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HIV vulnerability and resilience among heterosexual African, Caribbean and Black men in London Ontario, Canada

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A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree in Geography

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Abstract

Since Canada's first HIV diagnosis in 1981, prevalence rates have remained below endemic levels. This, however, tends to mask realities of HIV infection among sub-populations like heterosexual men of African, Caribbean, and Black (ACB) descent, who experience increased risk of infection compared to other groups. Research to unpack ACB men's vulnerability to HIV has prioritized behavioral risk factors, including the endorsement of traditional masculinity, partner concurrency, condomless sex, and poor use of preventive health services. As such, recommendations from these studies have centered on behavioral changes, which understate the role of structural risk factors in ACB men's HIV vulnerability. Furthermore, knowledge from these studies under-represents ACB men's agency and overly simplifies their vulnerabilities and resilient trajectories in relation to HIV. In advancing knowledge in this area, the weSpeak research project was implemented in four cities in Ontario (i.e., Ottawa, Toronto, London, and Windsor) from 2016 to 2020 to provide a holistic account of HIV vulnerability and resilience among heterosexual ACB men. This dissertation is drawn from the weSpeak project. It specifically focused on unpacking the HIV vulnerability and resilience of heterosexual ACB men at the nexus of behavioral and structural risk factors in London, Ontario, using a qualitative approach. Through snowball and random sampling, thirty self-identified heterosexual ACB men and seven service providers participated in four focus groups (n=24) and thirteen (n=13) in-depth interviews.

Analyzing the data using NVivo 12 revealed the overarching role of structural factors in ACB men's HIV risk. For instance, the perception that masculinity is a sexual performance factor was limited to younger ACB men who had internalized stigmatized and stereotyped Black masculinities. Most ACB men practiced

resourceful masculinities that allowed them to engage with their health. Furthermore, some ACB men had limited understanding and awareness of their high-risk of HIV mainly because they were disconnected from institutions providing HIV services. Aside from these hidden vulnerabilities, the research also revealed the high resilience of ACB individuals to HIV. Most ACB men demonstrate resilience by drawing on intrapersonal and interpersonal resources, including friends, families, and religious communities. Health policymakers and stakeholders can leverage these findings to engage ACB men in designing interventions targeted at their HIV needs. Overall, the removal of race-based discrimination in access to health resources will ultimately contribute to HIV risk reduction among ACB men and, therefore, improve their health and wellbeing in Canada.

Keywords: African Caribbean and Black (ACB); Heterosexual; HIV/AIDS; Vulnerability; Masculinity; Preventive Health; Resilience; London; Ontario; Canada

Summary for Lay Audience

Canada has recorded low HIV cases among the general population since the first diagnosis in 1981. However, some groups in the country are more at risk of HIV infection than others. For example, research shows that African, Caribbean, and Black (ACB) men with a straight sexual orientation are more at risk of HIV infection because of behaviors such as unprotected sex, multiple sexual partners, and poor use of HIV healthcare. Therefore, existing studies recommend behavioral change as a solution that can reduce ACB men's HIV risk. However, missing from these studies is an examination of the contributory roles of health policies and services, as well as ACB men's everyday challenges of living in Canada as a racial minority population.

Furthermore, we do not know from these studies if ACB men engage in activities that build their capacity to reduce their vulnerability to HIV. This dissertation was part of a larger study called weSpeak, which was implemented in four cities (i.e., Ottawa, Toronto, London, and Windsor) in Ontario from 2016 to 2020. The aim was to understand and explain to policy makers factors that contribute to ACB men's increased risk to HIV. Specifically, this research was conducted in London to find out how factors like behaviors, health policies, and everyday challenges of ACB men come together to make them vulnerable to HIV infection. Overall, thirty-seven people participated in four focus groups and thirteen in-depth interviews. The study findings revealed that HIV risk for ACB men resulted from challenges they faced as a racial minority population as well as from risky behaviors that were intended to meet the larger societal expectation of ACB men's masculinity.

Additionally, institutions such as AIDS service organizations were not actively engaging with ACB men. Therefore, some of them were not aware of their high HIV risk. It also emerged that ACB men resorted to their innate qualities, friends, families,

and religious communities to improve their capacities and resilience to HIV. Health policy stakeholders can take advantage of ACB men's willingness to reduce their risk of HIV and engage them in the design of policies specific to their needs.

Co-Authorship Statement

This dissertation is made up of three manuscripts (Chapters 4, 5 & 6) that are either revised and resubmitted or under review in peer-review academic journals. In Chapter 1, I present the study's research objectives and questions. The literature review focusing on the epidemiology and HIV risk of various groups in North America are presented in Chapter 2. Moreover, in this chapter, I discuss heterosexual African, Caribbean, and Black (ACB) men's HIV vulnerability within the social determinants of health. In Chapter 3, I delve into the methods of this study, justifying the use of a qualitative research methodology. Chapter 7 summarizes the main study findings in particular reference to the research questions and objectives. The three papers in the manuscript are as follows:

Chapter 4: Antabe, R., Arku, G., and Luginaah, I. "Uncovering HIV vulnerabilities beyond the usual layers: Contemporary masculinities and heterosexuality of the Black Man in London, Ontario, Canada" *Sexuality, Culture and Health (under review)*

Chapter 5: Antabe, R., Arku, G., and Luginaah, I. "I went in there, had a bit of an issue with those folks": Everyday Challenges of Heterosexual African, Caribbean, and Black (ACB) Men in Accessing HIV/AIDS Services in London, Ontario" *BMC Public Health (Revise and resubmit)*

Chapter 6: Antabe, R., Arku, G., Luginaah, I. "Black heterosexual men Resilience in times of HIV Adversity: Findings from the weSpeak Study" *BMC International Health and Human Rights (under review)*

While these manuscripts are co-authored with my thesis supervisors, their role was to guide the study and review the drafts of the manuscripts and the entire thesis. I

conceptualized the study, conducted the literature review, data collection, and analysis, and wrote the thesis.

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To Dr. Kilian Atuoye and family (Cecilia and Mariana), thank you for your encouragement and for looking out for me. To Florence W. Anfaara, Jemima Baada, Dr. Vincent Kuuire, Dr. Yujiro Sano, Dr. Shiela Boamah and Jeremy Grimstead, you have been phenomenal in making my graduate school experience great. I am eternally grateful. To Lori, Joe, Angelica, Lelanya, Karen, and Joe and all the staff and faculty of UWO Department of Geography, a big thank you to you for making my graduate school experience enjoyable.

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Dedication

This Ph.D. dissertation is dedicated to my parents,

Mr. Charles Antabe and Mrs. Veronica Baturo, and the entire Antabe family

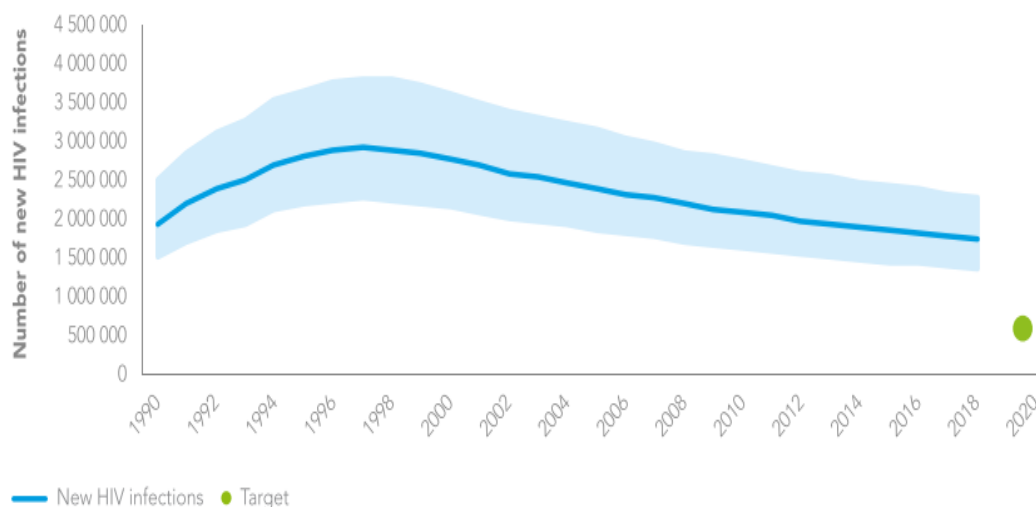
CHAPTER ONE: INTRODUCTION

1.1. Background to the Study

The Human Immunodeficiency Virus (HIV), which causes Acquired Immune Deficiency Syndrome (AIDS), has remained a major global public health concern four decades after it was first reported in the United States (Gall et al., 2017; Iwuji & Newell, 2017; UNAIDS, 2017a). In its 2019 report, The United Nations Programme on HIV and AIDS (UNAIDS) — the global taskforce mandated to ensure an accelerated, comprehensive and coordinated international effort to address HIV— revealed that an estimated 74.5 million people have so far been infected since the start of the epidemic. It further reported a global mortality rate of 32 million as of 2018 (UNAIDS, 2019a).

HIV is known to weaken the body's immune system and its capacity to fight new infections and diseases. Therefore, it has remained a major comorbidity with several diseases such as diabetes, cardiovascular complications, tuberculosis, as well as hepatitis (Lerner, Eisinger, & Fauci, 2020; Maciel, Klück, Durand, & Sprinz, 2018; UNAIDS, 2019a). Although records indicate a steady decline in the incidence of HIV by 40% since the peak of infections in 1997 (Figure 1), there are currently 37.9 million people living with the virus, with 1.7 million new infections in 2018 alone (UNAIDS, 2019a). Most HIV infections and mortalities occur in the global south especially in sub-Saharan Africa, South East Asia, and the Caribbean (HIV/AIDS & Organization, 2007; UNAIDS, 2019b).

Figure 1: Number of Global New HIV Infections, 1990-2018, and 2020 target



Source: UNAIDS, 2019

In view of its eminent global health threat, reducing the spread of HIV below endemic levels remains the overriding goal of global stakeholders, governments and medical research (Kallings, 2008). Thus, in 1985, four years after the first recorded case of AIDS, the World Health Organization (WHO) organised the International AIDS Conference in Atlanta (USA) that brought together scientists and governments from around the globe to plan a containment strategy (Herzlich & Pierret, 1989). After this conference, governments around the world rolled out programs to avert what seemed like a public health calamity given the rapidity of its spread across national borders (Jarlais, 1992). Key strategies recommended for reducing new infections include public education and awareness, where individual level factors such as correct and consistent condom use, and reducing dense sexual networks is emphasized (Rojanapithayakorn, 2006; UNAIDS, 2019b). The need for public awareness on HIV transmission is also predicated on addressing misconceptions about the etiology and transmission of HIV. Earlier medical suggestions that only men who have sex with men (MSM) were vulnerable, and the subsequent christening of HIV as a ‘gay

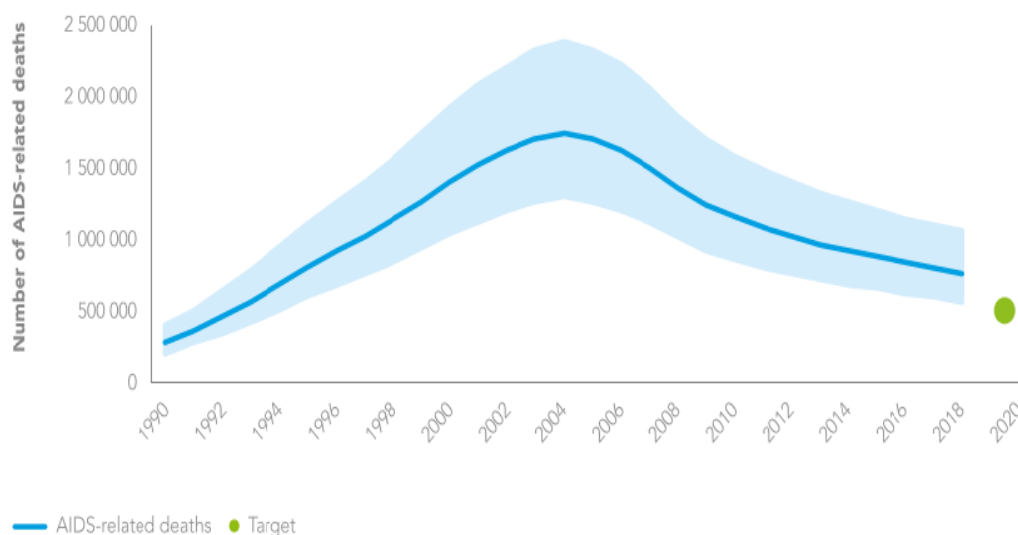
immune disease' or a 'gay plague' may have entrenched a false sense of immunity among non-MSMs (Curran, Jaffe, & Centers for Disease Control, 2011; Li, Wong, Cain, & Fung, 2016). Thus, over three decades after the first reported case of HIV, misconceptions about the transmission of the virus remain a key driver of new global infections (Antabe, Sano, Anfaara, & Luginaah, 2020; Sano et al., 2016). Other recommended strategies include increased HIV testing especially targeting high-risk populations, and treatment for persons living with HIV (PLWHA) (WHO, 2016).

In emphasizing testing as a global HIV prevention strategy, it is argued that individuals' awareness of their HIV status could lead to the adoption of positive behaviors which reduce their exposure to HIV. Those who test positive for HIV can benefit from early initiation of HIV treatment (Carlos et al., 2016; Huntingdon, Sharpe, De Wit, Duracinsky, & Juraskova, 2020; Tsevat et al., 2009; UNAIDS, 2018a). According to UNAIDS, as much as 25% of PLWHAs in 2017 were unaware of their HIV positive status, although there were wide regional and intra-country differences (UNAIDS, 2018a). This revelation has dire consequences for preventing new global infections. Consequently, there are now calls for the integration of HIV screening with routine medical care. For HIV endemic contexts, it is further suggested that testing should be mandatory for all visiting patients (Bassett & Walensky, 2010; Palmer, Mason, Pasi, & Tobiwa, 2000).

When detected early, HIV can be managed as a life long chronic condition, allowing PLWHAs to live normal lives after diagnosis. Thus, the 40% decline in HIV-related deaths from the 1990s to 2017 (see Figure 2) has largely been attributed to the discovery of antiretroviral treatment (UNAIDS, 2018b). More recently, advancement in HIV treatment with concepts such as 'Undetectable=Untransmittable' (U=U), allows PLWHAs to suppress their viral loads to become untransmittable during sexual

intercourse (Calabrese & Mayer, 2019; Eisinger et al., 2018). In the more endemic contexts of Southern and Eastern Africa, late HIV diagnosis and poor access to antiretroviral therapy (i.e. 67% coverage for PLWHAs) may be driving high HIV morbidity and mortality (UNAIDS, 2019b).

Figure 2: Number of Global HIV-related Deaths, 1990 to 2018 and 2020 target



Source: UNAIDS, 2019

The underlying assumption about these approaches to HIV prevention has been that, within the population, there is unhindered and equal access to HIV information, testing and treatment for everyone (Poku, 2016; WHO, 2016). Based on this assumption, risk to HIV infection is explained by individual level behavioral attributes and unwillingness to use HIV prevention resources (Rotheram-Borus, Swendeman, & Chovnick, 2009). However, studies posit that, access to these HIV prevention resources could be affected by demographic, socioeconomic and geographical factors. For instance, gender, race, age, income, occupation type, housing and neighbourhood type, health insurance coverage, immigration status, region and rural-urban residency may influence access to HIV-related resources

(Baidoobonso et al., 2013; Haque, et al., 2018; Hasan et al., 2013; Sano et al., 2016; Shrestha et al., 2017; Taylor, DeHovitz, & Hirshfield, 2020).

