ORIGINAL PAPER

J Health Inequal 2022; 8 (1): 66–74

Submitted: 23.04.2021; accepted: 14.02.2022

DOI: https://doi.org/10.5114/jhi.2022.113899

JOURNAL of Health Inequalities

Determinants of HIV vulnerability among heterosexual ACB men in Ottawa, Canada

Josephine Etowa[1], Egbe Etowa[2], Ikenna Mbagwu[1], Ahmed Habre[3], Hector Addison[4], Eno A. Essien[5], Haoua Inoua[3]

[1]Faculty of Health Sciences, University of Ottawa, Canada
[2]Department of Sociology, Anthropology & Criminology, University of Windsor, Canada
[3]AIDS Committee of Ottawa, Canada
[4]African Canadian Association of Ottawa, Canada
[5]Black Coalition for AIDS Prevention, Toronto, Canada

ABSTRACT

Introduction: Although significant progress has been made in the fight against HIV/AIDS, structural factors continue to undermine this progress, especially among racialized populations in many countries. For instance, African, Caribbean and Black (ACB) men in Canada face barriers – such as unemployment, stigma, and racism – that increase their vulnerability to health-related events including HIV/AIDS. However, there is a paucity of culturally appropriate responses to address these factors within the ACB population in Canada. Hence, this paper sought to identify the structural barriers that increase the vulnerability of ACB heterosexual men to HIV, and the strategies for building resilience in response to HIV.

Material and methods: This paper is based on the qualitative findings from the weSpeak project, which was a mixed-methods study informed by community-based participatory research (CBPR). Qualitative data were collected from 63 participants in Ottawa, Canada through focus group discussions (FGD) and in-depth interviews (IDI). The participants included ACB heterosexual men, service providers, and policy/decision-makers. All interviews were recorded, transcribed verbatim and analysed using NVivo Version 11.

Results: The themes were: 1) systemic barriers to employment and income, 2) healthcare access and uptake, 3) stigma, discrimination and racism, 4) strategies for responding to HIV vulnerabilities. The participants highlighted the difficulties that new immigrants faced with recognition of their academic credentials, which then limits their income and job opportunities. Healthcare services were underutilized because of privacy issues, insufficient physicians and long waiting periods. Also, HIV-related stigma, anti-Black racism and stereotypes were factors that limited health and economic options for the participants. However, the participants acknowledged that health education, collaboration and engagement with faith-based leaders can reduce HIV vulnerabilities.

Conclusions: The study highlights the role of structural factors in increasing HIV vulnerability among ACB heterosexual men, and the need for multilevel interventions to foster better a HIV response within the ACB community.

KEY WORDS: HIV/AIDS, racism, heterosexual ACB men, HIV vulnerability, systemic factors.

ADDRESS FOR CORRESPONDENCE: Prof. Josephine Etowa, Faculty of Health Sciences, University of Ottawa, Canada, e-mail: jetowa@uottawa.ca

INTRODUCTION

Globally, significant progress has been made in reducing the burden of HIV/AIDS. However, existing structural factors undermine this progress among racialized demographic groups in many countries, including Canada. In Canada, racialized populations – such as African, Caribbean and Black (ACB) people – have been among the most vulnerable to HIV infection [1]. For instance, although ACB people accounted for approximately 3.5% of the Canadian population [2], they constituted about 25.5% of HIV cases with known race/ethnicity [3]. Additionally, Black people constituted about 4.3% of Ontario's total population in 2013; however, ACB people infected with HIV through heterosexual contact accounted for 18.8% of the estimated number of people living with HIV/AIDS (PHA) in the province [4].

This disproportionate impact of HIV on minority groups, including ACB people, is due to concomitant structural factors that increase their vulnerability to health-related events including HIV, and contribute to the increased health inequity faced by the ACB population [1, 5]. For example, newcomers – including those living with HIV – not only face barriers to treatment such as high cost of medication and non-basic healthcare, but they also face specific obstacles such as lack of social support, stigma, racism, and lack of healthcare coverage [6–8]. Additionally, Black men in North America continue to face systemic barriers in employment and job opportunities compared to their White counterparts [9, 10]. Also, Black people are often given derogatory stereotypical labels such thuggish and brutish [11]. This could lead to 'stereotype threat', which is an unpleasant psychological experience of confronting negative stereotypes about factors like race, ethnicity, and gender [12], and this could ultimately contribute to healthcare disparities [13]. On a similar note, the long waiting list prior to seeing a physician – which is common in Canada – could lead to adverse health outcomes among ACB people, including new immigrants [14]. Moreover, prevalent racial discrimination in the healthcare and work settings could also give rise to health inequities and increased sexual risks, which increases the likelihood of contracting HIV. For instance, physicians' prejudice, which could be in the form of stereotypical assumptions and unwillingness to interact with members of minority groups about health-related behaviours, could lead to missed opportunities for health education on preventive strategies [15–17]. Thus, these factors could augment ACB people's vulnerability to HIV and lead to poor health outcomes. It is also important to recognize that better access to services involves more than just entering an agency and asking for help. The agencies and programmes may need to recognize and accommodate ACB men's circumstances and priorities. Although Black men should be engaged in reflective work to sharpen their critical consciousness of systemic and structural factors that affect health, well-being and community responses to HIV, these issues cannot be resolved by engaging ACB men alone; policy makers and other stakeholders have an important role to play in helping to address the determinants of ACB men's health.

