, policy makers, funders, advocates, service providers, health care providers, researchers, ACB community members, and people living with HIV/AIDS.

13 FOCUS GROUPS 8 CITIES 132 PARTICIPANTS

Focus Groups: discussions with community and religious leaders, educators, students, policy makers, advocates, service providers, health care providers, researchers and people living with HIV/AIDS.

These data collection processes gathered input about: (a) the vision for ACB communities in Ontario in the context of HIV for the next five years; (b) lessons learned from the first seven years of the ACB Strategy implementation; and (c) key strategies in the ACB Strategy that should be added, dropped or revised. Key informant interview and focus group participants were specially selected as individuals who were: comfortable discussing HIV in a public forum (for focus group participants); familiar with HIV-related issues within ACB communities; and able to think strategically about both “big picture” vision and pragmatic action.

The focus groups were conducted in two phases. Phase one, along with the key informant interviews, gathered broad input about key developments since the previous ACB Strategy, visioning for the next five years, and key action areas for the renewed Strategy. The second phase of focus groups served to build on the input gathered in the first phase and in the key informant interviews. Participants were asked to discuss issues identified that needed further follow-up or depth. The final input was collected through the online survey and helped to set priorities for inclusion in the renewed ACB Strategy. While the focus groups and interviews generated extensive “wish lists” of actions to be included in the renewed ACB Strategy, the survey asked stakeholders to prioritize the items in these “wish lists,” to note if anything important was missing from the action areas listed, to identify any new and emerging issues in their communities, and to provide suggestions on effective rollout and dissemination of the renewed ACB Strategy.

Our Current Reality

Epidemiology

African, Caribbean and Black (ACB) people form diverse communities. They mostly came to Canada through immigration waves in the last 50 years, although some Black Canadians can trace their roots in Canada to the early 1600s. According to the 2011 Census,³ 57% of Canada's Black population lives in Ontario. The 539,205 Black persons in Ontario comprise 4.3% of the population and 16.4% of visible minorities. Most of the African and Caribbean immigrants to Ontario were born in the following countries: Jamaica (111,475), Guyana (80,070), Trinidad and Tobago (54,680), South Africa (18,405), Nigeria (17,220), Kenya (14,170) and Ethiopia (13,150). The Black population is the third largest visible minority in Ontario, after the South Asian and Chinese populations.

The epidemiologic term “**people from countries where HIV is endemic**” refers to countries where HIV prevalence in the general population is 1% or greater (with some countries having a prevalence of 20% or more) and where heterosexual contact accounts for more than 50% of infections. Most of these countries are in sub-Saharan Africa or the Caribbean.

For the purposes of this document, the term “African, Caribbean and Black” (ACB) is used, except when citing epidemiologic data.

From 1985 to 2011, 4,348 persons from “HIV-endemic” countries were diagnosed with HIV in Ontario, of whom 2,229 (51%) were female.⁴ These cases constituted 13% of Ontario cases overall but 23% of the cases diagnosed since 2001. HIV infections in the HIV-endemic category are diagnosed at a younger age than cases in other categories and affect a high proportion of women. About 200 persons have been diagnosed annually from 2007 to 2011. Of the 224 children infected by mother-to-child transmission from 1984 to 2009, 143 (70%) of those with known exposure category were born to women from HIV-endemic countries.⁵

From 2009 to 2011 in Ontario, based on the Laboratory Enhancement Program (LEP),⁶ the HIV-endemic exposure category comprised 9.1% of new HIV diagnoses among men, and 56.1% of new HIV diagnoses among women.⁷ LEP data from Ontario also revealed that Black men constituted 9.5% of men who have sex with men (MSM) in Ontario diagnosed from 2009 to 2011. HIV infections and AIDS cases follow a similar distribution pattern.

In Ontario, in 2009, an estimated 5,160 people from HIV-endemic countries were living with HIV (60% male and 40% female).⁸ The overall HIV prevalence rate among people in Ontario from HIV-endemic countries was 1.1%. The majority of these persons were in Toronto (59%), followed by Ottawa with 15%. Not all persons living with HIV have been diagnosed; an estimated 47% of men and 65% of women living with HIV have been diagnosed. Among populations from HIV-endemic countries, women make up an increasing proportion of new HIV infections; this proportion was 51% in 2009.