The role of these factors in influencing health access, specifically exposure to HIV, raises critical questions about the over-emphasis on individual behavioral risk factors and the role of structural factors in people's exposure to infections and diseases. This is particularly important for socially marginalized populations who are seldom captured by health policies and may therefore experience added barriers to accessing important resources to improve their health (Baidoobonso, Husbands, George, Mbulaheni, & Afzal, 2016; Geary, 2014).

Increasingly, understanding the role of structural factors in population health outcomes has necessitated using the social determinants approach to unpack the contributory roles of non-biomedical factors—defined as the medium through which social factors shape health inequality, including exposure to HIV. In North America for example, some scholars have argued that the poor health outcomes suffered by men of African, Caribbean and Black (ACB) descent are linked to their poor social and material circumstances. In the United States, the worsening economic situation of African American men is reflected in the widening health and mortality gaps between them and their White counterparts (Griffith, Metzl, & Gunter, 2011). Earlier, Xanthos et al. (2010) found lower socioeconomic status, racial discrimination, and high incarceration rates as major determinants of poor health among African Americans. Similarly, Mount et al. (2012) found poor awareness of health conditions, a sense of fatalism due to unresolved medical conditions and the fear of academic and medical spaces to be key social determinants of Black men's health in the United States.

In Canada, Frohlich et al. (2006) also observed race to be a persistent social determinant of health, and healthcare accessibility for racial minorities who suffer

disproportionate health burdens. Specifically, a report by the Public Health Agency of Canada underscored anti-Black racism as a social determinant of health for ACB people. The report iterated that Black people fared poorly on all measures of socioeconomic indicators, a situation that adversely impacted their health (Public Health Agency of Canada, 2020). This may suggest that people of ACB descent, especially ACB men who are more likely to be structurally exposed, may be predisposed to poor health outcomes. Thus, to understand ACB men's HIV vulnerability, it may be necessary to go beyond superficial descriptions of their unwillingness to adopt HIV preventive strategies. Their HIV vulnerability in Canada must be situated within the intersection of race, gender, immigration status and discrimination, examining how these factors work to shape access to HIV information, testing, and treatment in a racially hierarchical society (Husbands et al., 2013).

1.2. Research Problem

Canada's low HIV prevalence (*i.e.* below 1%) over the last three decades tends to mask the realities of infections in some sub-populations that are disproportionately impacted (Haddad, Li, Totten, & McGuire, 2018). Among ACB people, the risk of HIV infection is higher compared to others in the Canadian population. Thus, although ACBs constitute less than 5% of Canada's population, they nonetheless make up 21.9% of PLWHAs (Bourgeois et al., 2017). Additionally, they are 12.5% more likely to be infected compared to the general population (Haddad et al., 2018). Although the Indigenous and the Asian populations also appear to be at an increased risk, ACBs emerge as the most vulnerable to HIV (Bourgeois et al., 2017; Husbands et al., 2013).

Furthermore, evidence suggests that men who have sex with men (MSM) and injection drug users (IDU) have persisted as key exposure categories for HIV infection. Nevertheless, infections through these categories of exposure as a proportion of overall HIV infections in the country have been declining. For instance, MSM accounted for 80% of all HIV cases in 1985 but this number has consistently dropped, estimated at 41.4% in 2018. Furthermore, infections through IDU as an exposure category have slightly declined from an average of 20.7% between 2003-2011 to 18.3% by 2018 (Haddad et al., 2019; Public Health Agency of Canada, 2014b). In contrast, however, heterosexual infections for the same period increased from an average of 30.8% to 32.8% (Haddad et al., 2019). With 48.6% of all infections through heterosexual exposures attributed to ACB people, rising heterosexual infections puts them at increasing risk. Indeed, it is reported that heterosexual exposures alone account for close to 90% of all HIV infections in the ACB community. Furthermore, it is suggested that immigrants from HIV endemic countries in Africa and the Caribbean account for almost half of all heterosexual infections. Additionally, ACB people also constitute 82.5% of all HIV cases from unknown sources. These statistics demonstrate the susceptibility of ACB community members to HIV in Canada (Haddad et al., 2018, 2019; Public Health Agency of Canada, 2014a).

Heterosexual ACB men are emerging to be particularly vulnerable. For instance, in 2016, ACB men accounted for 17.9% of all HIV cases among men in Canada, mostly through heterosexual exposures (Bourgeois et al., 2017). Earlier, Remis, Swantee, and Liu (2012) observed that ACB men accounted for 60% of all HIV infections through heterosexual exposures in the ACB community. In Toronto, it was also observed that ACB men accounted for 16.5% of HIV infections among men

in the city. Unfortunately, despite their heightened risk to HIV infection, it is suggested many ACB men living with HIV may not be aware of their HIV status as they do not test for their HIV status, with most being diagnosed in their late stages of HIV infection (Remis et al., 2012; Wilton et al., 2019).

To unpack the underlying factors accounting for heterosexual ACB men's risk to HIV infection, their behavioral characteristics have been linked to risky practices which increase their exposure to the virus. Accordingly, it is argued that their perceived endorsement of traditional masculinities emboldens them to engage in risky sexual and health behaviors including condomless sex, concurrent partnership, feminization and under-utilization of HIV preventive health care (Bowleg, Teti, Malebranche, & Tschann, 2013; Husbands et al., 2017). It has also been suggested that behavioral factors can explain ACB men's perceived lack of investment in HIV resilience practices (Yosso, 2005). Given these behavioral characterizations, heterosexual ACB men's HIV needs may have been left unattended in Canada's policies since their vulnerability to infection is often seen as 'self-inflicted' (Husbands et al., 2013).

While acknowledging that ACB men are at increased risk of HIV infection in Canada, there is increasing recognition among scholars that factors such as racial identity, gender, class and socioeconomic status may influence their access to health resources (Baidooobonso, 2013; Konkor et al., 2020). ACB men in Canada are on lower echelons of society and may experience racism, stereotypes and discrimination that could potentially influence their utilization of health resources, including HIV information, testing and treatment (Baidooobonso et al., 2012; Husbands et al., 2013; Rodney & Copeland, 2009). This seems to suggest that situating heterosexual ACB men's HIV vulnerability within behavioral/individual-level risk factors alone may be

an overly simplistic approach which fails to account for the overarching role of structural factors which may influence healthcare access and risky sexual practices. Using the context of London, Ontario which has a relatively high HIV prevalence, this dissertation is focused on the overarching research question: what are the HIV vulnerabilities and resilience strategies of heterosexual ACB men in London, Ontario? This research question is explored at the nexus of behavioral and structural factors, with the three interconnected research objectives outlined below.

1.3. Research Objectives

1.3.1. Objective 1: Explain how masculinity ideas and practices as behavioral characteristics influence heterosexual ACB men's perceived risk and response to HIV.

ACB men's endorsement of traditional masculinities is said to trigger adverse health behaviors which increase their exposure to HIV (Hall & Applewhite, 2013). Missing from this discourse however, is ACB men's account of their masculinity ideations and practices amidst HIV risk. With some studies (see Fleming, DiClemente, & Barrington, 2016), suggesting that some practices of masculinities may positively impact health behaviors, it will be useful to examine if ACB men are repositioning their masculinities in response to HIV. To achieve research objective one, the following specific questions were examined.

1. How do heterosexual ACB men frame their lived masculinities in relation to HIV?
2. How do masculinity ideations and practices influence heterosexual ACB men's risk of HIV infection?

3. To what extent are heterosexual ACB men modifying their masculinity beliefs and practices in response to HIV?

1.3.2. Objective 2: Explain potential barriers to heterosexual ACB men's access to preventive health services

The underutilization of preventive health care including HIV information and testing services has emerged as a major contributory factor of HIV risk among vulnerable populations (Doshi, Malebranche, Bowleg, & Sangaramoorthy, 2013; George et al., 2014). While the benefits of these services are widely acknowledged, ACB men's limited use of preventive health services is not fully explained and accounted for, except through the usual suspects of behavioral factors. Informed by challenges racial minorities may face in accessing health resources in the context of Canada, the second research objective sought to examine the role of structural factors which prevent ACB men's access to HIV-related preventive health care services. Research objective two is addressed with the following research questions.

1. What factors affect heterosexual ACB men's access to preventive health care in London Ontario?
2. How do structural factors influence ACB men's access to preventive health care?
3. In what ways do heterosexual ACB men's lived experiences of racism, discrimination and stereotypes influence their willingness to access preventive health care services?

1.3.3. Objective 3: Examine how heterosexual ACB men may be acquiring assets to build resilience to HIV infections.

Acquiring protective assets as resilience against HIV is especially recommended for high-risk populations in reducing new infections. Yet, we know little about how heterosexual ACB men may be acquiring protective assets amidst HIV adversity. Existing studies on ACB men have used a deficit-based approach which focuses only on their vulnerability, thus limiting our understanding of which assets are useful to building their resilience to HIV. Research objective 3 therefore sought to examine ways in which they may be acquiring protective assets to overcome HIV adversity. To achieve this objective, these specific research questions were to be examined.

1. How does resilience emerge in the lived experiences of heterosexual ACB men?
2. What protective assets are used by heterosexual ACB men to overcome HIV adversity?
3. What are the sources of ACB men's resilience to HIV infection?
4. How do structural and institutional resources help heterosexual ACB men build resilience to HIV?

The outlined research objectives and the overarching research question are explored within the geographies of health. In the next section, I summarize key geographies of health and their underpinnings in this dissertation.

1.4. Geographies of Health

Population health has been of interest to geographic enquiry for a long time. Compared to other fields of health enquiry, the focus of health geography has been to

examine how spatio-temporal characteristics shape population health outcomes (Gesler, 1986). Geographies of health aim to unpack the contributory role of the physical, built and social environments in a population's susceptibility to infections and diseases (Brown, McLafferty, & Moon, 2009; Kearns & Moon, 2002; Luginaah, 2009). Thus, for geographies of health, a population's vulnerability to disease and infections is not simply a derivative of the viral-vector relationship with a host; but it is conceptually constructed to include the contributory role of environmental and sociocultural contexts in facilitating this relationship (Luginaah, 2009). Over the years, the study of population health has revolved around three broad approaches/traditions largely informed by epistemological and theoretical differences on how population health come to be shaped by environmental factors (Brown et al., 2009; Gatrell & Elliott, 2014).

The first approach focuses on the application of spatial analysis techniques to understand spatial variation in a population's morbidity and mortality, which sometimes take on a historical perspective (Mayer, 1996; McNally, Williams, Phillips, & Strachan, 2000; Parr, 2002). Termed 'medical geography and disease ecology,' this approach examines the role of the physical environment, and together with perspectives from disease ecology, analyse interactions between sociocultural and economic factors that position people to be more susceptible to certain diseases and infections (Mayer, 1996; Mayer & Meade, 1994; Meade, 2014). The second approach, tagged 'medical geography and geography of medical care,' is concerned with the spatial distribution of formal and informal medical care. Thus, the focus of this strand of medical geography is to understand how the spatial organization, structure and management of medical care ensures maximum utilization of medical services (Parr, 2003; M. Powell, 1995). Through spatial location-allocation models, the locations of

medical care facilities which guarantee maximum access and utility for a targeted population are determined (Brown & Watson, 2010; Oppong & Hodgson, 1994). This tradition also uses statistical modelling to estimate how distance to, and availability of medical care contributes to population health, morbidity and mortality.

The growing interest in population health inequalities which hitherto has not been a focus of earlier strands of medical geography, birthed the third strand—health geography. Grounded in the epistemologies of humanism, health geography employs post-positivist and interpretivist approaches to interrogate how social factors are intrinsically linked to people's health outcomes and ways it may produce, reproduce and enforce inequalities in population health (Kearns & Collins, 2010; Kearns & Moon, 2002; Luginaah, 2009; Rosenberg, 1998). While acknowledging the contributory explanations offered by the earlier streams of medical geography, health geography through a plurality of theoretical underpinnings, brings to the fore how social stratifications defined as gender, ethnicity, race, immigration status, employment, income, educational attainment and occupation are important mediums through which an individual's health is shaped (Rosenberg, 2014, 2016).

For health geography, therefore, it is important to understand how the materiality and materialism of people's lives influence ways they are exposed to diseases and how they experience health inequality (Gatrell & Elliott, 2014; Rosenberg, 2014). Furthermore, for health geography, underlying population health inequalities are power relations that determine how different social categories gain access to productive resources that improve health (Dunn & Hayes, 2000). Particularly, the socially disadvantaged, marginalized, vulnerable and oppressed populations may be bound to experience worse forms of health inequalities as their

health needs may not be prioritized by social policies (Brown et al., 2009; Brown & Watson, 2010; Husbands et al., 2017).

Underpinned by an interpretivist persuasion, health geography brings into focus the fluidity of the concept of health and how it is differently constructed based on the contextual characteristics of a population (Kearns & Collins, 2010; Luginaah, 2009; Rosenberg, 2016). The discipline reconceptualizes space as 'place' to highlight the influence of contextual factors on people's health by emphasizing that spaces are not neutral but embody unique features defined by history, culture, and social attachments. For instance, Cummins et al. (2007) underscore the need to recognize the mutually reinforcing and reciprocal relationship between people and 'place' when examining population health disparities. In this regard, 'place' encompasses the contextual factors that shape subjective views of disease etiology and health. In his article, Luginaah (2009, page 92) further emphasized the importance of 'place' to health geographic enquiry "...health geographers have reconceptualised the notion of 'place' as a complex cultural symbolic phenomenon constructed through relationships between people and their settings, rather than mere sites where observations are located." Therefore, 'place' symbolizes the interaction between the physical environment, culture, social beliefs and economic resources that underly disparities in population health outcomes (Cummins et al., 2007; Gatrell & Elliott, 2014; Luginaah, 2009).

The plurality of theoretical perspectives employed by health geography has positioned it to theorize individuals' vulnerability and risk of HIV infection beyond biomedical constructs of disease diffusion (Rosenberg, 1998). The focus of the dominant biomedical model centres on individual behavioral risk factors including poor knowledge of HIV transmission and non-adherence to HIV prevention strategies

such as abstinence and condom use. This rationalist approach therefore conceptualizes risk to HIV infection at the individual level, failing to account for the broader sociocultural and political contexts that facilitate the spread of HIV (Hunter, 2010b; Kalipeni, Craddock, Opong, & Ghosh, 2004). Earlier studies such as Wallace et al. (1995) linked the incidence of HIV/AIDS and tuberculosis in the New York Metropolitan region to public policies that worsened poverty, created homelessness, and dissipated communities. Wallace et al. (1995) further highlighted the deficiency of a behaviorist approach in explaining the spread of HIV. In line with this, health geography attempts to unpack HIV risk at the nexus of behavioral, cultural, and socioeconomic characteristics and how this may further be informed by social and health policies (Hunter, 2010a; Kalipeni et al., 2004).