Even though these issues are glaring, there seems to be a paucity of culturally specific responses to address these factors that increase the vulnerability of ACB men to HIV/AIDS. This could be due to the social and epidemiological dynamics of the virus and vulnerability factors, and because the ACB communities are highly diverse [2]. Hence, there is a need for HIV/AIDS policies and programmes that are tailored to the specific needs of the ACB population in Canada, taking into consideration their uniqueness as well as their subtle differences. Therefore, the aim of this study is to assess the structural barriers that increase the vulnerability of ACB heterosexual men to HIV, and identify strategies for building resilience in response to HIV. It is hoped that the evidence-informed results from this study will facilitate generating health policies and programmes that will help reduce health inequities, and improve access to HIV preventive and care services for members of the ACB population.

MATERIAL AND METHODS

This paper is based on the qualitative findings of the weSpeak project: a 5-year multisite research programme across four sites (Ottawa, Toronto, London and Windsor) in Ontario, Canada. The aim of the programme is to reduce HIV vulnerabilities and promote resilience through active engagement of self-identified heterosexual ACB men, service providers and other relevant stakeholders in community HIV responses, programmes, research, and policy. This multi-phase, mixed-method programme is informed by community-based participatory research (CBPR) and intersectionality. Intersectionality is an analytical tool used in equity work to understand and interpret the complexity of the world around us [18]. It emphasizes that health issues are influenced by broader social factors and do not occur in isolation, but rather these factors intersect and mutually enhance their negative impacts on health outcomes [19]. Community-based participatory research (CBPR) is an approach of working collaboratively with and through groups of people or communities affected by the issues being investigated with a goal of not only studying the issue, but also to address issues affecting the well-being of the community [20]. The eligibility criteria were: self-identifying as heterosexual ACB men (including transmen who identify as heterosexual), being at least 16 years old, persons living with HIV (PHA) or HIV-negative persons, being able to communicate in English or French, and residing in Ottawa, Ontario. Peer recruiters were engaged and trained, and they recruited the study participants through their day-to-day activities and extended networks.

The participants in the focus group discussions (FGD) were selected and screened as follows: (a) prospective participants contacted the research coordinator (after seeing electronic or printed advertisements, or hearing about the research from the trained peer recruiters); (b) the coordinator administered a screening questionnaire to ensure that prospective participants were eligible, and to monitor criteria which are important to focus group composition (e.g., their preference or ability to participate in English or French), and record their contact information (to issue final invitations); (c) the team determined the final number and composition of the focus groups; and (d) if there was an insufficient number of men with the desired characteristics specific to our programme objectives (e.g., not enough African or Francophone men), we would invite those men to participate in an in-depth interview to ensure equity and inclusion.

The qualitative data collection also included FGD with service providers and policy/decision makers to explore their perspectives on heterosexual ACB men, HIV vulnerabilities and strategies to engage ACB men in community HIV responses. The team compiled a list of organizations that work with ACB communities or have a large base of ACB service users, including AIDS Service Organizations, Community Health Centres and other relevant service organizations. For policy/decision makers, the team and local advisory committee generated a list of possible participants, from whom the actual participants were recruited. Prior to each FGD and in-depth interview (IDI), the research team administered a short demographic and health practices questionnaire to establish the profile of the participants.

DATA COLLECTION

Qualitative data were collected through FGD and IDI of 63study participants (i.e. ACB men and service providers/community stakeholders) in Ottawa, Canada. There were a total of 5 FGD consisting of 40 ACB men and 1 FGD made up of 7 service providers/community stakeholders. Sixteen ACB men partook in the IDI. The FGD and IDI were based on FGD and interview Guides which covered the following topics: knowledge/understanding of HIV, access to and availability of HIV and related health services; participants' understanding of vulnerability, resilience, masculinity, heterosexuality and health. Also, the FGD examined how participants understood the study's key concepts, such as vulnerability, resilience, heterosexuality, and masculinity, in relation to ACB identity, HIV, and health. The guides were developed in a way to draw from insights and critical issues that emerged from the literature review that formed the foundation of the study proposal, thus the key concepts outlined above. The IDI prompted the ACB men to discuss issues related to vulnerability, relationships, sex and other sensitive or personal issues that cannot be effectively broached in FGD. Both FGD and IDI assessed how vulnerability, resilience, heterosexuality, and masculinity emerge in their everyday experiences, and in relation to structural/systemic issues/themes such as race, class and gender.