In 2009, ACB people represented an estimated 19% of people living with HIV in Ontario,⁹ with a relative rate of heterosexual HIV acquisition that was 24 times higher than among others infected heterosexually.¹⁰ Modeling estimates suggest that the proportion of new HIV infections among people from HIV-endemic countries will likely continue to increase, as it has over the last 20 years. In the five-year period from 2004 to 2009, the number of people in the ACB population living with HIV (HIV prevalence) increased by 55% and HIV incidence (new infections) increased by 16%, primarily in women.¹¹

Immigration alone cannot explain the high prevalence of HIV and AIDS in the ACB population. Canada is now able to identify, through testing, immigrants and refugees who are HIV-positive and link them with appropriate services. For those who are tested in Canada, surveillance data alone cannot identify whether HIV transmission occurred abroad or in Canada, although people from Africa and the Caribbean can and do acquire HIV after arrival in Canada; this latter group likely constitutes a growing proportion of ACB persons living with HIV in Ontario. Achieving a better understanding of the patterns and locations associated with the acquisition of HIV could lead to better prevention, diagnosis, care, treatment and support services among people from countries where HIV is endemic.

It should also be noted that rates of HIV infection among ACB people who inject drugs, are prison inmates or have hepatitis C co-infection are not well documented.¹²

Social Determinants of Health

Understanding factors, such as age, religious beliefs and cultural influences of ACB people, whether first, second or third generation¹³ Canadians, affects our collective ability to provide effective and specific HIV/AIDS services. New immigrants may be recovering from traumatic experiences in their country of origin, trying to cope with and navigate Canada's immigration system, while at the same time struggling to understand and adapt to Canada's cultural norms and practices. All of these factors may place health and self-care (including HIV/AIDS prevention) as a lower priority and, without proper support, may place them at even greater risk for HIV infection.

The social determinants of health can be categorized as:

PROXIMAL (e.g., health behaviours, physical and social environment)

INTERMEDIATE (e.g., community resources, systems and capacities)

DISTAL (e.g., historic, political, social and economic contexts)

The determinants of health clearly influence the ACB population's vulnerability to HIV/AIDS. A person's vulnerability increases or decreases based on income, education, unemployment, housing, early childhood development (e.g., history of child abuse), physical and social environments, cultural practices and norms,

access to health services, support networks, gender dynamics, a history of sexual violence, having experienced difficulties with the immigration process and racial discrimination from Canadian society in general. Social stability, recognition of diversity, safety, good working relationships, and cohesive communities provide a supportive society that reduces or avoids many potential risks to good health. Rather than focusing only on the risk behaviours of ACB people, our response will be more effective if we seek to understand the lived experience of the population in relation to these determinants and offer supports that address the root causes of HIV/AIDS. If we are able, for example, to provide culturally competent services, we may be able to lessen the impact of some of these determinants and help to build the coping skills and resiliency of ACB people, which in turn, can lessen their vulnerability to HIV/AIDS. In addition, ACB people living with HIV are also affected at all levels of the social determinants of health.