Thus, situating the risk of HIV infection within the social determinants of health – gender, income, occupation, and formal educational attainment – may influence how individuals are differently exposed to HIV (Baidooonso, 2013b; Konkor et al., 2020). Furthermore, other social categories including racial minority status and immigration status are known to impact access to economic and health resources, which can in turn influence susceptibility to HIV (Bowden, Rhodes, Wilkin, & Carolina, 2006; Castañeda et al., 2015; Hunter, 2010a). From the perspective of health geography, therefore, defining HIV vulnerability must consider contextual, socioeconomic characteristics and power relations which create subjective realities of infection for different people within the same population and place.

1.5. Organization of the thesis

This thesis is organized into seven interconnected chapters. This first chapter gives the background to the study and highlights the current problematic conceptualization of HIV risk and prevention. It proceeds to outline the research objectives and posed research questions this dissertation sought to address. Chapter One concludes by situating this research within the field of health geography. Part one of Chapter Two, tracks the history and spread of HIV globally, narrowing down to the epidemiology of the disease in the context of Canada, emphasizing heterosexual ACB men as an emerging vulnerable group. Part two of Chapter Two discusses HIV vulnerability within the larger framework of the social determinants of health. In Chapter Three, I discuss the study design, explaining the sampling and analytical approach. Chapters Four to Six form the empirical component of the dissertation, where the research objectives and questions guiding them are adequately addressed. Specifically, Chapter Four addresses the first research objective which centers on explaining the role of ACB men's masculinity practices as behavioral characteristics of their HIV vulnerability. The second research objective on barriers faced by heterosexual ACB men in accessing HIV-related preventive health services is addressed in Chapter Five. In Chapter Six, I address the final research objective of assessing how heterosexual ACB men may be acquiring protective assets to build resilience to HIV. In the last chapter, I give a summary of the study, discussing the significant contributions and highlighting areas for future research.

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CHAPTER TWO

2.0. LITERATURE REVIEW AND THEORETICAL CONTEXT

2.1. Introduction

In this chapter, I discuss the historical trajectory of HIV in North America, with particular emphasis on the emergence of HIV vulnerable groups over time. I then focus on heterosexual ACB men's health outcomes including their risk of HIV within the theoretical framework of social determinants of health where the focus is on how non-clinical factors contribute to their poor health. In the concluding section, I give a summary of the salient issues raised in this chapter.

2.1.1. Early spread of HIV in North America

Although the first known cases of HIV in 1981 were reported in the United States, it is widely believed that the virus predates this first diagnosis (Hall et al., 2009; Schneider, Gynn, Kajese, & McKenna, 2006). Following the 1981 diagnosis, and the first decade of HIV, epidemiological evidence suggest MSM were disproportionately impacted, accounting for 61.3% and 70% of overall infections in the United States (US) and Canada, respectively. For this same period, heterosexual infections made up 10.1% and 5% of overall infections in US and Canada, respectively (Centers for Disease Control and Prevention, 2006; Public Health Agency of Canada, 2014b; Schneider et al., 2006).

Over time, the epidemiology of HIV began to change, and new groups, noticeably, injection drug users and people with heterosexual orientation became increasingly susceptible to infections. In Canada, for instance, while the Public Health Agency reported the major route of HIV exposures was 76.6% MSM, 9.1% IDU and

7.7% heterosexual between 1985-1994, these figures changed significantly to 44% MSM, 20.7% IDU and 30.8% heterosexual between 2002-2011 (Public Health Agency of Canada, 2013). The changing epidemiology of HIV, marked by increasing risks of other groups over time has been attributed to several factors, most notably, policy inertia during the initial stages of the virus spread. It is noted that, the disproportionate impact of HIV on MSM in the early years of the pandemic resulted in the christening of HIV as a ‘gay-related immune disease’ in medical circles. This entrenched misconceptions about the etiology and transmission of the virus, and subsequently created a general sense of invincibility to HIV given that infections were perceived to be only possible among MSM (Geary, 2014; Platt & Platt, 2013).

In the second decade of HIV in North America, new infections began to show clear demarcations by race, as racial minority populations were becoming over-represented in new infections (Hall et al., 2009). In both the US and Canada, racial minorities including Blacks, Indigenous, Hispanic and Asian populations recorded HIV prevalence rates that were much higher than those of the white population (Centers for Disease Control and Prevention, 2006; Haddad et al., 2018; Hall et al., 2009).

2.2. HIV Risk Groups in North America

Groups with an increased risk of HIV infection in North America have largely remained the same since the 1990s. From the first HIV diagnosis and the initial naming of HIV as a ‘Gay-related immune deficiency’ (GRID), MSM as a social group recorded the highest prevalence, albeit with incidence declining over the years (Centers for Disease Control and Prevention, 2006; Public Health Agency of Canada,

2014a; UNAIDS, 2010). In Canada, the MSM exposure category has persisted as the most common route over time, accounting for 40% of HIV infections in 2018 (Haddad et al., 2019). While this is the case, infections through injection drug use have risen from the low 1990s incidence levels to become a major HIV infection route among injection drug users. Thus, between 1981 and 1995, injection drug use (IDU) represented 26.8% of all reported cases of HIV in the US. In Canada, it was estimated to have accounted for 17.3% of all infections between 1985 and 2007 (Public Health Agency of Canada, 2014b). Although IDU had become the second biggest HIV exposure route in North America by the second decade after the first diagnosis, increased education and free needle supply programs resulted in a substantial decline of new infections through this route (Burack & Bangsberg, 1998; Mitty et al., 2008).

Furthermore, while heterosexual contacts remained the third biggest exposure category for HIV in early stages, it overtime overtook IDU to become the second biggest exposure category in North America. Increasing heterosexual infection was particularly devastating for people of African, Caribbean and Black (ACB) descent as they became disproportionately represented in heterosexual exposures in both the US and Canada (Centers for Disease Control and Prevention, 2011; Liu & Remis, 2007; Public Health Agency of Canada, 2014b). The reported HIV prevalence for ACB people in the US for instance, was found to be 8 times above the reported rate for whites, and while they constituted just 12% of America's population, they made up 46% of PLWHAs (Moore, 2011).

In Toronto, Canada, Liu and Remis (2007) also observed that HIV cases among ACB people rose abruptly from 5.3% in 1985-89 to 31.9% in 2000-04. Epidemiological data further suggest that ACB men were not only more susceptible to new HIV infections but were also being increasingly diagnosed in the late stages of

infection. Across Canada, rising HIV cases among the ACB population may have been linked to rising heterosexual infections which may not have been receiving the same attention as other routes. Thus, an estimated 90% of all HIV infections among the ACB community are attributable to heterosexual infections, and out of this, about 60% are reported for heterosexual ACB men (Haddad et al., 2018; Remis et al., 2012). Invariably, the transmission of HIV within a community context tends to be influenced by broader social factors. These dynamics are discussed within the context of social determinants of health theoretical framework in the next section.

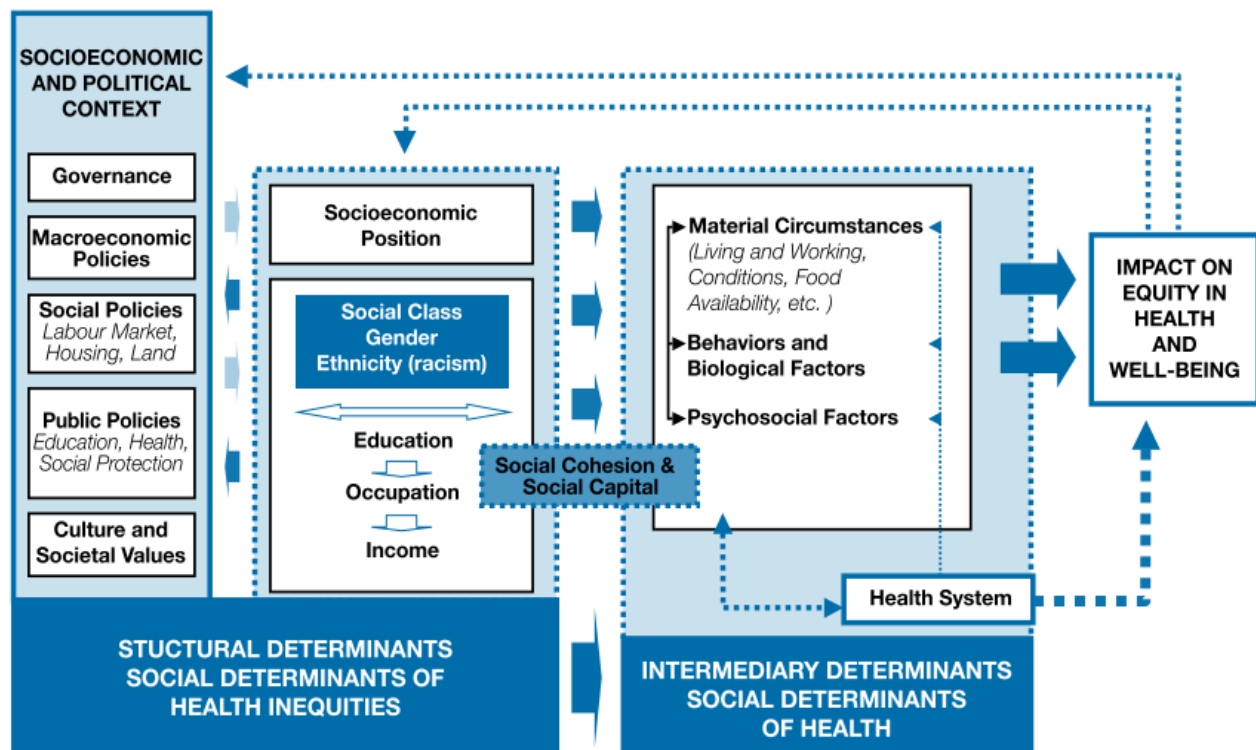
2.3. Social Determinants of Health and ACB men's HIV Vulnerability

ACB men's HIV vulnerability tends to be examined through a biomedical conceptualization of infectious diseases risk. Because of the hegemony of this approach, studies in this vein tend to emphasize individual behavioral change as the main strategy of reducing HIV vulnerability among ACB men, and the ACB population (Geary, 2014). However, the increasing recognition of the influence of social factors on people's health (*see* Lopez & Gadsden, 2016; Richmond & Bigcanoe, 2013; Solar & Irwin, 2010) has necessitated the examination of heterosexual ACB men's overall health beyond epidemiological constructions of disease, risk to infections, and poor health outcomes, to situate it within the social determinants of health (SDH) framework.

In unpacking the contributory factors explaining quality of health and health outcomes for individuals and groups such as heterosexual ACB men, the SDH framework underscores the role of social factors, interactions and hierarchies and their underlying processes in shaping health outcomes (Marmot, 2005; Raphael, 2006).

According to SDH, the social, economic and political organization of human society—identified as structural characteristics—create social stratifications that are defined by income, education, occupation, gender, race/ethnicity, sexual orientation, immigration status, class, among others (Solar & Irwin, 2010). While these structural factors may not directly impact health outcomes, they tend to do so indirectly, through their effect on the intermediary social determinants of health which include people’s material circumstances (i.e., living, working and housing conditions); behaviors and biological factors, and psychosocial factors (Chapman, 2010; Solar & Irwin, 2010). In this regard, it is the position of the SDH framework that people’s disease exposure, susceptibility to infections, and quality of health reflect their respective positions on the social hierarchies and stratifications shown in Figure 3.

Figure 3: The Social Determinants of Health Framework



Source: Solar and Irwin, (2010)

Consequently, populations at increased risk of infectious diseases such HIV are those experiencing increased exposure to health compromising conditions because of their low social positioning (Marmot & Wilkinson, 2005). These factors as highlighted in the SDH, also operate through feedback mechanisms to reinforce poor health for socio-economically disadvantaged people. For instance, due to poor health, vulnerable people are unable to adequately position themselves to improve their socioeconomic status. This in turn serves as a barrier to achieving quality health (Solar & Irwin, 2010).

Through the overarching socioeconomic and political context, where power processes are vested in a privileged few, the system of poor health for marginalized and exposed populations such as ACB men is reinforced and perpetuated over time (Marmot & Wilkinson, 2005; Solar & Irwin, 2010). Additionally, the SDH framework underscores the perpetuation of health inequalities through the influence of structural factors as they impact access to socioeconomic and health resources. In the next section, I examine the components of the SDH in contextualizing heterosexual ACB men's risk to HIV.

2.4. Structural/Social Determinants of Health Inequities

2.4.1. Socioeconomic and Political Context

ACB men's risk of HIV infection is greatly influenced by the socioeconomic and political context of North America given that it creates and reinforces ways social groups experience health (Raphael, Curry-Stevens, & Bryant, 2008; Weinstein, Geller, Negussie, & Baciu, 2017). The organization of society and social interactions in this context are wrought in its history of colonialism and slavery, where statecraft

ensured unequal access to resources through the creation of social hierarchies, particularly along the lines of race (Reading & Greenwood, 2015; Smedley, Stith, & Nelson, 2003). Consequently, racial minority populations such as ACB men, based on their social hierarchy are positioned to experience poor health outcomes including high HIV infection. For instance, scholars have shown how ACB men's health needs have remained unaddressed, and of a lesser priority to political, policy and health stakeholders, despite overwhelming evidence suggesting the need for urgent action to address their poor health outcomes (Baidoobonso, Husbands, George, Mbulaheni, & Afzal, 2016; Husbands, Oakes, & Ongoiba, 2014). In Canada, studies have observed a racial gradient in the quality of health as the country's political and socioeconomic context engenders a structural inertia in responding to the needs of racialized, and structurally exposed populations (Nestel, 2012; Richmond & Big-canoe, 2013; Smedley et al., 2003).

In these contexts, therefore, health policies and services are crafted to suit the needs of the predominantly white population, and are invariably not aligned well with the specific health needs of minority populations including ACB men. Resulting from this, ACB men as a racial minority population may feel unwelcomed and alienated from HIV-related health services that are critical for positioning them to avoid infection (Khan, Kobayashi, Lee, & Vang, 2015; Musa, Schulz, Harris, Silverman, & Thomas, 2009; Powell et al., 2019). Particularly for HIV testing which requires confidentiality and trust from health personnel, the acute underrepresentation of ACB men in the staffing of such institutions can result in the underutilization of services offered in these spaces (Quinn, Wolfe, & Vergeront, 2019). This is suggestive of the fact that ACB men's underutilization of HIV-related services is explainable within the current structural context where HIV-related health services tend to be geared

towards other high-risk groups (Husbands et al., 2014; Middleton & Francis, 2018). Some scholars therefore suggest that structural and cultural competence necessary for increasing the use of HIV-related services by ACB men may be lacking (Husbands et al., 2017; Wickham, 2017).

The socioeconomic and political contexts also represent underlying structural mechanisms and processes that ensure ACB men as a racial minority are not positioned to acquire resources needed to mitigate their exposure to health-compromising conditions (Solar & Irwin, 2010). This has been achieved by structuring ACB men into the lower echelons of various social hierarchies, thereby reducing their access to many socioeconomic and health resources (Husbands et al., 2014).