DATA ANALYSIS

Our data analysis was guided by the population health promotion framework and critical social theory. These theories informed the whole research process including how we interpreted participants' stories. For example, critical social theories and intersectionality enable the data analysis team to interpret study data (participants' sharing, stories, action, our observation, etc.) in ways that take into consideration the complex intertwined and intersecting influences of the historical, economic, social, political, and cultural forces that shape participants' perspectives and experiences. The critical social science paradigm acknowledges that social reality is shaped by historical and present social, cultural, and political values that crystallize over time. These frameworks called for analytical strategies that enable the data analysis team to make connections about how one's behaviours or perspectives are not "solely" individual choices but are shaped by the forces in their environments (e.g., unsafe playgrounds for children, racism at work). At the same time, it is critical to recognize that people have "agency" and transformation is possible when given the opportunity in supportive environments. These theories helped us to provide insight on how HIV vulnerabilities among the ACB men could be associated with their socioeconomics as determined by their sociopolitical environment. The critical social theory explained why ACB heterosexual men may be disproportionately affected by HIV compared to other groups (e.g. race and gender) and its ultimate goal is to enable us to address socially related health disparities between heterosexual ACB men and other racial and gendered groups. The critical social theory provided an understanding of the results from the thematic analysis of the data from FGD and IDI.

All interviews were transcribed verbatim and analysed using NVivo Version 11 (QSR International). Thematic analysis as described by Braun & Clarke (2006) [21] guided the data analysis and interpretations. It is aimed at identifying the patterns in the information that described and organized our observations, or interpretations of phenomena observed in the data. Braun and Clarke's thematic analysis comprises a six-step process namely, 1) familiarization with the data, 2) generating initial codes, 3) searching for themes, 4) reviewing themes, 5) defining and naming themes; and 6) producing the report – a concise, coherent, logical, and non-repetitive account supported by vivid examples. These were iterative processes which ensured that preliminary interpretations were challenged and data were revisited

in the light of further data collection and new insights into the data. Preconceptions and assumptions were challenged, and a consensus was reached in understanding the data. Thematic analysis was deemed suitable for this study because it is participatory and accessible; it enhances participation among team members (knowledge users, peer research associates, and academic researchers) in collaborative data analysis and interpretation. Peer debriefing and an audit trail helped to establish the trustworthiness of the data [22]. The resulting themes from the analysis are among the major issues that affect HIV-related health inequities among heterosexual ACB men.

ETHICAL APPROVAL

Ethical approval for this study was sought and obtained from University of Ottawa Research Ethics Board and Ottawa Public Health Research Ethics Board, as well as from other affiliated institutional research ethics boards in all four sites (Ottawa, Toronto, London, and Windsor) of the larger weSpeak study. The approved ethics protocol was strictly adhered to throughout the five-year programme including ensuring participants confidentiality and explaining study aims and objectives to the study participants and obtaining informed consent.

SOCIODEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

A total of 63 respondents participated in the study. Approximately 68% of the respondents were 25 years and above, while about half (53.97%) of the participants spoke both French and English. Almost three-quarters (71.43%) identified as Black African. The sociodemographic characteristics of the study participants are shown in Table 1.

RESULTS

The thematic analysis of qualitative data revealed the following themes: 1) systemic barriers to employment and income, 2) healthcare access and uptake, 3) stigma, discrimination and racism, and 4) strategies for responding to HIV vulnerabilities.

SYSTEMIC BARRIERS TO EMPLOYMENT AND INCOME

In discussing the structural oppressions that heterosexual ACB men face – which increase their vulnerability to HIV – one prevalent sub-theme among participants was the inherent systemic barriers to employment and income. These barriers refer to the policies and practices that limit the ability of heterosexual ACB men to access essential resources and opportunities to gain meaningful employment and achieve financial stability. For some participants who were new immigrants with years of professional experience from their home countries, the Canadian labour market was a challenging milieu for them to navigate, as their academic credentials were not recognized in Canada. This was mentioned by one participant:

> *"So if you are ACB, in Canada, it is pretty challenging in that way. I have seen a lot of people in this kind of situation. When you are basically a doctor in Africa and you come here, it does not happen that way; they want you to restart all the process. They want you to restart and pay money to them from the ground."*
> (FGD 037, 16-24 Youth, PHA)[1].