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- ³ Statistics Canada, Canada Census, 2011. <http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/details/download-telecharger/comprehensive/comp-ivt-xml-nhs-enm.cfm?Lang=E>
 - ⁴ Remis RS, Liu J. Report on HIV/AIDS in Ontario, 2011 (report in preparation). Ontario HIV Epidemiologic Monitoring Unit, University of Toronto.
 - ⁵ Remis RS, Swantee C, Liu J. Report on HIV/AIDS in Ontario, 2009. Ontario HIV Epidemiologic Monitoring Unit, University of Toronto. http://www.ohemu.utoronto.ca/doc/PHERO2010_report_preliminary.pdf
 - ⁶ The Laboratory Enhancement Program is an enhanced surveillance program whereby supplementary information is collected on risk factors, HIV test history and race/ethnicity for all new HIV diagnoses.
 - ⁷ Sullivan AS, Remis RS. Analysis of race/ethnicity, Laboratory Enhancement Study, Dalla Lana School of Public Health. University of Toronto, March 2012. http://www.ohemu.ca/2012/LEP_ethnicity_2009-2011.pdf
 - ⁸ RS, Swantee C, Liu J. Report on HIV/AIDS in Ontario, 2009. Ontario HIV Epidemiologic Monitoring Unit, University of Toronto. http://www.ohemu.utoronto.ca/doc/PHERO2010_report_preliminary.pdf
 - ⁹ Statistics Canada, Canada Census, 2011. <http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/details/download-telecharger/comprehensive/comp-ivt-xml-nhs-enm.cfm?Lang=E>
 - ¹⁰ Kaul R, Cohen CR, Chege D, Yi TJ, Tharao W, McKinnon LR, Remis R, Anzala O, Kimani J. Biological factors that may contribute to regional and racial disparities in HIV prevalence. *American Journal of Reproductive Immunology*. 2011 Mar;65(3):317-24.
 - ¹¹ Statistics Canada, Canada Census, 2011. <http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/details/download-telecharger/comprehensive/comp-ivt-xml-nhs-enm.cfm?Lang=E>
 - ¹² Public Health Agency of Canada, *HIV/AIDS Epi Update, 2011*. <http://www.phac-aspc.gc.ca/aids-sida/publication/index-eng.php#er>
 - ¹³ First generation refers to persons born outside Canada and who are now, or have ever been, landed immigrants in Canada, or who are non-permanent residents. Second generation refers to persons born inside Canada with at least one parent born outside Canada. Third generation (or more) refers to persons born inside Canada with both parents born inside Canada. Source: <http://www12.statcan.gc.ca/census-recensement/2006/ref/dict/pop036a-eng.cfm>

Our Strengths

Four types of organizations are delivering HIV prevention, care, treatment and support services to the ACB community in Ontario: AIDS service organizations, ethnoracial HIV/AIDS organizations, broader ethnocultural organizations, and others such as community health centres and HIV clinics/hospitals. Using community development models, organizations actively engage community members in the development and implementation of projects and activities, working through existing community structures and forums, and targeting specific sub-populations such as men who have sex with men (MSM), youth and women.

In certain areas of Ontario, a number of diverse organizations have built networks to meet the HIV/AIDS-related needs of the ACB community and to ensure services are culturally appropriate and can be offered in both French and English. Consistent with the ACB Strategy, ACCHO and community-based organizations emphasize the importance of partnerships in building cultural competencies and meeting the needs of key populations. ACCHO's efforts have contributed to the creation of additional stakeholder networks across the province and to the establishment of national and international networks, such as the Canadian HIV/AIDS Black, African and Caribbean Network (CHABAC), and the African Black Diaspora Global Network (ABDGN).

Researchers and community partners in Ontario have been collaborating over the last five years. They have done this in a number of ways, including through regular ACB Research Think Tanks to set research priorities and conduct research (including community-based research) on issues such as HIV-related stigma, the needs of ACB women living with HIV, and gay and bisexual ACB men. However, more comprehensive evaluations are needed to determine the effectiveness of initiatives in preventing new HIV infections or responding to the needs of those living with HIV/AIDS in the ACB population. Such information is integral to developing future evidence-informed interventions.

With leadership from the 12 ACB Strategy Workers in 11 agencies across Ontario, communities have taken up the challenge and are doing their part to reduce the growing number of infections in the ACB population and to meet the needs of ACB people living with, or at risk for HIV/AIDS. Despite these important and significant efforts, much remains to be done. We still need to work to develop and deliver effective programs and policies that address the root causes of HIV vulnerability and improve the quality of life of ACB people living with HIV/AIDS. Ontario has the capacity and a strong foundation from which to act.

Our Vision for the Future

The figure below summarizes the multiple ways that ACB stakeholders envision the HIV-related context of ACB communities in Ontario over the next five years.