2.4.2. *Socioeconomic Position*

Measures of socioeconomic status; namely, educational attainment, occupation, employment and income tend to influence individuals' quality of health and susceptibility to diseases and infections. As these markers are generally correlated with morbidity and mortality, the observation that ACB men in North America score low on these measures puts them at increased risk of disease and infection including HIV (Isaacs & Schroeder, 2004; Rodney & Copeland, 2009; Williams, Mohammed, Leavell, & Collins, 2010). Compared to nonminority populations, racial minorities—particularly ACB men—are more likely to face economic discrimination, be unemployed or underemployed, live in poor housing and/or neighborhoods, experience incarceration, achieve low educational attainment, and lack comprehensive health insurance coverage (Geary, 2014; Husbands, Makoroka, & George, 2000). Invariably, the stratification of populations along the lines of socioeconomic status also stratifies health. Compared to racialized populations like ACB men, those with

high socioeconomic status enjoy better health outcomes (Navarro, 2009). Thus, ACB men are not only exposed to heightened HIV vulnerability, but also report general poor health outcomes including high blood pressure and cardiovascular complications (Williams & Mohammed, 2013; Williams et al., 2010).

Low socioeconomic status as experienced by ACB men directly acts to adversely impact their health by limiting their access to economic resources such as income. For those with higher socioeconomic status, these resources facilitate access to quality health services (Navarro, 2009; Raphael, 2006). Low socioeconomic status may also contribute indirectly to poor health by limiting access to social capital, and reinforcing other forms of social marginalization that reduce the dignity of life, leading to depression, anxiety, and feelings of shame (Marmot, 2005). For immigrant ACB men with a precarious immigration status, their exposure to health-compromising factors may heighten as they are forced into perilous employment, hopelessness, and structural challenges (De Maio, 2010; Grant, 2005; Lebrun & Dubay, 2010). In Canada, a precarious immigration status was found to be associated with both poor mental and physical health, and in some cases, denial of critical health services and care (Magalhaes, Carrasco, & Gastaldo, 2010). These legal and socioeconomic challenges imply that ACB men and indeed, members of the ACB community, face additional barriers and challenges that impede their effective utilization of health services including those that prevent and treat.

2.4.3. Social Class and Racism

Social class and experiences of racism are known to predispose racial minority populations to poor health outcomes. In the context of North America, racism and

race-based discrimination are either institutionalized or overt in relation to racial minorities' access to health services (Bailey et al., 2017; Hyman, 2009). The institutionalization of racism is reflected in the seeming policy disinterest in the design of interventions that prioritize the specific health needs of racial minority populations, despite being disproportionately burdened by, for instance, HIV morbidity and mortality (Bolton, Giger, & Georges, 2004; Egede, 2006; Jackson & Nadine Gracia, 2014).

In Canada, Frohlich et al. (2006) alludes to a persistent racial disparity and gradient in the quality of health between whites and racial minorities, despite Canada's claim to health equity and universal health care access. This is partly because Canada's health service delivery protocols which are mainly targeted at nonminority populations, lack cultural sensitivity to the health needs of racial minorities. In Toronto for instance, Amibor and Ogunrotifa (2012) revealed that, lack of cultural sensitivity in service delivery served as a major barrier to ACB people's access to HIV preventive services. Similarly, among racial minorities living with HIV, lack of cultural competence in health care delivery remained a key concern to seeking treatment (Barlow et al., 2008; Djiadeu et al., 2019). In health care spaces, minority populations report poor reception from health staff and practitioners that affect their willingness to return to these facilities and services (Egede, 2006; Levy, Ansara, Stover, & Health, 2013).

Furthermore, medical events of recent history such as the Tuskegee Syphilis study have created mistrust for medical spaces among ACB men contributing to their underutilization of health services (Alsan & Wanamaker, 2018; Scharf et al., 2010). Additionally, the stigma and stereotypes experienced by ACB men as 'active transmitters' of HIV work to exclude them as willing agents in prevention.

Specifically in London, Ontario, Canada, media reportage about Charles Ssenyonga, a Ugandan immigrant accused of deliberately infecting ‘innocent’ and unsuspecting women with HIV, exposed a racially biased and stereotypic depiction of ACB men as HIV spreaders (Husbands et al., 2017; Miller, 2005; Mykhalovskiy, Sanders, Hastings, & Bisailon, 2020). The entrenchment of these race-based stereotypes may be working to keep ACB men from the health care spaces where they can test, seek treatment, and information on HIV.

Evidence also suggests that some racial minorities who experience racism are more likely to purchase sex, engage in unprotected sex, and keep more than one sexual partner (Reed et al., 2013). Other coping strategies of racism include substance abuse, injection drug use, smoking, alcoholism, and violence, and a general sense of hopelessness which not only works to increase their vulnerability to HIV infection, but also exacerbates their poor health (Gardezi et al., 2008; Martin, Tuch, & Roman, 2003; Paradies, 2006). Furthermore, race-based discrimination for racial minorities disrupts the neuroendocrine function which affects the body’s metabolism; with adverse impacts on its ability to fight infection including the human immunodeficiency virus (Coburn, 2000).

Closely intersected with socioeconomic status, social class also underlies the poor health suffered by racial minorities and other marginalized populations. This is through their disconnection to the control of strategic and productive resources that can be leveraged to improve their health (Marmot, 1995, 2005). However, unlike socioeconomic status, social class further underscores how population health inequalities are informed by the control of productive resources, including physical, financial, and organizational assets (Solar & Irwin, 2010). Consequently, population health differences could be explained through an individual’s social class, given its

association with health enabling privileges and resources. Thus, controllers of productive resources who tend to have a higher social class report better health outcomes than those with low social class whose lives and material conditions are structured to be dependent on these productive resources (Muntaner Bonet, Borrell, Benach, Pasarín, & Fernandez, 2003; Solar & Irwin, 2010).

Given the history and place of racial minority populations, privileges associated with high social class (including quality healthcare) cannot be leveraged, especially for ACB people who do not control productive resources (Cooper, 1993). Therefore, understanding ACB men's health inequalities, including their HIV risk, should be broadly examined to include the structural processes that confine them to lower social and occupational classes where they are exposed to poor remunerations and economic inequalities (Solar & Irwin, 2010). Racial minority populations such as ACB men have livelihoods tied to low occupational class jobs because of their low social class status. However, these low occupational class jobs place greater demands on their health, with the potential to compromise the body's ability to prevent diseases and infections such as HIV (Bartley, 2003; Ravesteijn, Van Kippersluis, & Van Doorslaer, 2013). Despite this, ACB men as racial minority do not possess the relational power to influence how they are compensated, given that this power is vested in the predominant racial population who are the 'owners' and 'controllers' of these productive assets (Solar & Irwin, 2010).

2.5. Intermediary Social Determinants of Health

The structural determinants of health, directly and indirectly, impact people's health outcomes. The intermediary social determinants of health comprise all those factors that directly influence the multiple ways individuals are exposed to health-compromising conditions. These are identified to include the material circumstances

and living conditions, behavioral and biological factors, as well as psychosocial factors (Solar & Irwin, 2010). In the next paragraphs, I highlight how the deleterious socioeconomic condition of ACB men serves as conduit for reporting poor health outcomes including high HIV prevalence. In particular, I discuss behavioral and psychosocial factors as intermediary social determinants of ACB men's HIV.

2.5.1. Behavioral Factors for HIV Vulnerability

Masculinity beliefs and practices have emerged in discussing ACB men's risk of HIV infection. Masculinity is a fluid concept that underlies gendered societal power relations. It may encompass those ideologies that place men as 'superior' and perpetuates patriarchy through social interactions, sexual relations with women, norms on gendered roles, and expectations within households and the community at large (Bowleg et al., 2011; Bryce, 2018; Courtenay, 2000b).

Although evidence suggests masculinity beliefs and practices vary among ACB men based on factors including sociocultural and socioeconomic circumstances (Courtenay, 2000b), it emerges as a potential route to their risk of infection. Given their racial minority status, they are said to practice subordinate or more traditional forms of masculinity than hegemonic masculinity with increased implications for their health, including the risk of HIV infection (Connell & Messerschmidt, 2005; Jacques-Aviñó et al., 2019). Thus, while ideas about masculinity among men are linked to poor health outcomes, subordinate and traditional forms of masculinity practiced by marginalized men such as ACB men may endorse high-risk behaviors that impact their social and sexual relations and ways they respond to their health needs (Hammond, Matthews, & Corbie-Smith, 2010; Springer & Mouzon, 2011). For instance, endorsing traditional masculinities has been linked to a higher likelihood of endorsing high HIV risk behaviors such as partner concurrency, condomless sex, and

not testing for their HIV status or seeking treatment (Bowleg, Burkholder, et al., 2013).

It is therefore noteworthy that the ideas, understanding, and practices of masculinity among ACB men are shaped by their circumstances as defined by the structural social determinants of health. For instance, masculinity is differently practiced based on the intersections of race, sociocultural characteristics and socioeconomic position (Bowleg, 2004; Bowleg, Burkholder, et al., 2013). Among Black men who have sex with men and women, Mackenzie (2019) found that their practices of masculinity and sexual identities were influenced by the way they responded to the structural effects of racism, economic subordination and homophobia. Consequently, through mechanisms that keep ACB men economically marginalized and discriminated against, they are unable to achieve the 'ideal' White Eurocentric and hegemonic masculinity. Therefore they resort to subordinate and traditional masculinity constructs, which endorses behaviors such as suppression of emotions and vulnerability, toughness, and dominance in relationships (Courtenay, 2000b; Levant et al., 2003; Wade & Rochlen, 2013). These behaviors engender adverse health outcomes with direct implications for HIV vulnerability. In the broader context of years of structural violence against ACB people in North America, they may be expected to practice their masculinity in ways that are different from the Eurocentric hegemonic masculinity standards that further impacts their responses to HIV risk (Bowleg et al., 2011; Cooper, 2005).

Furthermore, while behaviors like condomless sex and partner concurrency are blamed for ACB men's HIV infection, existing evidence suggests that these are influenced by their socioeconomic and political contexts. For instance, experiences of racism, race-based discrimination, history of incarceration, homelessness, and

knowledge about HIV transmission influence sexual behaviors, including the inconsistent use of condoms (Hagiwara, Grollman, & Green, 2019; Kennedy, Nolen, Applewhite, & Waiter, 2007; Snowden, 2015). Consequently, ACB men who are more likely to experience multiple intersections of these race-based disadvantages are primed to have inconsistent use of condoms. Despite this, however, Daniels and Abma (2017) have shown that, among unmarried men in the US, ACB men were more likely to use condoms than Hispanic and non-Hispanic white men. Similarly, it was noted by Adimora, Schoenbach, and Doherty (2006) that although partner concurrency was high among ACB men, this might be because of the competition for ACB men due to the low ratio of men to women because of their higher death rates and incarceration levels.

Additionally, the structure of the health system creates differential access to health services based on social stratifications like race (Solar & Irwin, 2010). In Canada, evidence suggests lack of cultural competence in health service delivery directly works to compromise the quality of health, and health services for vulnerable groups such as ACB men (ICAD, 2008; Wickham, 2017). Downey and Manchikanti Gómez (2018) and other researchers have posited that the problem of structural incompetence in the health system arises from non-incorporation of the significance of social determinants of health for racial minorities and economically disadvantaged populations into the training of medical and health practitioners (Metzl & Hansen, 2014). In this regard, there is no consideration of how the material circumstances and social conditions of racial minorities impact their health and treatment choices.

This is closely tied to the lack of cultural competence where health services are carried out in tandem with orthodox and western-centered treatment protocols, which alienate subpopulations such as immigrants and cultural minority groups (Capell,

Dean, & Veenstra, 2008). For Canada, which receives high volumes of immigrants, and encourages multiculturalism, health and healthcare could potentially have different culturally ascribed meanings and practices which might be an effective utilization of health services by immigrants, racial and cultural minorities (Kalich, Heinemann, & Ghahari, 2016; McKeary & Newbold, 2010; Richmond & Big-Canoe, 2013). To increase health service utilization for Black Canadians, Wickham (2017) has called for the design of culturally appropriate services targeting this population. Specifically, targeting ACB boys and men with culturally sensitive HIV prevention materials has been recommended as a solution to meeting their unique HIV needs (ICAD, 2008).

ACB health personnel and professionals working in medical and AIDS Service Organizations (ASOs) in Canada have been involved in attempts to mainstream culturally competent services for ACB people (Baidoobonso, 2019; ICAD, 2008). For example, Afro-Caribbean medical personnel and other professionals are involved in the design of health services and programs that specifically target the health needs of ACB people. This was observed to have increased the use of health services by members of this population (Wickham, 2017). In addition to this, ACB medical personnel have collaborated with ASOs and other health institutions to lobby and draw policy attention to the HIV needs of the ACB community emphasised the need for cultural competence and service sensitivity to the needs of the ACB community (Baidoobonso, 2019; Wanigaratne et al., 2020). Prominent among these organizations, especially in Ontario, where most ACB people in Canada live are the Canadian HIV/AIDS Black, Africa and Caribbean Network (CHABAC), Black Coalition for AIDS Prevention (BLACK CAP), Women's Health in Women's Hands (WHIWH);

Africans in Partnership Against AIDS (APAA); the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) (Baidooobonso, 2019).

2.5.2. Psychosocial Factors

Population health disparities have also been viewed through the psychosocial circumstances of people within a population. As intermediary social determinants of health, psychosocial factors encompass ways in which people's experiences and perceptions of their living and material influence their bodies' susceptibility to poor health outcomes (Cassel, 1976; John Lynch et al., 2001; Solar & Irwin, 2010). That is deprived populations' vulnerability to poor health hinges on their being aware of their precarious socioeconomic circumstances compared with those of privileged and wealthier community members. Invariably, these comparisons create a sense of shame, underachievement and worthlessness for economically disadvantaged people such as ACB men, leading to the build up of chronic stress which directly impacts their health (Cassel, 1976; Wilkinson, 1997a, 1997b).

In North America, these factors are heightened as ACB people are structured into the bottom of social hierarchies with poor material conditions (Geary, 2014; Husbands et al., 2014). In a review, Thorpe and Whitfield (2018) underscored how psychosocial factors partly explain ACB men's poor health in the US, given the toxicity of the social environment they live in. ACB men, cognisant of their place in an unequal society, coupled with experiences of racism and race-based discrimination, are exposed to more stress and neuroendocrine disruptions which reduce the bodies' ability to maintain good health and fight viral infections such as HIV (Coburn, 2000; Seiler, Fagundes, & Christian, 2012). Furthermore, from the life course perspective, ACB men could have a reduced capacity to fight infectious diseases because of the

deplorable state of their material circumstances from conception to adulthood to death (Lynch & Smith, 2005).

These factors (i.e., structural and intermediary social determinants of health) through interactions and feedback mechanisms as shown in Figure 3, not only work to ensure that socially vulnerable and structurally exposed populations such as African Caribbean men suffer health inequity, but that they also heighten their health disparities over time (Solar & Irwin, 2010). Evidence that the proportion of HIV infections through other risk exposure categories are declining, while those of African Caribbean men are soaring, affirms the need to understand their exposure and vulnerability through the lenses of the SDH.