Similarly, there were limited opportunities for employment and upward financial mobility for ACB men, irrespective of how highly skilled they were. Hence, some of these men were left with little option but to take on low-skilled jobs to survive. Regarding this, a participant noted:

> *"…I work with so many people who are also under-employed and they have highly qualified skills, and they come here and all they have to do is to work in a warehouse. Even if you get that, that is great. It is very difficult for people to make a living… A well-educated man with a Master's degree going on a, what is it…OW? You don't want to talk about it…"*
> (FGD 03, Adult 25+, Service Provider)

These factors gave rise to inadequate income, which disproportionately affected heterosexual ACB men's ability to access essential resources that would improve their health. One participant noted that an "empty stomach has no ears":

> *"…In this sense, we will talk about housing, employment; all these things bring us back to poverty. That is something very important in health determinants; the minimum needs to be met. They say an empty stomach*

TABLE 1. Sociodemographic characteristics of the study participants

Variables	Number of participants (*n*)	%
Age (years)*		
16–24	20	31.75
≥ 25	43	68.25
Ethnicity		
Black African	45	71.43
Black Caribbean	7	11.11
Black American/Canadian	7	11.11
Other	4	6.35
Language		
English (only)	26	41.27
French (only)	3	4.76
Both	34	53.97

**Youth: 16–24 years, adult: ≥ 25 years.*

[1]Next to each participant's quote, we have identified by the participant's interview (IDI/focus group discussion (FGD) ID, age group, and HIV status

has no ears. For me to feel comfortable, my basic needs have to be fulfilled. I cannot think of anything else when I lack the money to buy milk for my child…My reasoning is limited to my stomach, that's what must first be resolved to evolve."
(FGD 026, 25+ Adult, Non-PHA)

Also, financial instability can make some ACB men accept sex in exchange for financial favours as a means of economic survival, which might increase their vulnerability to sexually transmitted infections including HIV.

"There are people who think that, in order for them to get out of this situation, they need to befriend people who are in a high social position. And those people, you'll probably find them in the Canadian community. You might look for a rich Canadian lady. That is how the majority of people want to find an easy way out... This is the problem. You are not equal to that lady. It is difficult to find a balance...The person you chose to be with also has her priority. She knows you well and she will also ask you what she wants...she would ask you to fulfil your duty, otherwise you are out."
(FGD 026, 25+ Adult, Non-PHA)

HEALTHCARE ACCESS AND UPTAKE

Even though healthcare services were available, some participants felt that their personal privacy was compromised during service delivery. For example, a participant living with HIV mentioned that HIV clinics are usually situated in open places where people could see those visiting the clinic. The participant recalled:

"People will say: last month we saw him, this month again we see him; he must have that thing [HIV]; otherwise, why is he always there?"
(FGD 035, 25+ Adult, PHA)

Furthermore, the participants identified that there are usually insufficient physicians and long waiting periods before one could get treatment at the hospitals, and this could have a negative impact on their health. A participant noted approvingly:

"Yeah, the challenges there are the constant government (silence…), limiting access to health care, or limiting access to professionals, doctors. At one time, you could not go for a medical check-up within a certain number of times. Initially for men over fifty, it was six months. Now, it is maybe a year. So this is limiting access to health care. That I think would be having some big effect on the health of the community."
(FGD 024, 25+ Adult, Non-PHA)

STIGMA, DISCRIMINATION AND RACISM

Some ACB men face stigma in their access to HIV-related care services. This was evident by the isolation of a PHA from other patients at a hospital:

"Right here in the general hospital. Why should I be isolated? When my wife came to visit, they told her she could not come with the children. I started wondering: what is so dangerous in my situation? I called my family doctor to ask him what was going on with the doctor here at the hospital; what did you tell these people? I am completely isolated here; I saw people coming to me wearing gloves. I think someone saw it, but this was supposed to be confidential."
(FGD 035, 25+ Adult, PHA)

ACB men face racial barriers while navigating the job market in Canada. For instance, a participant stated the difficulty his brother had while trying to get a desired job role because of the religious stereotype associated with his name:

"...He applied for a job in Vancouver. They told him basically all the stuff he needed for the job, [and] he already has all the qualifications. Because his name is M..., they told him he will have to change that to get the job. Because of the terrorism happening all over the world, he had to change his name to like Mo to get the job."
(FGD 037, 16-24 Youth, PHA)

Similarly, there is a lack of opportunities for ACB men because of inherent anti-Black racism and White privilege. A participant stated:

"I came here in Canada with specific objectives in mind. Sometimes, I try to tell my friends that we have families back home in Africa. If you come from Africa, you do not have the same chances as a White man who was born here…"
(FGD 056, 16-24 Youth, Non-PHA)

Other stereotypes that ACB men are faced with include the notions that Black people are dangerous, and a menace to the society. A participant observed thus:

"I don't know, like if you think of a scenario like you are walking down the street and it's probably really really late, I think you will react differently to coming up the side walk to a group of White guys, or to a group of Asian guys coming out of a bar, as opposed to a group of Black guys coming out of a bar."
(FGD 034, 16-24 Youth, Non-PHA)

However, these discriminatory assumptions then fostered a high sense of responsibility on ACB men to work harder, and achieve more within their fields of endeavour:

"If someone makes the assumption that I am not as smart as I am, it does become a mission to let them know that that is not the case. I just let them know that Black people also have the potential to build the engine or to build the house that you are living in or to be the doctor that treats your family."
(FGD 04, 16-24 Youth, PHA)

STRATEGIES FOR RESPONDING TO HIV VULNERABILITIES WITHIN THE ACB COMMUNITY

To deal with the systemic barriers, stigma, discrimination and racism faced by the heterosexual ACB men,

they mobilized a number of resources to address these vulnerabilities to HIV. These included the use of 1) faith-based organizations and leaders, 2) public health education, and 3) collaboration, empowerment and decision making.

ENGAGEMENT WITH FAITH-BASED ORGANIZATIONS AND LEADERS

The participants acknowledged the importance of the roles that faith-based organizations play in improving the HIV situation within the ACB population. A participant stated:

> *"I remember from grade seven to the end of grade eleven, I didn't see my dad that often. That's when I knew I had HIV. All things were falling apart and then I had my best friend when we were kids. We all go to the same church and in the church, we call each other brothers and sisters and I call him [best friend's dad] my uncle."*
> (FGD 04, 16-24 Youth, PHA)

This faith-based engagement with the people also fosters resilience among the ACB population, as one participant noted in approval:

> *"ACB men that I met, they have strong ties to the faith community. They have a strong sense of family and community; resilience comes from having these social supports."*
> (FGD 03, 25+, Service Provider)

Ultimately, the continuous involvement of faith-based and spiritual leaders in HIV prevention and community building were reported by some participants as life-saving:

> *"As I said it, my faith saved me and prevented me from becoming a mad man."*
> (ID not provided, 25+, PHA)

PUBLIC HEALTH EDUCATION

The participants were of the opinion that ACB people need to be trained on the utilization of resources and services available to them in the community. The phrase "keep spreading the news" was emphasized by one of the participants while highlighting the importance of sustained research and community awareness activities:

> *"Keep spreading the news, continue awareness activities, [and] ask the people who finance research to do more. Don't let your guard down; otherwise, a community [and] an entire part of the society could be wiped out by this disease if they do not seriously invest efforts in this."*
> (FGD 027, 25+ Adult, Non-PHA)

Also, there was an acceptance that enough was not done in the area of HIV research among ACB men. This illustrates the little value placed on Black people, even though they are the ethno-racial group most vulnerable to the disease. One participant noted:

> *"Research, research, research, that's what the government should be focused on. But since it doesn't affect middle class White people mostly, so we are all good. We don't give a shit about that. It's like being careful about the people who have HIV, but nothing about the treatment."*
> (FGD 033, 16-24 Youth, Non-PHA)

COLLABORATION, EMPOWERMENT AND DECISION MAKING

Some study participants mentioned the importance of connecting and working with groups or organizations to advocate for common programmes that will be beneficial to the ACB community. A participant stated:

> *"I have been thinking about making sure that these businesses promote an equal representation of ACB men in senior positions and even middle management to help them. Again, that involves a lot of talking to businesses, people, and also setting up programmes that promote our culture and aim to eradicate poverty."*
> (FGD 027, 25+ Adult, Non-PHA)

Furthermore, others were of the opinion that ACB voices must be at the table when discussing and formulating policies and programmes specific to the ACB community, so as to have cultural components that make them comfortable partaking in such programmes:

> *"I do a lot of volunteer work in the community. I am passionate about programmes that can help Black people (adults and seniors). There are services out there that don't have a cultural component. That has to be essential; people need to feel that sense of dignity and respect. I include a cultural component in our programmes, [and] we incorporate these aspects."*
> (FGD 03, 25+ Adult, Service Provider)

DISCUSSION

Our analysis highlighted some factors that increased the vulnerability of heterosexual ACB men to HIV, and also found strategies for responding to these vulnerabilities.