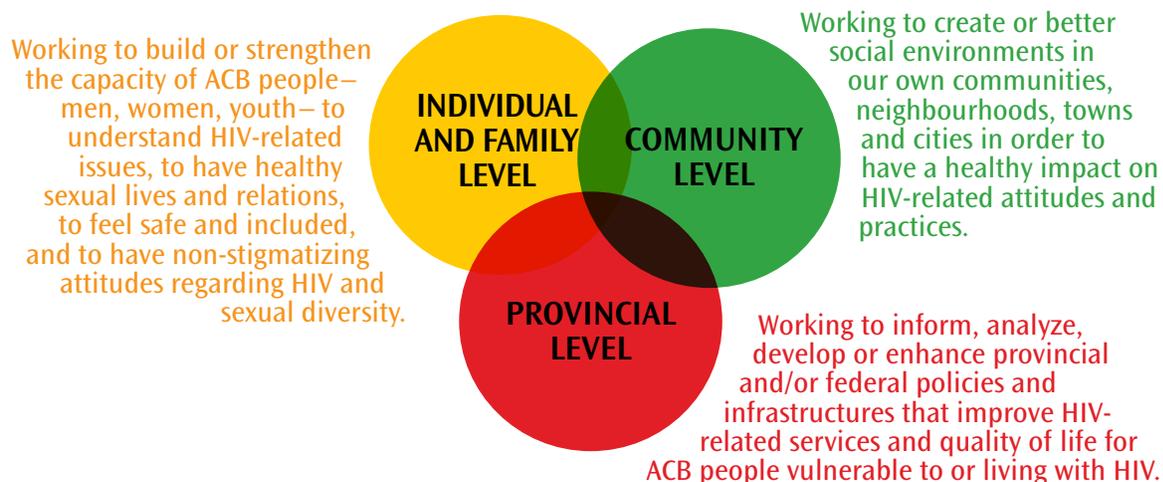
Our Strategies

We know that ACB people in Ontario are more vulnerable to HIV than most other groups. We know that ACB individuals experience different kinds of vulnerabilities across the life course and that there are important health disparities compared to non-ACB people. We also know that these health inequities are affected by the social determinants of health at proximal, intermediate and distal levels.

The suggested strategies seek to cover a broad range of these vulnerabilities and determinants, while at the same time giving focus and common purpose in addressing HIV-related issues faced by ACB communities in Ontario over the next five years.

These strategies were identified as priorities through the comprehensive consultation and validation process used in developing this renewed ACB Strategy. Identifying a manageable number of key strategic priorities helps us to focus our efforts and achieve maximum impact. But there are many other related areas of action that various stakeholders will choose to focus on as well, in fitting with their capacities, mandates, constituencies and local contexts.

In order to capture strategic directions at all three levels of the social determinants of health – proximal, intermediate and distal – and to clearly identify specific actions for various levels of stakeholders, the renewed ACB Strategy is organized by strategies at three levels:



STRATEGIES AT THE LEVEL OF INDIVIDUALS AND FAMILIES

OUR CHALLENGE	OUR KEY STRATEGY ↓	OUR KEY ACTIVITIES ↓	INDICATORS OF SUCCESS ↓
Common misconceptions about HIV prevail in ACB communities. Immigrants from Africa and the Caribbean may be unaware that HIV is a concern in Canada. Some ACB people may feel that HIV is a disease only amongst gay people, or that they can tell if a person has HIV.	1.1 Build awareness of HIV as a concern for ACB people in Canada, and ensure understanding of HIV risk and prevention.	1.1.1 Provide accurate and age-appropriate information about HIV risk behaviours and risk reduction.	ACB community members are well informed about HIV risk, prevention and issues within ACB communities.
		1.1.2 Encourage and give parents the tools and skills to talk with their children about healthy relationships and sexuality.	
		1.1.3 Use public awareness campaigns and a variety of information dissemination methods to provide accessible and relevant HIV risk and prevention information.	Parents feel more comfortable discussing sexuality and HIV prevention with their children.

OUR CHALLENGE	OUR KEY STRATEGY ↓	OUR KEY ACTIVITIES ↓	INDICATORS OF SUCCESS ↓
Stigma and discrimination surrounding HIV persists in ACB communities. This results in silence, reluctance to test, and for PHAs, difficulties with disclosure. Also, many ACB people do not know that they are living with HIV.	1.2 Remove stigma, fears and other barriers around HIV testing and disclosure.	1.2.1 Encourage voluntary HIV testing and counselling through accessible, confidential and culturally safe testing services.	ACB people express less stigmatizing attitudes around HIV.
		1.2.2 Raise awareness that all ACB people may be at risk for HIV, how to reduce risks, and how to get tested.	
		1.2.3 Support people living with HIV to feel safe about sharing their HIV status when appropriate.	Rates of HIV testing increase among ACB people.
		1.2.4 Create opportunities for peer support from people who have lived long-term with HIV, particularly around the time of diagnosis.	ACB people living with HIV feel safe and supported in disclosing their HIV status when they are ready to do so.