2.6. Summary

In this chapter, I provided a historical account of HIV in the context of North America, and discussed its epidemiological changes focusing on the most vulnerable groups in the last three decades. Subsequently, I specifically laid out the complex HIV vulnerabilities of heterosexual African Caribbean men and contextualized them within the social determinants of health framework. In the process, I provided a holistic perspective on the factors and interconnected pathways through which structural dynamics contribute to the HIV vulnerabilities and poor health outcomes of African Caribbean men.

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CHAPTER THREE

3.0. STUDY CONTEXT, DESIGN AND IMPLEMENTATION

3.1. Introduction

While this dissertation was conceptualized, designed and implemented as one holistic study, the adoption of the integrated thesis format makes the next three chapters seem fragmented and disconnected from each other. In this chapter, therefore, I present the overall research design and implementation and how other processes in the research were informed and linked to the dissertation's subjectivist ontological and interpretivist epistemological underpinnings. Overall, the chapter expands on the methods section in each of the next three empirical manuscripts (*i.e.* chapter 4, 5 and 6) and explains the appropriateness of a qualitative approach in examining the posed research questions in the dissertation as a unit. I begin the chapter by discussing the key characteristics of the study context, with a focus on access to healthcare, and conclude with a summary of the key aspects of the chapter.

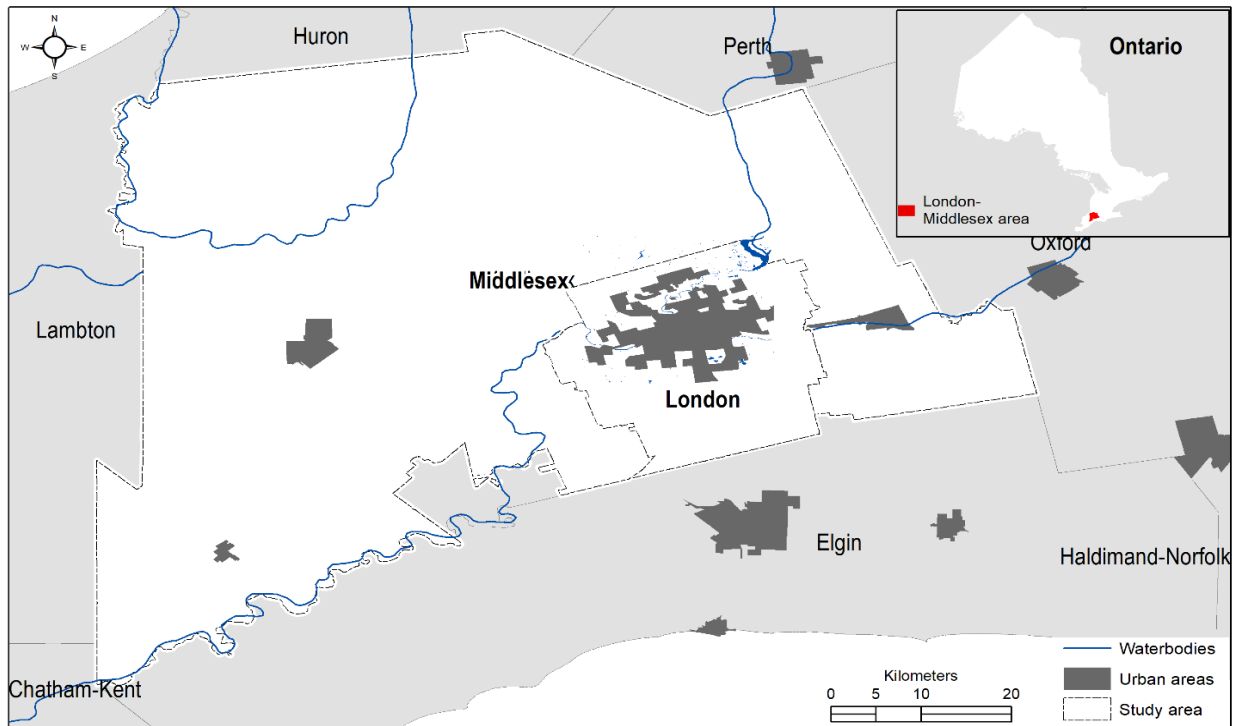
3.2. Study Context

London, Ontario, is a mid-size city in the Canadian province of Ontario, and the largest city in Middlesex County in Southwestern Ontario (see Figure 4). In the 2016 Canada Census, the population of the city was 383,822, representing a growth of 4.8% from the 2011 Census (Statistics Canada, 2017). In 2018/19, London's population increased by 2.3%, which was the second highest in Canada for this period (CBC London, 2020). By population size, London is the 15th largest city in Canada, and the 6th largest in Ontario (City of London, 2020b). Between 2006 and 2011,

London experienced a net migration of 94%, but this declined to 89% between 2011 and 2016. While international migration has traditionally been the leading contributor to the city's population growth and accounted for 71% of the increase between 2011 and 2016, this has been dwindling and giving way to intra-provincial migration over the past fifteen years (Edwards, 2018). Immigrants constitute 22% of the city's residents, which is slightly below Ontario's average of 29% (City of London, 2020a). Visible minorities make up 19.5% of residents with majority being Arab (18%), South Asian (16%) and Black (15%). As a percentage of the overall population, ACB people constitute only 2.6% (City of London, 2020a; Statistics Canada, 2017).

The London population generally enjoys relatively easy access to health care. A study on geographic access to health care in Southwestern Ontario revealed that in the London Census Metropolitan Area and region, residents in the city reported the best access to health care (Shah, Clark, Seabrook, Sibbald, & Gilliland, 2020). Furthermore, a 2016 report indicated that relative to other sub-Local Health Integration Networks (LHIN) in Southwestern Ontario, London-Middlesex was the only locality with enough primary health care providers. Of the 312 primary health providers in the region, 86% of them were located in this city (Human Environments Analysis Laboratory, 2016). Overall, 63% of residents of London-Middlesex reported excellent general health while 74% indicated excellent mental health. Similarly, residents in London had the lowest prevalence of obesity in the region. London's apparently good health care accessibility may be because of the city's status as a medical hub of the Southwestern Ontario corridor.

Figure 4: Map of Study Area—London and Middlesex Area, Ontario



Source: The author owns the copyright to this map

Despite these positive indicators, the Human Environments Analysis Laboratory report of 2016 found stark health inequalities in the city. For instance, racial minority populations, immigrants, the economically disadvantaged, and other socially vulnerable residents faced barriers in accessing primary health care compared to whites (Human Environments Analysis Laboratory, 2016). Among major barriers to these disadvantaged groups' access to health care are language, and 'poor timely access' to medical appointments. Furthermore, the report indicates that there are complaints of situations where some residents are unable to have all their medical concerns addressed. It further noted that, residents in the city had the lowest accessibility to team-based medical care (Human Environments Analysis Laboratory, 2016). The precarious employment of immigrants also gave them limited options for

seeking and honouring medical appointments, and in poor residential neighborhoods, there was an acute need for primary health care.

Other researchers have reached similar conclusions whereby racial minorities in the city face many challenges and barriers to utilizing health care services. Both Indigenous and Black populations in London reported additional barriers accessing needed medical care and were also more likely not to have a family physician (Konkor, Lawson, et al., 2020; McConkey, 2017). The persistence of these health access barriers for racial minorities in the city may have compelled some ACB men who reported racism in health facilities to resort to health care outside the city (Baidoobonso et al., 2010; Baidoobonso et al., 2012). These studies have therefore called for structural competence and cultural sensitivity in attending to the health care needs of immigrants and racial minorities in the city.

Furthermore, the London-Middlesex Health Unit indicated alarming rates of infectious diseases, particularly HIV and hepatitis C leading to the declaration of a medical emergency in 2016. From 2005 to 2015, HIV prevalence rates for the city almost doubled, from 5.9 cases per every 100,000 to 9 cases per 100,000 (Spalding, 2016). Comparatively, the reported HIV prevalence rates for Ontario and Canada in 2015 were 6.1 and 5.8 per 100,000 respectively (Public Health Agency of Canada, 2016). Additionally, there has been a surge in hepatitis C cases by as high as 60%. Thus, while the Ontario provincial prevalence rate was 30.2 per 100,000, that of London was 53.7 per 100,000 in 2015 (Public Health Ontario, 2017; Spalding, 2016). Suggestions that rising drug use may be driving the high prevalence of infectious diseases in the city resulted in the declaration of a medical emergency followed by the implementation of programs in response to these trends. These programs included the supply of free needles, and the creation of safe spaces for supervised injections by the

Regional HIV/AIDS Connections (Dubinski, 2017; Middlesex-London Health Unit, 2019). While these steps by the city's health authority and affiliated agencies are laudable, what is missing are specific strategies to address rising heterosexual infections, which the Public Health Agency of Canada suggests disproportionately affect the ACB community.

3.3. The weSpeak Study

The weSpeak study project was implemented from 2016-2020 in four cities in Ontario; namely, Ottawa, Toronto, London, and Windsor. It was funded through grants from the Ontario HIV Treatment Network (OHTN), and the Canada Institutes of Health Research (CIHR). The study project is a follow up to findings from an earlier exploratory study in Ontario called iSpeak (2011-2013), which sought to explain the HIV-related health needs of people of ACB descent in London and Toronto. iSpeak recommended focused attention on heterosexual ACB men who may face peculiar challenges and barriers in their everyday lived experiences that could potentially increase their exposure to HIV. Furthermore, heterosexual ACB men remained an understudied population whose risk to HIV infection had not generated enough academic enquiry.

Given this context, weSpeak aimed to present a holistic understanding of the underlying factors that make heterosexual ACB men vulnerable to HIV through a community engaged study approach. Findings from this study are intended to refocus health policy on heterosexual ACB men's health needs as a way of reducing their exposure to HIV. Consequently, weSpeak set out to examine heterosexual ACB men's HIV vulnerability at the nexus of behavioral and structural factors. For instance, given

the link between men's health behavioral characteristics and endorsement of traditional masculinity ideations, part of the weSpeak research focus was to understand how these masculinity practices potentially influenced ways heterosexual men respond to their risk of HIV infection. This approach is significant in the literature given that previous studies had privileged biomedical perspectives of populations' risk to infectious diseases, thus missing the potential role of structural factors. For instance, structural policies on health care including health policy design and implementation, type and availability of health services, and HIV sensitization strategies work to directly impact a population's risk to HIV infection.

Furthermore, the weSpeak study was also focused on building the resilience of ACB men by first documenting their resilience trajectories and strategies in avoiding HIV infection. In this regard, knowing which protective assets, and ways these assets are employed by heterosexual ACB men to reduce their risk of HIV infection could be useful if upscaled and implemented by policy as part a holistic paradigm to address their HIV needs. Overall, the weSpeak study engaged heterosexual ACB men in critical dialogue about their HIV vulnerability and ways they can build resilience to new infections.

3.4. Study Design

The weSpeak data collection took place in two phases. The first phase was dedicated to the collection of qualitative data while the second phase collected quantitative data. The qualitative data formed the focus of this dissertation. The use of a qualitative approach was necessitated by the research questions which constitutively were intended to provide depth to ACB men's HIV vulnerability at the intersection of

behavioral and structural risk factors. This study, therefore, provided the target population the opportunity to share their stories, views and represent themselves in discourses about their own vulnerability to HIV.

Based on the dominance of the biomedical approach to HIV risk, the few existing studies on HIV-related health care needs of ACB men have provided limited space for the participation of the study population in study design and implementation. Most of these studies have applied universal concepts and standards of HIV vulnerability which often missed contextual nuances particularly the unique dynamics in ACB communities. This does not only make heterosexual ACB men voiceless in the academic construction of narratives of HIV risk, but it also limits our knowledge of how they perceive their own risk and the resources they deem essential to building their resilience to HIV. Concomitantly, given the context-specific influence and dynamics of a population's exposure to infectious diseases, emphasis on a qualitative enquiry is highly useful to unpacking the underlying and unobserved factors that inform health behaviors and health care access. The use of a qualitative approach further underscores the interpretivist positioning of this thesis within the social determinants of health theoretical underpinnings discussed in Chapter 2.

The design of this study is guided by some ontological and epistemological assumptions. Ontology is concerned with 'reality' or the nature of 'existence' or 'being' (Packer & Goicoechea, 2000). Emanating from this, reality is seen through two broad lenses: 'objectivity' and 'subjectivity' based on the researcher's perspective on how to deduce knowledge from this reality. Thus 'objective reality' assumes that what we know as knowledge exists outside our human sensory experiences, while for 'subjective reality' knowledge is seen as a derivative of our experiences and interactions with and within our environment (Lincoln, Lynham, & Guba, 2011;

Packer & Goicoechea, 2000; Sandberg, 2005). Epistemology on the other hand, addresses the issue of ‘knowing’ by posing questions about how we can access knowledge through both the ‘objective’ and ‘subjective’ realities (Lincoln et al., 2011; Sandberg, 2005). Consequently, epistemology focuses on the validity of the processes in deriving this knowledge and setting the limits of its applicability based on the inherent assumptions about the process (Aitken & Valentine, 2006). To unpack and simplify these realities of existence and the process of knowing, theories (including Intersectionality and Critical Race theory) are employed to contextualise these epistemologies.

Following from the ongoing discussion, scholars tend to discuss HIV-related needs and resilience trajectories of populations through objectivist and interpretivist epistemologies. Objectivism serves as a precursor to the biomedical view of HIV transmission where reducing a population’s risk requires adherence to preventive strategies such as consistent and correct use of condoms (Adam, 2011; Geary, 2014; Wilson, 2000). However, with the subjective and interpretivist tradition within which this dissertation is situated, HIV infection is not merely a viral-host relationship, it encompasses a range of social interactions and factors that shape people’s exposure to the virus. While there is a recognition that HIV transmission is only biologically plausible, interpretivist epistemology recognises that exposure to the virus is differentially experienced based on diverse individual social realities and positions.

Accordingly, social characteristics including race, gender, socioeconomic status, sexuality, and immigration status are indispensable to unpacking people’s vulnerabilities to HIV. In this regard, our knowledge about HIV risk for a defined population can largely be described as situational and based on existing contextual characteristics (Broom & Willis, 2007; Turyahikayo, 2014).

Furthermore, Sayer (1992) opined that describing research as quantitative or qualitative only highlights the methods used. Therefore, describing research as either *extensive* or *intensive* more accurately communicates the type of knowledge to be produced and its assumptions. Thus, the intent of an extensive research design underpinned by the objective epistemology aims at highlighting patterns, trends, commonalities and differences that can be generalizable in a broader context. The intensive approach as adopted by this thesis, focuses on localized processes and how they inform and mould a phenomenon of interest (Dixon, 2014; Andrew Sayer, 2010). In this regard, the epistemological and ontological assumptions about the nature of knowledge to be produced by this dissertation informed the choice of research questions which constitutively was to have an in-depth understanding of how heterosexual ACB men become vulnerable to HIV, and ways through which they build resilience against it. Health geographers have also emphasized the importance of the intensive approach to enquiry if the intention of the researcher is to seek in depth rather than broad generalized findings (Baxter & Eyles, 1999; Elliott, 1999; Gatrell & Elliott, 2014).