Some participants reported that foreign-trained ACB professionals in Canada – such as medical doctors – usually find it difficult to work in the same professions in Canada because of systemic barriers in place. Similar to this finding, a Canadian study noted that many foreign-trained immigrants – including physicians – face institutional barriers such as difficulty in getting their credentials accredited, as well as inability to obtain licences to practise in Canada, and most of these eventually accept blue-collar jobs [23]. This barrier seems to also be prominent in other sectors as another Canadian report highlighted that Black Canadians in the Ottawa-Gatineau region continue to face systemic barriers to career progression, even though their population has almost doubled in the last 10 years as a result of arrival of Black immigrants who are very well educated [9]. For some newly landed ACB immigrants who want to continue in their career paths, they also face difficulty in getting hired at similar positions as the previous roles they had in

their home countries. Consequently, to survive and afford basic necessities (including adequate healthcare services), many of them resort to low-paying jobs that do not match their levels of education and expertise [23, 24]. These kinds of scenarios – including unemployment – could compel them to adopt any means of economic survival, including engaging in commercial sex [25], which could increase their risk of contracting HIV. These are in tandem with our study findings which identified limited employment opportunities – due to non-recognition of foreign credentials – as a key issue in HIV vulnerability.

Furthermore, inadequate income and low socioeconomic status (SES) could also exacerbate health inequities and lead to poor health outcomes among immigrants and racial minorities including ACB men [26]. A study compared the racial income inequality among Black Canadians and Black Americans and found that within each country, Black adults were over-represented in the lowest income levels and under-represented in the higher income levels [27]. It has also been noted that the high poverty rate among African Americans leads to adverse health outcomes such as limited access to HIV prevention and care services, and a higher risk of contracting HIV [5].

Likewise, in many parts of Canada, there is limited provincial and federal health insurance plan coverage for refugees [28]. Also, the long waiting time for Specialist Consultation in Canada was more likely to affect new immigrants and those with low income, of which this demographic makes up a large proportion of the ACB population. This long waiting period could lead to some adverse health impacts such as anxiety, anguish, and deterioration of health [14, 29]. All these health-related factors could increase ACB heterosexual men's vulnerability to diseases, including HIV/AIDS.

Racial discrimination and stigma are prevalent factors that affect ACB men's vulnerability to HIV. This study indicated that ACB men usually face healthcare-related stigma while accessing HIV care services. This could make their utilization and responsiveness to healthcare resources inadequate, leading to poor health outcomes [5]. Studies in Canada also showed a related finding: immigrants, refugees and minorities were more likely to have inadequate access to healthcare services [6, 8]. Racial discrimination, which encompasses processes such as stereotypes, beliefs, and prejudices that result in avoidable and unfair inequalities in resources and opportunities across different racial or ethnic groups, have been shown to exist even in the healthcare settings [15, 16]. This could be in the form of a doctor's unwillingness to interact with members of minority groups or deeply rooted stereotypes about the health-related behaviours of minority patients [16]. Consequently, these could lead to increased sexual risks. For instance, a study which examined the relationship between everyday racial discrimination and sexual HIV risk behaviours among 526 predominantly low-income urban Black heterosexually identified men found that traumatic stress as a result of racial discrimination increased sexual risk behaviours, especially among younger men [17]. At the workplace, Black men usually face serious challenges in trying to gain the trust of their co-workers by putting in more work that is not commensurate with their pay. Ironically, in some instances, these efforts are not enough as Black people are still prone to discriminatory firing from work [30]. Our study also highlighted that Black men face certain stereotypes that allude to them being dangerous. This is similar to findings from a study which concluded that "the stereotype of young Black men as criminal is deeply embedded in the collective American consciousness (and unconscious)" [31].

In the midst of all these issues that ACB men face, there were some HIV-related community response strategies identified in this study, which the participants acknowledged as essential in helping to build resilience and combat the scourge of the disease. For instance, the participants suggested that engagement with faith-based organizations (FBO) and leaders can help ACB men build resilience. Such strategies have been implemented in the past. For instance, the Black PRAISE project in Greater Toronto and Ottawa was a successful intervention in which Black churches and their congregants were productively engaged to promote critical awareness of HIV among Black Canadians [32]. Also, a qualitative study of 38 influential African American faith leaders in Philadelphia identified key themes including encouraging HIV testing, incorporating HIV/AIDS discussions in their sermons, conducting community outreaches and HIV prevention campaigns [33]. This shows that engaging ACB faith leaders can go a long way to ultimately reducing HIV vulnerabilities among ACB men.

The participants also spoke approvingly of the significance of public health education, continuous research and collaborations which promote culturally appropriate ACB programmes that include ACB people at the decision-making tables. These strategies of public education, HIV awareness and collaborations have been utilized in the past successfully within Black communities [34]. Similarly, a study in Zimbabwe revealed the positive impact that these support groups had on PHA [35]. This is in line with previous calls for the utilization of 'critical enablers' for a more effective HIV response through community mobilization [36].

STRENGHTS AND LIMITATIONS

To the best of our knowledge, this study is the first to explore the structural factors that increase HIV vulnerability, and strategies for building resilience among ACB heterosexual men in Ottawa, Canada.