OUR CHALLENGE	OUR KEY STRATEGY ↓	OUR KEY ACTIVITIES ↓	INDICATORS OF SUCCESS ↓
<p>Federal immigration policies, such as mandatory medical screening for immigrants, and cutbacks to the Interim Federal Health Program, have implications for ACB people. Immigrants, migrant workers, refugees and people without status may be unaware of their rights, fear that an HIV diagnosis will jeopardize their chances of staying in Canada, or be unable to access care and services. Newcomers newly diagnosed with HIV are prone to feelings of hopelessness, addiction and depression. A positive diagnosis in Canada may also pose challenges around housing, disclosure and reunification with children and family, and may affect a person's ability to work and send money to family outside of Canada.</p>	<p>1.3 Provide supports to immigrants, migrant workers, refugees and people without status (including those who are living with HIV), to ensure that they know their rights and are able to access the services available to them.</p>	<p>1.3.1 Provide immigrants, refugees, people without status and migrant workers with more mental health and social supports to help them cope with stresses and traumas.</p> <p>1.3.2 Help individuals to access housing, income and employment.</p> <p>1.3.3 Provide targeted information and assistance for newcomers to help them understand how the Ontario healthcare system works, HIV treatment advancements, their right to confidentiality, and the possibility of living a long and healthy life with HIV.</p>	<p>Newcomers, immigrants, migrant workers, refugees and people without status know where to seek supports and services.</p> <p>A wide range of health and social services are connected to meet the multiple needs of immigrants, migrant workers, refugees and people without status.</p>

STRATEGIES AT THE LEVEL OF COMMUNITIES

OUR CHALLENGE	OUR KEY STRATEGY ↓	OUR KEY ACTIVITIES ↓	INDICATORS OF SUCCESS ↓
<p>The majority of ACB people in Canada have some religious/spiritual affiliation. Knowledge gaps about HIV coupled with a strong religious identity influence views about HIV/AIDS and coping strategies. This results in particular beliefs – and consequently, behaviours – that may increase the vulnerability of ACB communities to HIV/AIDS. Of particular importance are beliefs around sex, sexuality and death.</p>	<p>2.1 Engage religious/spiritual leaders and faith-based communities in order to reduce misinformation, stigma and homophobia, and build support for people living with HIV.</p>	<p>2.1.1 Work with religious/spiritual leaders to bring discussions of HIV stigma and homophobia to faith-based communities.</p> <p>2.1.2 Identify high profile faith-based leaders who are willing to speak out, lead by example, and act as internal champions.</p> <p>2.1.3 Work to develop and extend faith-based alliances between religious leaders and HIV stakeholders.</p> <p>2.1.4 Reach families through religious/spiritual events, couples through marriage counselling, and young people through youth groups.</p>	<p>More religious/spiritual leaders have open discussions about issues of HIV stigma and homophobia with their congregants.</p> <p>HIV stakeholders report more cooperative partnerships with faith leaders.</p> <p>HIV issues have been discussed at a range of religious/spiritual community events.</p>

“We need to be reminded that it is not our role to judge others.”

– Focus group participant

OUR CHALLENGE	OUR KEY STRATEGY ↓	OUR KEY ACTIVITIES ↓	INDICATORS OF SUCCESS ↓
<p>HIV-related stigma and homophobia persist within ACB communities. This results in silence, reluctance to test, and for those already diagnosed, difficulties with disclosure. Cultural norms around gender roles reinforce double standards around sexual relationships, and often leave women without the ability to negotiate safer sex. Community leaders are critical in changing personal risk perceptions and attitudes around prevention/testing/treatment.</p>	<p>2.2 Engage supportive community leaders to talk with their friends, clients, students and community members about HIV stigma, racism, gender equity, biphobia, homophobia and transphobia.</p>	<p>2.2.1 Identify, engage and mobilize ACB organizations, leaders, business owners, professionals, and respected elders in opening up discussions on HIV, sexuality, sexism, homophobia, biphobia and transphobia.</p> <p>2.2.2 Identify culturally-integrated methods and venues for planting seeds of discussions and creating more visibility of HIV issues within ACB communities.</p> <p>2.2.3 Support people living with HIV to speak out on issues of HIV in their community.</p>	<p>HIV stakeholders report more cooperative partnerships with community leaders.</p> <p>HIV issues have been discussed at a range of community events.</p> <p>More ACB people living with HIV report that they have been able to be open about their experiences.</p> <p>PHAs report fewer incidents of stigma or discrimination from service providers and community members.</p>

“Our leaders are people who have clout in the community - the club owners, the musicians, the DJs, also barber shops, hair salons, West Indies grocery stores, restaurants.”