Given its interpretivist inclination, this work specifically draws on intersectionality theory, and critical race theory to guide and unpack the social determinants of ACB men's heightened HIV risk. The use of intersectionality theory as propounded by Kimberlé Crenshaw in 1989 expands our understanding of how race interacts with other socially defined identities to produce margins of vulnerability that intersect to expose people to undesirable outcomes such as poor health. Similarly, critical race theory helps to contextualize how race in a racially hierarchical society becomes an indispensable medium through which people access important health and

socioeconomic resources that in/directly impact their quality of life (Freeman et al., 2017; Yosso, 2005).

In both extensive and intensive research design, researchers have strived to ensure rigour in the validity and reliability of research findings. While rigour in extensive research design is established through the replicability and generalizability of findings, rigour in intensive research varies widely depending on the specific approach used. Nevertheless, validity for intensive designs revolves around credibility, transferability, confirmability, and the exactness with which the phenomenon under study is reported in the findings (Baxter & Eyles, 1997; Lincoln et al., 2011). To achieve rigour in intensive research, attention is paid to the framing of questions and ways in which they are posed to research participants. Furthermore, the interpretation of participants' voices is presented in ways that do not distort or misrepresent the original meanings and intents of the study participant.

For this dissertation, I ensured rigour in three ways. First, with the mixed qualitative approach, I verified emerging themes from the focus groups during the one-on-one in-depth interviews where participants were able to discuss the validity or lack thereof of these themes. Some scholars have suggested that such an approach of implied triangulation is employed in qualitative research to ensure rigour (Barbour & Morgan, 2017; Dixon, 2014). Secondly, the research employed both snowballing and random sampling strategies to recruit participants from varying backgrounds and experiences to fully capture the diversity of the ways they responded to the risk of HIV infection. Thirdly, there was constant cross checking with members during interview sessions where participants' responses were repeated back to them verbatim by the interviewer to ensure that they were accurately captured and communicated during data analyses and presentation of findings.

An intensive research design encourages that researchers state their positionality and how that could have affected the study (Lincoln et al., 2011). I identify as a black immigrant heterosexual male living in London, Ontario. My positionality afforded an insider status within the ACB research community and although the research benefitted from this position especially during the recruitment stages, I acknowledge it could have potential bias in how I analysed and interpreted study findings.

As an insider, it was easier for me to establish trust with my research participants who openly shared with me their experiences of vulnerability and resilience to HIV. For instance, during participant recruitment, some of the participants expressed how happy they were that someone from the ACB community was doing this research. Some of them referred to me as ‘bro’ in a way reducing the potential power differences between me as a researcher and my participants. They were comfortable to share their experiences with me during the data collection stages especially in getting them to open-up during both focus group discussions and in-depth interviews. Drawing on my lived experiences as an immigrant, I was able to connect with participants who were immigrants or had parents or grandparent who had migrated to Canada. These personal connections foregrounded my initial discussion with participants on the relevance of the study since I aim to draw policy attention on better ways to tailor HIV services to serve the ACB community. This resulted in the collection of rich and varied data that adequately captured the wide spectrum of individual and structural vulnerabilities for this population.

During data analysis, interpretation and writing, my lived experiences as a Black male clarified and contextualized ACB men’s perspective on how they become vulnerable to HIV and what resources are needed in positioning them to overcome the

HIV adversity. While my insider positionality had the utility of breaking down barriers between me and ACB men, and ensuring my access to information, it was difficult to detach myself from the shared experiences of participants and this could have potentially influenced me in an unconscious way with data interpretation and writing (Merriam et al., 2001; Chavez, 2008; Berkovic et al., 2020). Potential biases that could have resulted from my positionality were addressed during data coding and analyses stages when the team used member-checking techniques to ensure data quality.

3.5. Research Implementation

This research was implemented between February 2016 and April 2017. Approval for the study was given by the Western University Non-Medical Research Ethics Board in 2015. Actual field data collection took place from November 2016 to April 2017 for the qualitative phase of the weSpeak study. In the periods leading to data collection, the weSpeak research team in London held a series of meetings to identify the various ways and venues of recruiting our study population. These meetings were deemed necessary because the ACB population in London Ontario is less than 5% of the city's total population and the targeted heterosexual ACB male population needed for the study was even smaller and harder to find and recruit.

weSpeak Ontario developed the data collection protocols with the participation of all four local sites (Ottawa, Toronto, London, Windsor). Per these protocols, all sites used the same interview guide with little modification. The Research Coordinator (who had extensive experience in conducting qualitative research) and I, familiarized ourselves with the interview guide by organizing mock interview sessions for both focus groups and in-depth interviews. Through this, we became aware of the questions that required further probing and clarity during the actual interviews. For example,

while the word 'heterosexual' was commonly used in the interview guide, we quickly discovered during the mock interview sessions that the word 'straight' was more appropriate during interviews because it did not lead to follow-up questions from participants on its meaning and connotation. These trial interviews also helped us to develop clear communication strategies for all questions and study participants thereby easing actual data collection.

As part of our strategies, the interview team visited service spaces in London which attracted ACB men such as Black-owned/operated barbering salons, eateries, cafes, restaurants, grocery shops, mosques and churches. We also recruited study participants at social events such as soccer games and food fairs as well as activities to mark the Black history month within the community. We also posted study participant recruitment flyers at major area hospitals and at the offices of various AIDS Service Organizations, including the Regional HIV/AIDS Connections (RHAC) that serve ACB people. While we recruited most of our participants through random intercepts at the spaces and activities noted above, we recruited others through snowball sampling and referrals. We also got some participants from which posted notices asking prospective participants to contact designated persons.

The Research Coordinator screened all prospective participants to ensure that they were eligible to participate in the study. The ACB men who qualified to participate in the study were those who self-identified as heterosexual, 16 years or older, spoke English, lived in London, Ontario, and agreed to give a written or verbal consent to be interviewed. These were then invited to participate in the focus groups or the follow-up in-depth interviews. Focus groups took place at the RHAC and a popular Black salon in downtown London. Overall, a total of 30 heterosexual ACB men were recruited for this phase and they participated in three focus groups and

thirteen in-depth interviews. The demographic characteristics of the ACB men who participated in in-depth interviews and focus groups are presented in Table 1.

Table 1: Socio-demographic characteristics of in-depth interviews and focus group participants

Participants Characteristics	Frequency (n=30)	Percentage %
Ethno-identity		
African	12	40.0
Caribbean	10	33.3
Black	8	26.7
Region of Birth		
Africa	7	23.3
Caribbean	5	16.7
Canada	16	53.3
Other	2	6.7
Immigration Status		
Canadian Citizen	23	76.7
Landed immigrant/Permanent citizen	4	13.3
Refugee/Protected Person Claimant	2	6.7
Other/Student Study Visa	1	3.3
Age		
16-24	8	26.7
25-38	12	40.0
39+	10	33.3
Employment Status		
Employed	12	40.0
Self-employed	6	20.0
Student/part time	7	23.3
On disability	3	10.0
Unemployed	2	6.7
Annual Income (CAD\$)		
<20,000	18	60.0
≥ 20,000	12	40.0
Educational Attainment		
High school or less	12	40.0
Some college/university/completed college/university	18	60.0
Masters or higher		
Marital Status		
Married or common law	10	33.3
Single (never married/divorced/separated)	20	66.7
HIV Status		
HIV+	3	10.0
Never tested/don't know/HIV-	27	90.0
Religion		
African Traditional	1	3.3
Christian	22	73.3
Muslim	3	10.0
Other/no religion	4	13.3

To get diverse perspectives on issues surrounding the target populations' vulnerability and resilience to HIV, Service Providers were also recruited for a focus group (*see* Table 2 for the characteristics of this sample).

Table 2: Socio-demographic characteristics of focus group for service providers

Participants Characteristics	Frequency (n=7)	Percentage %
Ethno-Racial Identity		
African/Caribbean/Black	3	42.9
White/Caucasian	4	57.1
Country/Continent of Birth		
Canada	5	71.4
Africa/Caribbean	2	28.6
Gender		
Male	5	71.4
Female	2	28.8
Age (years)		
30-39	1	14.3
40-49	3	42.9
50+	3	42.9
Professional Background		
Medicine/Nursing/Public Health	2	28.6
Social Work/Community Services/Chaplaincy	4	57.1
Other	1	14.3
Nature of Agency		
AIDS Service Organization	3	42.9
Community Health Organization	1	14.3
Settlement and newcomer services	1	14.3
Health Clinic/Hospital/Public Health Agency	1	14.3
Other	1	14.3
Type of Service		
Medical/Dental care		
Mental Health Services/Counselling	1	14.3
HIV/AIDS & Sexual Health Support	4	57.1
Other	2	28.6
Years at Agency		
<10 years	1	14.3
≥10years	6	85.7
Religion		
Christian	6	85.7
Other/no religion	1	14.3

The recruitment of these providers was through flyers posted at their workspaces and through snowball methods. Eligibility for Service Providers was based on serving at the frontline of HIV healthcare service delivery for a minimum of at least five years, which would have given the person enough experience and knowledge to talk about how ACB men access their services. Race, gender and sexual orientation were not used as eligibility criteria for this group in order to get the perspective of providers regardless of their backgrounds. Overall, a total of seven Service Providers took part in one focus group.

3.6. Conclusion

In this chapter, I explored access to health care in the study context with particular focus on the challenges and barriers that racial minorities face in accessing these services. I then proceeded to give the ontological and epistemological underpinnings of this dissertation while discussing the use of an interpretivist and a qualitative addressing my research questions. In the last section of this chapter, I detailed the design and implementation of the study.

3.7. References

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CHAPTER FOUR

4.0. UNCOVERING HIV VULNERABILITIES BEYOND THE USUAL LAYERS: CONTEMPORARY MASCULINITIES AND HETEROSEXUALITY OF THE BLACK MAN IN LONDON, ONTARIO, CANADA

Abstract

Despite Canada's low HIV prevalence, heterosexual African, Caribbean and Black (ACB) men are overburdened with HIV infections. From a behaviorist perspective, studies have suggested that practices of traditional masculinities are key they drivers of new infections because they endorse high-risk behaviors. Others have also highlighted complex pathways through which ACB men engage with their masculinities to address health-related challenges. Informed by these, we draw on analyses of interviews (n=13) and focus group discussions (n=17) with heterosexual ACB men in London, Ontario, to understand how masculinities are practiced in response to HIV. Our findings suggest that performing masculinities as a racial marker may predispose some ACB men to a high-risk of HIV infection. However, the practice of alternate and emerging masculinities empowers ACB men to reduce their risk of infection and to build resilience. It is advisable for health policy stakeholders in Canada to leverage these findings to reduce new HIV infections among heterosexual ACB men.

4.1. Introduction

Canada's low HIV prevalence tends to mask the realities of higher infection rates among minority populations. For instance, although people of African, Caribbean, and Black (ACB) descent make up less than 5% of Canada's population, they account for 25% of people living with HIV in the country (Haddad et al., 2018). Furthermore, ACB people account for 17.5% of all new HIV infections and are 12.5% more likely to be newly infected compared to others in the general Canadian population (Haddad et al., 2018). It is estimated that new HIV infections among ACB people might continue to worsen in the absence of adequate policy responses (Public Health Agency of Canada, 2013). This is because heterosexual risk exposures, which account for more than 89% of all reported HIV cases among Blacks, have been rising over the last three decades in Canada (Public Health Agency of Canada, 2013). While ACB women are acknowledged as a vulnerable group within the ACB community, heterosexual ACB men are emerging as a high-risk group who still do not attract enough policy attention with regards to HIV exposure (Husbands et al., 2019). Accordingly, it was reported by Remis, Swantee and Liu (2012) that ACB men accounted for 60% of all new HIV diagnoses in the ACB community, through heterosexual exposures. Furthermore, between 2015 and 2016, heterosexual ACB men accounted for 17% of HIV infections among men and 16.5% of new HIV diagnoses in Ontario (Haddad et al., 2018).

It has been suggested that although most men practice some forms of masculinity, ACB men are more likely to practice traditional masculinity, and this could be increasing their susceptibility to HIV infections (Bowleg & Raj, 2012; Husbands et al., 2017). Masculinity encompasses the ideologies that define social interactions, sexual relations, gendered roles, and expectations tied to beliefs about

men's superiority, and this tends to adversely impact their health needs (Bowleg et al., 2011; Bryce, 2018; Courtenay, 2000b). For instance, Courtenay (2000) suggests that traditional beliefs of masculinity where men are expected to be tough and naturally resilient, discourage access to preventive healthcare, including HIV testing. Similarly, holding traditional views of masculinity may encourage sexual risk-taking (Nelson et al., 2019). Taken together, practices of masculinity among ACB men are argued to be particularly harmful to their overall health – specifically to their exposure to HIV.

However, there is still a lack of in-depth focus on how ACB men's varying masculinity beliefs and practices intersect with their vulnerability to HIV infection. In this paper, we specifically sought to examine ways heterosexual ACB men's construction of masculinity and lived masculinities may be responding to HIV risk in the context of London, Ontario. The study forms part of a larger research project in Ontario, Canada, which aims to contextualize HIV vulnerability and resilience trajectories among heterosexual ACB men. The weSpeak project uses a multidisciplinary community-based approach to engage community stakeholders, including policymakers and service providers, in critical dialogue on ways to reduce HIV vulnerability among heterosexual ACB men and to help build their capacity to be resilient to new infections.

4.1.1. Masculinities and ACB men's health

Generally, men's endorsement of hegemonic and traditional masculinities is observed to negatively impact their overall health outcomes. According to Bowleg et al. (2011), masculinity among men encompasses those ideologies that place them as 'superior' and perpetuate patriarchy by defining social interactions, sexual relations with women, norms on gendered roles, and expectations within households and the community at large. It is contended by Courtenay (2000) that although these

ideologies of masculinity are pervasive among all men, it is practiced differently based on intersections of race, class, sexuality, and socioeconomic status. Earlier scholars have posited that, in North America, ‘hegemonic’ or ‘ideal’ masculinity tends to be Eurocentric and connotes self-confidence, dominance, higher social status, and class. Other connotations include serving as a provider and protector, being tough and unfeminine, and suppressing emotions (Bryce, 2018; Levant, Hirsch, Celentano, & Cozza, 1992).

Given the intersection of these factors and the difficulty of ACB men in achieving the ideal Eurocentric masculinity, they are said to compensate by practicing more ‘traditional’ forms of masculinity—defined as entrenched beliefs and the endorsement of behaviors and activities typically considered to be within the domain of men or women (Kachel, Steffens, & Niedlich, 2016; Mankowski & Maton, 2010). It is argued that traditional masculinity encourages attitudes and behaviors that have a devastating impact on men's health. For instance, embodying toughness and aggression, endorsing anti-feminine conduct, and showing dominance in relationships with women have both direct and indirect impacts on men’s health behaviors and exposure to HIV (Bowleg et al., 2011; Malebranche, Fields, Bryant, & Harper, 2009). For instance, in demonstrating masculinity through sexual performance, men tend to prove their manliness and dominance over women through sexual prowess such as sustained penile erection, prolonged sexual activities and sexual intercourse with many women (Connell, 1995; Szasz, 1998). Also, partner concurrency, non-adherence to condom use, and poor use of preventive health care have implications for their risk to HIV infection (Courtenay, 2000b; Loutfy et al., 2012).