However, one of the limitations of our study is that it utilized purposive sampling in selecting participants for the focus group discussions. As a result, the findings might not be generalizable to all ACB heterosexual men

in Ottawa. Also, due to their differential experiences, ACB heterosexual men may have dissimilar perceptions about the factors that increase their vulnerability to HIV. Thus, future studies should consider these differential experiences while implementing the sampling techniques.

CONCLUSIONS

This study highlighted some hitherto uncommon factors that were identified as determinants of HIV vulnerability. These factors are deeply rooted in Canadian society and have had untold adverse health outcomes among ACB men. Therefore, in addition to individual-level interventions to address HIV, a key focus should be put into enacting contextually tailored policies and programmes to address these long-standing systemic barriers such as racism, discrimination, limited employment opportunities, and non-recognition of foreign credentials, amongst others. Also, empowering and engaging ACB community members, faith-based organizations and leaders, and social networks is key to reducing HIV vulnerability among heterosexual ACB men.

ACKNOWLEDGEMENT

Special thanks to the entire weSpeak programme team including principal investigators, collaborators, community partners, and participants for their valuable contributions; and other stakeholders who contributed to the programme.

The Ontario HIV Treatment Network and the Canadian Institutes of Health Research funded the research. Neither funder is responsible for the content of this manuscript.

DISCLOSURE

The authors report no conflict of interest.

REFERENCES

1. Public Health Agency of Canada 2015. Chapter 4: Population-Specific HIV/AIDS Status Report: People living with HIV/AIDS – Current Evidence on Social Determinants of Health. Available from: https://www.canada.ca/en/public-health/services/hiv-aids/publications/population-specific-hiv-aids-status-reports/people-living-hiv-aids/chapter-4-current-evidence-social-determinants-health-affecting-people-living-hiv-aids.html (accessed: 22 February 2021).
2. Statistics Canada 2019. Diversity of the Black population in Canada: an overview. Available from: https://www150.statcan.gc.ca/n1/pub/89-657-x/89-657-x2019002-eng.htm (accessed: 13 April 2021).
3. Haddad N, Weeks A, Robert A, Totten S. HIV surveillance report 2019. Canada Communicable Disease Report 2021; 47(1): 77-86. Available from: https://www.canada.ca/en/public-health/services/reports-publications/canada-communicable-disease-report-ccdr/monthly-issue/2021-47/issue-1-january-2021/hiv-surveillance-report-2019.html (accessed: 13 April 2021).
4. African and Caribbean Council on HIV/AIDS in Ontario 2013. Ontario HIV/AIDS strategy for African, Caribbean and Black communities 2013-2018. Available from: https://www.catie.ca/en/resources/ontario-hivaids-strategy-african-caribbean-and-black-communities-2013-2018 (accessed: 16 March 2021).
5. Centers for Disease Control and Prevention 2020. HIV and African American people. Available from: https://www.cdc.gov/hiv/group/racialethnic/africanamericans/index.html (accessed: 10 March 2021).
6. Pollock G, Newbold B, Lafreniere G, Edge S. Perceptions of discrimination in health services experienced by immigrant minorities in Ontario. Pathways to Prosperity: Canada, 2011. Available from: http://p2pcanada.ca/library/discrimination-an-health/ (accessed: 18 March 2021).
7. Rapid Response Service(a). Treatment access barriers and related best practices for newcomers living with HIV and/or HCV. Ontario HIV Treatment Network 2014. Available from: https://www.ohtn.on.ca/wp-content/uploads/sites/9/2014/11/RR90-Newcomers.pdf (accessed: 02 March 2021).
8. Woodgate RL, Busolo DS, Crockett M, et al. A qualitative study on African immigrant and refugee families' experiences of accessing primary health care services in Manitoba, Canada: it's not easy! Int J Equity Health 2017; 16(1): 5.
9. Ngué-No F, McKie D. Local black Canadians face 'systemic barriers' to senior-level jobs, critics say. Available from: https://www.cbc.ca/news/canada/ottawa/black-population-ottawa-increase-barriers-work-1.4600403 (accessed: 01 April 2021).
10. Weller CE. African Americans face systematic obstacles to getting good jobs. Center for American Progress 2019. Available from: https://www.americanprogress.org/issues/economy/reports/2019/12/05/478150/african-americans-face-systematic-obstacles-getting-good-jobs/ (accessed: 27 March 2021).
11. Smiley C, Fakunle D. From "brute" to "thug": the demonization and criminalization of unarmed Black male victims in America. J Hum Behav Soc Environ 2016; 26(3-4): 350-366.
12. Aronson J, Burgess D, Phelan SM, Juarez L. Unhealthy interactions: the role of stereotype threat in health disparities. Am J Public Health 2013; 103(1): 50-56.
13. Burgess DJ, Warren J, Phelan S, et al. Stereotype threat and health disparities: what medical educators and future physicians need to know. J Gen Intern Med 2010; 25 Suppl 2 (Suppl 2): S169-177.
14. Harrington DW, Wilson K, Rosenberg MW. Waiting for a specialist consultation for a new condition in Ontario: impacts on patients' lives. HealthcPolicy 2014; 9(4):90-103.
15. Paradies Y, Ben J, Denson N, et al. Racism as a determinant of health: a systematic review and meta-analysis. PLoS One 2015; 10(9): e0138511.
16. Balsa AI, McGuire TG. Prejudice, clinical uncertainty and stereotyping as sources of health disparities. J Health Econ 2003; 22(1): 89-116.
17. Bowleg L, Fitz CC, Burkholder GJ, Massie J. Racial discrimination and posttraumatic stress symptoms as pathways to sexual HIV risk behaviors among urban Black heterosexual men. AIDS Care 2014; 26(8): 1-8.