– Focus group participant

OUR CHALLENGE	OUR KEY STRATEGY ↓	OUR KEY ACTIVITIES ↓	INDICATORS OF SUCCESS ↓
<p>For ACB communities, numerous barriers to accessing appropriate and responsive health services have been documented, including: institutional discrimination and the poor representation of ACB people among health care personnel, especially at the decision-making levels; lack of awareness by community members of the services available to them; lack of culturally sensitive information in relevant languages; lack of culturally competent health professionals; and lack of translation services. For PHAs, concerns include issues of confidentiality, anonymity, privacy, stigma and discrimination.</p>	<p>2.3 Improve the accessibility, cultural safety¹⁴ and inclusiveness of health and social services for ACB people.</p>	<p>2.3.1 Improve networking, collaboration and resource sharing among community-based organizations, both within and outside the HIV sector. Build coalitions to address other health and social issues (e.g., housing, mental health, addictions, LGBTQ supports, etc.).</p> <p>2.3.2 Distribute HIV-related information through allied service providers, such as healthcare centres, clinics, parenting classes, employment assistance, newcomer organizations, youth centres, LGBTQ organizations and ethnocultural associations.</p> <p>2.3.3 Provide cultural competence, anti-oppression and anti-racism training for healthcare professionals.</p>	<p>ACB community members describe their local services as non-judgmental, well-coordinated, accessible and culturally safe.</p> <p>PHAs report that they have the supports they need, are socially connected, and have improved quality of life.</p> <p>Service providers take into account health equity, social justice, and ACB cultures, religions, and beliefs about health, disease prevention and healthcare.</p>

¹⁴ Cultural safety takes us beyond cultural awareness and sensitivity, which are both based on the acknowledgement of difference. Cultural safety helps us to understand the limitations of cultural competence, which focuses on the skills, knowledge and attitudes of service providers. Cultural safety is predicated on understanding power differentials in health service delivery and redressing these inequities through anti-oppression education. Source: National Aboriginal Health Organization (2008). *Cultural competency and safety: A guide for health administrators, providers and educators*. Ottawa ON: NAHO.

STRATEGIES AT THE LEVEL OF THE PROVINCE

OUR CHALLENGE	OUR KEY STRATEGY ↓	OUR KEY ACTIVITIES ↓	INDICATORS OF SUCCESS ↓
<p>Within ACB communities, there are three overlapping and mutually reinforcing sources of stigma around HIV: (1) stigmatizing attitudes towards PHAs, based on assumptions about the infection (e.g., HIV/AIDS is a “gay disease,” promiscuity leads to infection, HIV is associated with death); (2) resistance to having ACB communities associated with HIV or HIV being viewed as a Black or African disease; and (3) homophobia or the denial of the existence of homosexuality within the community.</p>	<p>3.1 Reduce HIV-related stigma, discrimination and misconceptions by reshaping the discourse around HIV vulnerability, sexual orientation and cultural resilience.</p>	<p>3.1.1 Promote more accurate and less stigmatizing media coverage of HIV-related issues.</p> <p>3.1.2 Develop and implement provincial-level awareness campaigns to reduce intersecting dimensions of racism, sexism and HIV-related stigma.</p> <p>3.1.3 Develop and deliver training materials for healthcare professionals to build greater cultural competency with regards to ACB people, and in particular to PHAs.</p>	<p>LGBTQ ACB individuals feel a greater sense of belonging and less fear in coming out within the ACB community.</p> <p>People working with ACB community members acknowledge the impact of HIV on their community and take responsibility for reducing its impacts.</p> <p>PHAs report fewer incidents of stigma or discrimination from service providers and community members.</p>

“...just by speaking or working with someone who is a PHA, you are told that you could be infected by them.”