However, this behaviorist understanding of ACB men’s masculinity and its nexus with health behaviors does not account for the role of contextual and structural

determinants of HIV infection (Husbands et al., 2019). Furthermore, this understanding ignores critical issues of existing structural deprivation which could influence masculinity beliefs and practices, as well as adherence to condom use, partner concurrency, and the use of preventive health care such as HIV testing (Higgins, Hoffman, & Dworkin, 2010; Walcott, 2009). For instance, the observed influence of socioeconomic status on masculinity expectations makes ACB men particularly vulnerable to poor health outcomes. This is because ACB men may prioritize meeting economic obligations which compete with the need to make time to meet their health needs (Moreno-Bella, Willis, & Moya, 2019). Particularly in North America, the precarious economic position of ACB men implies they may demonstrate their masculinities in ways that are different from Caucasian men who have relatively better access to economic opportunities (Malebranche et al., 2009).

Similarly, it is argued that years of 'Jim Crow' which legitimized the political and economic subordination of ACB people in North America may have influenced legacies of masculinity, and how differently ACB men express these masculinity expectations compared to the Eurocentric hegemonic masculinity expected for other men (Malebranche et al., 2009). In this regard, the historical and racialized masculinity expectations and stereotypes for ACB men may be informing the narrative surrounding HIV infection, purporting that HIV risk is largely mediated by behavior. Through this understanding, HIV risk is preventable through modifications to the masculinities of ACB men (Bowleg et al., 2011; Courtenay, 2000b; Husbands et al., 2017). Consequently, this framing of ACB men's HIV risk may have adversely impacted their inclusion in HIV intervention programs and disproportional incarceration in HIV non-disclosure cases in Canada (Higgins et al., 2010; Mykhalovskiy & Betteridge, 2012). Therefore, the focus of this study is to have an in-

depth examination of how ACB men's masculinity beliefs and practices intersect with their HIV vulnerability using the context of London, Ontario.

4.2. Theoretical Context

This study draws on Critical Race Theory (CRT) to contextualize heterosexual ACB men's poor health outcomes, including HIV infection, relative to non-racialized groups. "CRT's major premise is that society is racially stratified and unequal, where power processes systematically disenfranchise racially oppressed people" (Hylton 2012, pg 1). Racial minority groups are confined to the margins of society, through covert mechanisms such as negative stereotypes as well as more overt discrimination such as restrictions in access to resources (Geary, 2014). Despite the semblance of some progress in outlawing overt race-based discrimination, it has persisted given its institutionalization in many facets of western society. It is, therefore, observed that, in racialized societies such as Canada, racial minorities may still face challenges in accessing resources which could enhance their health (Frohlich et al., 2006; Gosine & Pon, 2011).

In North America, in particular, years of systemic racism have marginalized racial minority populations. Therefore, ACB men's current health disparities, including their risk of HIV infection, may be premised on a colonialist antecedent where the health needs of the 'racial other' is not prioritized. For instance, the lack of cultural competence in health service delivery is a persistent barrier for racial minorities' (including recent immigrants of color) access to health services (Baidooonso et al., 2012; Derose, Escarce, & Lurie, 2013). Furthermore, a racially structured society not only makes ACB men structurally predisposed to live in poor housing and to be under/unemployed, but also to experience limited health insurance

coverage that circumscribes their access to quality healthcare (Baidooobonso et al., 2012).

Additionally, heterosexual ACB men's disproportionate HIV vulnerability is also stereotyped and reinforced by scholars as mostly behavioral and, therefore, 'self-inflicted' (Geary, 2014). As a result, while high HIV prevalence among other high-risk groups is recognized as a legitimate public health concern that needs immediate attention, heterosexual ACB men are yet to receive health policy attention and prioritization. The intersection of heterosexual ACB men's race and low socioeconomic status and class feeds into an existing discourse about how their masculinity practices may be the bane of their general poor health outcomes (Husbands et al., 2017). Consequently, the problematic characterization of ACB men's HIV infection is predicated on existing imagery of heterosexual ACB men as reckless 'transmitters' of HIV. In this regard, heterosexual ACB men are captured in HIV discourse as culprits rather than people whose circumstances merit immediate public health attention (Geary, 2014; Miller, 2005). The entrenchment of masculinity stereotypes and expectations, including notions that 'black heterosexual men are tough and do not show weakness' and 'black heterosexual men are hyper-sexual' may lead to the internalization and acting out of these stereotypes, that may further drive new infections in the community (Bowleg et al., 2011; Cooper, 2005). Over time, these stereotypes are also framed as social vulnerability, where ACB people's cultural beliefs and practices are perceived to contribute to their increased exposure to HIV.

Conscious of how these stereotypes are mainstreamed into knowledge production and reproduction, CRT challenges these assertions and knowledge production processes, especially those related to race. CRT elucidates racial minorities' perseverance in the face of social, economic, and political adversities

through community mobilization, language, family, and resistance initiatives in fighting inequalities (Sonn & Fisher, 1998; Yosso, 2005). In line with this, CRT scholars have challenged existing notions of ACB people's 'deficient' social capital and cultural resources to fight adversity and mobilize their communities to build their capacity to be resilient to HIV. The theory further calls for scholars in race-based research and knowledge production to question their positionality and assumptions about race when unpacking the disproportionate health disparities of racial minorities. Indeed, Bowleg et al. (2017) have alluded to the role of outsider positionality in race-based empirical research.

Furthermore, ACB men's voices are continuously missed in academic research as their HIV risk factors are mostly explained through the perspectives of scholars who tend to be disconnected from the lived realities of the ACB community. This potentially perpetuates and reproduces existing stereotypes because the leading scholarly voices in this space privilege the role of behavioral factors in ACB men's HIV vulnerability. Given that self-representation and presentation of counter-narratives, discourses, and scholarship changing the status quo is a core tenet of CRT, it is appropriate to use it in this study because it offers ACB men a platform to represent themselves and to have their voices heard on this issue (Simien, 2007; Yosso, 2005).

4.3. Methods

4.3.1. Study sample, data collection, and analysis

Data for this study forms part of the qualitative phase of weSpeak, an Ontario based study of HIV vulnerability and resilience among heterosexual ACB men rolled-

out in four cities: London, Ottawa, Toronto, and Windsor in 2015. This was a follow-up to an earlier study called *iSpeak* (2011-2013) which sought to examine the HIV-related needs and challenges among ACB men in Ontario. This manuscript is focused on examining the ways in which the construction and lived masculinities of heterosexual ACB men may be responding to their HIV risk. This is especially important because this group seems to have escaped the HIV policy radar of Canada. Underpinned by CRT, this study was also interested in finding out how racial identities may be influencing ACB men's access to the resources necessary to build adaptive strategies to HIV. Heterosexual ACB men discussed their access to economic and health resources and how they perceived the impact of these resources on their HIV vulnerability. Issues of structural violence and how these informed ACB men's masculinity beliefs and practices, access to preventive health care resources, and social services were also discussed. The study period spanned from November 2016 to April 2017. Research Ethics clearance was secured from the University of Western Ontario's Non-Medical Research Ethics Board (NMREB) in 2015.

To capture the varying spectrum of meanings and practices of masculinity and its intersection with heterosexual ACB men's vulnerability to HIV, we recruited self-identified heterosexual ACB men from diverse socioeconomic, immigration, geopolitical, and HIV serostatus backgrounds. The participation criteria for the study included: self-identifying as heterosexual ACB man, aged 16 years or older, able to speak English fluently, and living in the city of London, Ontario. Initial contacts with participants were made through flyers and posted notices in spaces where ACB men are known to frequently visit and converge. These included Black barbering salons, churches, mosques, and some coffee shops and cafes. Other platforms for recruitment included selected hospitals and clinics within the city. Contacts were also made with

Black ethnocultural associations where ACB people from the same origin countries in the Caribbean or Africa occasionally meet to socialize and offer social support to each other. The remaining participants were recruited through notices posted at the Regional HIV/AIDS Connection (RHAC) London and during activities marking Black history month in February. While the recruitment of HIV seropositive participants was through snowballing, the rest were recruited through convenient and purposive sampling. Prospective participants called or emailed the research coordinator who screened them for their eligibility to participate in the study. Based on the eligibility criteria outlined earlier in this section, a total of thirty (30) participants were selected to participate in focus group discussions and in-depth interviews.

Both focus groups and in-depth interview sessions centered on what it means for ACB men to act 'manly,' their beliefs about masculinity, and how it influences participants' health needs and practices. The researcher further probed them on potential differences between perceived societal ascribed masculinity and individual ACB men's assigned definitions of masculinity and how these influence engagements with HIV-related health needs. Issues of structural violence and aggression, including barriers to accessing social services and preventive health care spaces, were discussed. Furthermore, how socioeconomic issues intersected with and influenced the health of participants were probed in focus group and in-depth interviews. In-depth interviews allowed participants to delve into sensitive discussions including their sexual activities and practices, which could not be freely discussed focus group settings. Furthermore, in-depth interviews were necessary because they protected the identity of HIV-positive participants from accidental disclosure of their HIV status to third parties. In-depth interviews (IDI) were also used to further probe emerging themes from focus

groups. Grouping participants into age cohorts facilitated resonance and easy interaction, given the potential similarities in their lived experiences and practices of masculinity (Kitzinger, 1994; Vaughn, Schumm, & Sinagub, 1996). The focus groups were kept to a small number of participants to ensure group cohesion and participation in discussions (Baxter & Eyles, 1997; Rice & Ezzy, 1999). In line with the study's ethics protocol, all participants were made to sign a consent form. The sociodemographic characteristics of the participants are summarized in Table 1 in Chapter 3.

The in-depth interviews lasted between 45 – 60 minutes, while focus group discussions spanned 60 – 90 minutes. Both in-depth interviews and focus group discussions were semi-structured. The interviewer kept a field notebook where gestures and other expressions, including facial and emotions, were recorded to help contextualize findings. Emerging themes from focus groups including intersections of masculinity and sexual practices, systemic barriers and stereotypes, were further probed during in-depth interviews. Before each discussion and interview session, participant's consent was sought to audio-record their responses. Participants could also request to have the audio-recorder turned off or discontinue the interview at any point. Participants were given an honorarium of \$20 after each interview to subsidize the cost of transportation to the selected interview venues. They were assured that only pseudonyms will be used in study manuscripts and reports.

To analyse interviews, audio-recordings were transcribed verbatim and exported into NVivo, a qualitative data analysis software. Grounded in CRT, we were conscious of how dominant 'knowledge' about ACB men's masculinity and the drawn links to poor health outcomes may be a re-echo of long-held stereotypes—which some ACB men tend to internalize and act out (Kubota, 2012). Informed by this

understanding, the study team made up of four research assistants and a co-principal investigator, used mixed inductive-deductive approach to data analysis. Thus, our theoretical grounding in CRT guided parts of our theme identification while remaining themes were driven by the data (Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006). Team members read through the transcripts severally before proceeding to identify themes. This was subsequently followed by line-by-line coding in tandem with our specific research objectives (Merriam & Tisdell, 2015; Wong et al., 2019). Four members of the research team identified themes on the meanings and practices of masculinity. Coded transcripts were exchanged between research assistants to cross-check and ensure that coded statements were representative of assigned codes. The co-principal investigator with experience in qualitative research read through the transcripts and themes to ensure they were consistent.

4.4. Results

Overall, there were three (3) focus groups (FG) made up of ACBs of similar age cohorts, that is 16-24 years (n=5), 25-39 years (n=5) and 39+ years (n=7). This was followed by thirteen (13) in-depth interviews (IDI), which included three HIV seropositive participants. Emerging findings from our data analysis revealed fluid masculine beliefs among ACB men that informed a spectrum of masculinity practices. For instance, younger age cohorts subscribed to masculine beliefs that were intended to define and authenticate their identity as heterosexual ACB males. This included acting out stereotypical depictions of Black men's masculinity as sexual performance.

In contrast, older cohorts subscribed to masculinity that revolved around taking care of one's self and family, responsibility, health and wellbeing. Participants

identified structural risk factors such as stereotypes and expectations, stigma and limited engagement with service providers as key drivers of HIV infection in the community. Thus, the heterogeneity and fluidity of masculine beliefs and practices by ACB men contrast with current privileged discourses about homogenous masculinity that assumingly leads ACB men to engage in sexual and health behaviors that exposes them to risk of HIV infection. Heterosexual ACB men are practicing alternate masculinity and may be reconstructing masculinity that enables them to engage with their health needs.

4.4.1. Endorsing traditional masculinity in a quest for identity

The endorsement of traditional masculinities by heterosexual ACB men was used as a strategy to establish and reinforce their sense of an ‘authentic’ Black identity. These masculine beliefs and practices mostly tend to conform and reflect stereotypes and expectations of heterosexual ACB men’s masculinity as sexual performance with multiple women. The desire to meet these stereotypes exerts influence on ACB men’s masculinity practices and its intersection with their risk of HIV as the stereotypes are perceived to define an authentic identity for Black men. A participant in an in-depth interview remarked how ACB men are expected to demonstrate their heterosexuality and masculinity in ways that re-echo their stereotyped masculinity.

I think the way women view ACB men also plays a role in our image. I believe women view Black men differently as they would view white men. They view Black men as more powerful and not expressing too much love or expressing a form of weakness. I think that women look at Black men as very strong, I would say leaders, but also very powerful men in general, and it affects the way we act [FG 27 years, African Identified]

Implicitly, participants were influenced to fulfill these stereotypes and expectations as they attempted to define their authentic identity as heterosexual Black men. Thus, ACB men are not to show weakness and or exhibit behaviors that are deemed non-authentic for heterosexual ACB men. Over time, these stereotypes may have become normalized as heterosexual ACB men do not only act it out, but they also exert pressure on other heterosexual ACB men to meet this masculine expectation.

I have been trying to practice abstinence and all these things, and if I would talk to brothers [friends] from Toronto on the phone, the number one thing they want to hear about are stories of women I have had sex with [IDI 32 years, Black Identified]

Similarly, a participant acknowledged that the need to prove one's masculinity through sexual exploits leads to a competitive urge to have as many sexual partners as possible.

I would always compare, I would feel less than my black friends that has two, three or four girls on the go [IDI 25 years, Caribbean Identified]

The quest to establish an authentic sense of belonging may be driving some heterosexual ACB men to endorse traditional masculinities that are demonstrated through sexual performance. Kwasi, a 20-year-old in a focus group also observes this pressure when he stated “...*i feel like there is a pressure from society for me to not be able to turn a woman down if she asks or offers me sex.*” Particularly for younger cohorts of ACB men, limited economic engagement and opportunities put them at increased risk of HIV infection as they may be tempted to assert their masculinity to achieve identity and social acceptability among peers through sexual performance. Thus, ACB men show awareness of risk in performing traditional masculinities even in their quest for an identity.

4.4.2. Navigating stereotypes about Black masculinity

Participants acknowledged how entrenched stereotypes and expectations, from long-standing perceptions about their masculinity and sexuality, become overarching imposed expectations on them. A research participant observes the difficulty of separating these stereotypes and expectations from lived masculine practices.

Well, [the perceptions that] a black guy is obviously only concerned with sex affects our community's risk to HIV infection. I see in our [ACB] society that people can be influenced by these perceptions, and the more outlandish the thoughts seem to be, the more people want to go there [IDI 59 year Black Canadian Identified]

Another participant comments on the entrenchment of traditional masculine ideologies and their intersection with heterosexual Black men's identity and sexual practices. He commented on how ACB men's masculinity and sexuality are merged with popular discourse and expectations of them which they then act on.