18. Collins PH, Bilge S. Intersectionality. Malden, MA: Polity Press; 2016.
19. Bilge S. Recent feminist outlooks on intersectionality. Diogenes 2010; 57(1): 58-72.
20. Etowa JB, Bernard WT, Oyinsan B, Clow B. Participatory action research (PAR): an approach for improving black women's health in rural and remote communities. J Transcult Nurs 2007; 18(4): 349-357.
21. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res in Psych 2006; 3(2): 77-101.
22. Creswell JW, Poth CN. Qualitative inquiry and research design. Choosing among five approaches. 4th ed. Thousand Oaks, CA: Sage; 2018.
23. Foster LP. Foreign trained doctors in canada: cultural contingency and cultural democracy in the medical profession. International Journal of Criminology and Sociological Theory 2008; 1(1): 1-25.
24. Creese G, Wiebe B. 'Survival employment': gender and deskilling among African immigrants in Canada. International Migration 2012; 50(5): 56-76.
25. Kamndaya M, Kazembe LN, Vearey J, et al. Material deprivation and unemployment affect coercive sex among young people in the urban slums of Blantyre, Malawi: a multi-level approach. Health Place 2015; 33: 90-100.
26. Public Health Agency of Canada 2018. Key Health Inequalities in Canada: A National Portrait – executive summary. Available from: https://www.canada.ca/en/public-health/services/publications/science-research-data/key-health-inequalities-canada-national-portrait-executive-summary.html (accessed: 10 March 2021).
27. Attewell P, Kasinitz P, Dunn K. Black Canadians and Black Americans: racial income inequality in comparative perspective. Ethnic and Racial Studies 2010; 33(3): 473-495.
28. Government of Ontario 2020. Apply for OHIP and get a health card. Available from: https://www.ontario.ca/page/apply-ohip-and-get-health-card#section-3 (accessed: 26 February 2021).
29. Liddy C, Moroz I, Affleck E, et al. How long are Canadians waiting to access specialty care? Retrospective study from a primary care perspective. Can Fam Physician 2020; 66(6): 434-444.
30. Mong SN, Roscigno VJ. African American men and the experience of employment discrimination. Qual Sociol 2010; 33(1): 1-21.
31. Trawalter S, Todd AR, Baird AA, Richeson JA. Attending to threat: race-based patterns of selective attention. J Exp Soc Psychol 2008; 44(5): 1322-1327.
32. Husbands W, Nakamwa J, Tharao W, et al. Love, judgement and HIV: congregants' perspectives on an intervention for black churches to promote critical awareness of HIV affecting Black Canadians. J Racial Ethn Health Disparities 2021; 8(2): 507-518.
33. Nunn A, Cornwall A, Chute N, et al. Keeping the faith: African American faith leaders' perspectives and recommendations for reducing racial disparities in HIV/AIDS infection. PLoS One 2012; 7(5): e36172.
34. Rapid Response Service(b): Effective HIV prevention, education and outreach activities in African, Caribbean and Black communities. Ontario HIV Treatment Network 2014. Available from: http://www.ohtn.on.ca/wp-content/uploads/2016/12/RR78-ACB-Outreach.pdf (accessed: 02 March 2021).
35. Skovdal M, Magutshwa-Zitha S, Campbell C, et al. Community groups as 'critical enablers' of the HIV response in Zimbabwe. BMC Health Serv Res 2013; 13: 195.
36. Schwartländer B, Stover J, Hallett T, et al. Towards an improved investment approach for an effective response to HIV/AIDS. Lancet 2011; 377(9782): 2031-2041.

AUTHORS' CONTRIBUTIONS

JE prepared the concept of the paper. JE, AH, HA, EAE, HI collected data. JE, EE analysed data. JE, EE, IM wrote the article. JE, EE, IM critically revised the publication. All authors approved of the final manuscript.