– Focus group participant

OUR CHALLENGE	OUR KEY STRATEGY ↓	OUR KEY ACTIVITIES ↓	INDICATORS OF SUCCESS ↓
<p>Criminalization of PHAs for non-disclosure of their HIV status has disproportionately impacted ACB men. Fear of criminalization may drive people away from HIV testing, counselling and support, and deter them from disclosure. The public attention given to criminal prosecutions may create a false sense of security that the law will protect people from HIV infection. It may also undermine the message that every person is responsible for his or her own sexual health, and lead to human rights abuses by increasing the stigma and discrimination faced by PHAs.</p>	<p>3.2 Work to change laws and policies that negatively affect people living with HIV and ACB community members, and work to reduce the negative impacts of these laws and policies.</p>	<p>3.2.1 Join other provincial and national stakeholders in assessing the harms of criminalization.</p> <p>3.2.2 Develop analyses, common messages and communication tools to draw the discourse away from criminalization, and towards individual responsibility, and creating safety for PHAs to disclose.</p> <p>3.2.3 Provide guidance to service providers working with ACB people about how to advise PHAs regarding their legal responsibilities and effective disclosure strategies.</p>	<p>Collaborations have been made with other provincial and national organizations to address the harms of criminalization.</p> <p>ACB communities have clear messages about the limitations of a criminalization approach.</p> <p>ACB people living with HIV report that they understand the implications of criminalization with respect to disclosure.</p>

“Criminalization and the depiction of PHAs in the mass media only detracts from our efforts to reduce stigma. And service providers themselves don’t fully understand the implications of the latest ruling on the criminal law.”

– Focus group participant

OUR CHALLENGE	OUR KEY STRATEGY ↓	OUR KEY ACTIVITIES ↓	INDICATORS OF SUCCESS ↓
<p>More research (including community-based research) and comprehensive evaluation are needed to determine the effectiveness of interventions in preventing new HIV infections or responding to the needs of those living with HIV/AIDS in the ACB population.</p>	<p>3.3 Provide guidance and leadership to implement the ACB research agenda, link HIV stakeholders across the province, and translate research findings into interventions.</p>	<p>3.3.1 Conduct more research with, by and for ACB communities.</p> <p>3.3.2 Coordinate networking, joint action and collaboration (e.g., ACB Research Think Tanks) among organizations and individuals working in HIV and across the social determinants of health for exchange of research findings and promising practices.</p> <p>3.3.3 Establish a mechanism to improve sharing of resources and information about HIV-related services for ACB people and good practice, as well as to facilitate access to expertise.</p> <p>3.3.4 Foster knowledge exchange between service providers across the province to share best practices and collaborate on research/evaluation initiatives.</p>	<p>Research with, by and for ACB communities provides information that leads to evidence-informed interventions.</p> <p>There is a more holistic understanding of how HIV vulnerability and health intersect with culture, biology, education, employment, access to resources, migration experiences and identity.</p>

Our Shared Responsibility

This renewed ACB Strategy belongs to all HIV stakeholders and ACB communities in Ontario. The renewed ACB Strategy will provide guidance and unified purpose for the full range of stakeholders who are working to ultimately reduce the impact of HIV on ACB communities in Ontario. Success will depend on sustaining and enhancing the unique but complementary roles of frontline health and social service providers who work with ACB people; community and religious/spiritual leaders; people living with and affected by HIV; provincial organizations such as ACCHO; and funders such as the AIDS Bureau. Together, these stakeholders hold critical roles in the successful implementation of education, prevention and support services, and just as importantly, in mitigating personal risk perceptions and attitudes towards people living with HIV and those who identify as sexual minorities. Through networking, joint action and collaboration, organizations and individuals working in HIV and with ACB communities can exchange research findings and promising practices.

ACCHO will provide provincial-level leadership and assistance through knowledge exchange, research and coordination of joint initiatives. At a local level, ACB Strategy Workers will continue to play key roles in reaching out to ACB communities and allied professionals, working at grassroots levels to improve awareness and reduce stigma, while also creating shared messages and initiatives across Ontario. ACCHO plays a key role in supporting and training ACB Strategy Workers to ensure consistency and knowledge sharing. Funders will continue to be active supporters of the ACB Strategy by financially supporting the Strategy's staffing infrastructure and programming.

The renewed ACB Strategy will be monitored and evaluated periodically while guided by an evaluation framework. With coordination and support from ACCHO, it is the responsibility of all stakeholders at local and provincial levels to work towards achieving the strategic priorities of the renewed ACB Strategy.