That is the biggest thing a lot of times people don't understand that your sexuality and your masculinity are two different things. We label those things like he was talking about, sleeping with a lot of women as masculine and that plays into your masculinity. Sleeping with a lot of women should not make you more of a man, right? But it does, that is how society plays it [FG 40 years, Caribbean Identified]

In addition to the stereotypical depiction of masculinity among ACB men as sexual performance, other stereotypes are also intended to define the social-relational context of how ACB men demonstrate their heterosexuality and masculinity.

I'm supposed to be a super masculine guy. The first and foremost, I'm supposed to be into sports and like every single kind of sport and talk about sports. I'm not supposed to show much emotion whatsoever, I'm supposed to be this tough cookie and no matter what happens I have to be big and not cry or anything like that. I can't show emotion and I think that is the social norm for any ACB group of people [FG 20 years, African Identified]

Participants consistently acknowledged the pressure imposed on heterosexual ACB men in subscribing to ideas about masculinity such as dating multiple women, being

dominant in relationships, being tough, and detached from emotions and weakness. However, some ACB men resist these pressures in demonstrating their masculinity as they practice alternative masculinities and embrace meanings of masculinity that help to avoid risks and health challenges associated with endorsing traditional masculinities.

4.4.3. Alternate and emerging masculinities

Findings also point to alternate and emerging reconstructions of masculinity that shape what it means to behave ‘manly’ among ACB men. This reconstruction offers participants the opportunity to engage with alternative practices of masculinity that are useful in reducing their vulnerability to HIV and to improving their overall health. With these, participants demonstrated awareness of the deleterious impact of neglecting their own health needs in their performance of socially imposed masculinity. In an in-depth interview, a participant highlighted the importance of self-care as a vital component of the meaning of masculinity and behaving manly.

I think being manly is all about taking care of your health first. And then you can care about everyone else afterwards. But you can't care about nobody if you don't care about yourself [IDI 57 years, Black Identified]

For recent immigrants, navigating structural challenges to meet economic responsibilities in both migration origins and Canada may be especially daunting, meaning that they may not have the time and resources to dedicate to meeting their health needs (Derose et al., 2013; Owusu, 2003). Therefore, evidence that they are prioritising ‘self’ in defining masculinity and behaving manly is useful in meeting their health needs. Furthermore, alternate and emergent reconstructions of masculinity may be embracing hitherto feminized activities.

Manly is providing for yourself, taking care of your health, going grocery shopping, washing your clothes, those are all manly things [IDI 32 years, Caribbean Identified].

Defining masculinity to encompass previously feminized activities underscores alternate and potentially changing scope and understanding of masculinity which paves the way for addressing HIV as a health issue. These changes are happening alongside increasing critical thinking about platforms and spaces that propagate and entrench stereotypes about heterosexual ACB men's masculinity. A research participant suggested that a key driver of heterosexual ACB men's deleterious masculinity beliefs and practices is false and stereotyped media portrayals of Black culture. However, as the participants noted, these portrayals are mainly inconsistent with ACBs lived masculinity beliefs and practices.

That is what I see to be manly, to take personal responsibility for everything in your life, rather than the propaganda and media stuff where being manly means you have to pack a gun, sell drugs, do violence and rob a store.... That is what these people in my social group are being misled to think of what actually is manly and what is not [IDI 25 years, Caribbean Identified]

As implied by this quote, heterosexual ACB men are conscious of their misrepresentation in the media and how this results in adverse impacts on their community. Alternate masculinities and reconstructions of the meanings of masculinity are useful in building resilience to high HIV prevalence, especially in a context where beliefs and practices of traditional hegemonic masculinities are associated with an increased risk of HIV infection. This may also be in line with the observation by Husbands et al. (2017) that heterosexual ACB men are indeed aware of their increasing HIV vulnerability and are re-engaging with their masculinities to prevent and build resilience to new infections.

4.4.4. Sharing feelings of vulnerability with others

Heterosexual ACB men also demonstrate how they navigate their HIV risk and feelings of vulnerability by resorting to resources, including friends, family and close acquaintances. This contrasts with existing views that they are highly secretive about their health-related needs. For instance, while it is widely held that self-reliance as a traditional masculine practice prevents Black men from seeking health services (Addis & Mahalik, 2003), it emerged for this study that participants shared with others their feelings of vulnerability to HIV as a way to overcome it.

If me and you are hanging out for a while, you would end up telling me certain things, and I am telling you what goes on in my life. When these guys tell me something, it's cool and I respect that a lot, it gets things off their chest. A lot of dudes don't like to feel vulnerable [IDI 32 years, Caribbean Identified]

In contrast to claims about secrecy, the participant acknowledges that discussing one's vulnerability with friends and acquaintances is common among heterosexual ACB men—particularly about health care needs. This action makes them feel complete and connected in their attempt to overcome their vulnerability and build resilience. In addition to friends and close acquaintances, they also seek professional help in dealing with vulnerability.

Having friends and professionals that I consider to be smart, intelligent, likable people, willing to talk to me and say I'm okay. And then realizing that I'm okay, myself [IDI 59 years, Black Canadian Identified]

Practices of masculinity do not bar heterosexual ACB men from discussing their vulnerability or health-related needs. Participants talked about the importance of sharing their feelings of vulnerability with other heterosexual ACB men with similar challenges and lived experiences.

And I have been dealing with that [feeling of vulnerability] a lot recently. I have learned to be more open and communicate, because

just talking about it will make you feel a lot better in ways you wouldn't think. You would think the same problem is going to be there, but just talking about it does make a difference [IDI 26 years, Black Canadian Identified]

While secrecy about their own health needs and vulnerabilities is linked to the endorsement of traditional masculinities, research participants hinted at how the intersection of their race and gender may be serving as a barrier to accessing health care and useful resources in dealing with their feelings of HIV vulnerability. For instance, an HIV seropositive participant commented on availability and access to HIV-related services for heterosexual ACB men.

I don't see a lot of heterosexual services dealing with HIV out there and available. Like if we're going to talk about the heterosexual point of view there isn't [IDI, 45 years, Caribbean Identified]

Barriers to accessing preventive HIV health care among this population may also be due to the difficulty of accessing information on HIV. In particular, recent immigrants may not be aware of the concentrated HIV epidemic among ACBs given Canada's low HIV prevalence among the general population. Furthermore, participants spoke about the lack of structural competence in addressing HIV in the ACB community.

Politics don't give us the right information that we need like about HIV. They are only willing to give us more statistics on black people who are thieves, or they commit more robberies, murders and stuff like that or are in jail. They don't say oh you guys have the highest rate of HIV and therefore we should find a way to address it. They don't care about that [FG Age 27, African Identified]

The preceding quote shows that, while practices of masculinity may indeed permit heterosexual ACB men to engage with policy stakeholders and service providers, some structural factors and challenges may be impeding their access to preventive health care, including HIV services. These structural barriers may also centre on cultural competence in service delivery.

4.5. Discussion

Findings from this study demonstrate that beliefs and practices of masculinity linked to heterosexual ACB men's higher HIV prevalence may not be exhaustive of the fluid ways in which masculinities are practiced among them. Indeed, ACB men who may be holding traditional notions of masculinity may be doing so within the larger context of decades of structural violence where they are primed to demonstrate these forms of masculinity as identity. In this instance, we argue that perceptions of problematic Black masculinity in popular discourses and research spaces are largely a stereotypical representation of Black masculinity as posited by Castle Bell and Harris (2017), and King (2017) in the US. Evidence of alternative masculinities that ACB men use to engage their health and wellbeing may also be gaining more utility. This may be in the wake of increasing awareness that traditional and hegemonic masculine beliefs and practices imposed on them through mediums such as the media, entertainment and religion predispose them to poor health outcomes including HIV (Tudor, 2017; Ward, 2005).

The existence of these alternative masculinity beliefs and practices within the ACB community affirms previous Black scholarship (mostly from intersectional and critical race perspectives), which discounts and critiques a 'natural' and homogenous Black masculine belief that is deleterious to ACB men's health and wellbeing (Geary, 2014). It is possible that increasing Black activism and the translation of these concepts into Black communities may be yielding positive outcomes by debunking deleterious beliefs about what is 'authentic and African.' Furthermore, increasing Black community activism (e.g., Black lives matter) may be spearheading alternative masculinities, influencing the manner in which Black heterosexual men define and practice their masculinities and identities. This even occurs in the media where

resistance to racist stereotypes necessitates resistance to traditional or hegemonic masculinity which is intricately connected to racism (Debique, 2016; Hemphill, 2017).

Contrary to suggestions that practices of homogenous masculinity burdens heterosexual Black men, it emerged from this study that beliefs, meanings, and practices of masculinity among heterosexual ACB men are fluid. Given the intersection of race, class, socioeconomic status, and other structural factors that influence how masculinity is practiced, Black men's endorsement of hegemonic masculinity may be expected when examined within context (Bowleg & Raj, 2012; Connell & Messerschmidt, 2005). Living in a setting where the identity of racial minorities is detrimentally stereotyped, younger ACB men may in particular act to endorse these stereotypic expectations. Subsequently, some masculine practices among this structurally exposed population may tend to conform to societal expectations. In the United States, Ward (2005) further observes that practices of hypermasculinity among ACB men constitute a form of resistance to structural racism. It can, therefore, be argued that the pervasiveness of structural neglect and stereotypes about Black masculinity may have over time led to the internalization of some deleterious health behaviors that are now seen as 'innate' to this population (Staples, 1990; Walcott, 2009).

However, heterosexual ACB men also demonstrate meanings of masculinity that empower them to engage their health needs, including building resilience to HIV. For instance, heterosexual ACB men taking care of their health, as an important part of performing their masculinity may imply the existence of alternate masculinities that go beyond the feminization of healthcare (Courtenay, 2000b, 2000a). Through this, ACB men demonstrate that attending to their personal health needs is not opposed to masculine beliefs and may indeed be foundational to meeting other traditional

masculine expectations such as providing for the family. Implicitly, alternate constructs of masculinity among this population embrace progressive concepts that allow them to engage in preventive health care. Conscious of the debilitating health impacts of living out stereotypes, heterosexual Black men may have been moving away from previous masculine expectations and beliefs which are often influenced by long-standing marginalization (Husbands et al., 2017; Miller, 2005). This finding represents a significant shift from the current problematization of heterosexual ACB men's masculine beliefs and practices as predisposing them to poor health outcomes. Amidst their increasing vulnerability to HIV, reconstructing masculinity to engage their health needs is particularly useful in reducing infections.

In line with earlier studies on heterosexual ACB men's health in the context of increasing HIV vulnerability, findings from this study suggest that heterosexual ACB men are conscious of their increasing HIV vulnerability. They demonstrate this by resorting to progressive ways to fight HIV vulnerability. Indeed, ACB men may be engaging in resilience promotion activities that improve their overall health as they discuss feelings of vulnerability with trusted acquaintances and health professionals despite earlier suggestions that they are notoriously secretive about their health needs (Courtenay, 2000b). Through this, heterosexual Black men are indicating their resolve to reduce their vulnerability to HIV by seeking information about the spread and prevention of HIV from designated institutions. Consistent with Husbands et al. (2017), heterosexual ACB men show resourcefulness in building resilience to HIV vulnerabilities even in the absence of policies supporting them in this endeavour.

Despite their structural vulnerabilities, our findings further demonstrate that heterosexual ACB men are surmounting existing barriers to promote their resilience and to reduce their vulnerability to HIV. Although they face increased stigmatisation,

including being tagged as active ‘transmitters’ of HIV, heterosexual Black men show commitment in drawing from available resources to build resilience and reduce their overall vulnerability. Practicing alternate and more progressive ideas of masculinity also offers them the opportunity to reduce their exposure to the virus. These findings affirm and shed light on emerging scholarship on Black masculinity and health care prioritization, where exclusion from mainstream health policy and HIV prevention services based on stereotypic discourses endangers ACB men’s resilience to HIV infection. Indeed, earlier work by Bowleg, Teti, et al. (2013) in the US showed that heterosexual ACB men’s decreased use of health services amidst high HIV prevalence rates is linked to other structural factors including limited economic engagement, racism, and micro-aggressions.

4.6. Conclusion

The current discourse on heterosexual ACB men has permeated the existing literature on how their ‘problematic’ masculinity heightens their HIV vulnerability and poor health outcomes. In contrast, in addition to other emerging scholarship on Black masculinity, this study shows that heterosexual ACB men demonstrate resourceful masculinities and subscribe to a fluid and progressive concept of masculinity that allows them to engage with their own health needs. The existence of alternate ACB men’s masculine ideologies that make access to preventive health care part of the accepted ‘manly’ behaviors further demonstrates their willingness to engage their health needs. In this regard, the exclusion of ACB men from mainstream HIV intervention policies may be emanating from long-standing negative discourses about a ‘self-inflicted’ vulnerability (Geary, 2014; Miller, 2005). Such discourses not

only expose heterosexual ACB men to increased HIV risk, but also to lower health outcomes relative to the rest of the population.

Based on these findings, we call for a more critical approach to the study of Black masculinity and HIV. As contended by Geary (2014) and Bowleg et al. (2017), racism and structural inequalities have worsened poor health among heterosexual Black men, while privileging research and scholarship on problematic Black masculinities, sexuality, and access to health care. There is therefore a need for health policy stakeholders to engage the ACB community, specifically heterosexual Black men, to create policies and interventions that specifically focus on their vulnerability. The finding that meanings of masculinity among this population do not discourage them from engaging their health needs points to an opportunity for stakeholders to engage this community in crafting culturally relevant and structurally competent messages and programs that will create an opportunity for heterosexual ACBs to increase their use of health services at AIDS Service Organizations. It is also critical to remove structural racism and micro-aggressions, and economic exclusion as part of a holistic approach of HIV prevention in Canada and in other similar contexts.

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CHAPTER FIVE

5.0. “I WENT IN THERE, HAD A BIT OF AN ISSUE WITH THOSE FOLKS”: EVERYDAY CHALLENGES OF HETEROSEXUAL AFRICAN, CARIBBEAN AND BLACK (ACB) MEN IN ACCESSING HIV/AIDS SERVICES IN LONDON, ONTARIO

Abstract

In Canada, heterosexual African, Caribbean and Black (ACB) men are at a heightened risk of HIV infection. Among reasons assigned to this, is the assertion that they do not seek preventive healthcare to discuss their health needs including HIV testing and treatment. As part of a research project dubbed weSpeak, we examined the underlying factors limiting access to health services among this population in London, Ontario. I conducted four focus group discussions (N=24) and thirteen in-depth interviews (N=13) with ACB men and Service Providers. Interviews were audio-recorded, transcribed verbatim and exported into NVivo where we employed a mixed inductive-deductive thematic approach to analyze the data. Findings revealed that, some ACB men were unaware of their increased risk of HIV infection, as they lacked information on HIV and how to access preventive health services. ACB men reported being disconnected from HIV resource spaces and services. The study also found that stereotypes, systemic racism and stigma were significant barriers to ACB men's access to health services. The findings point to an urgent need for health policy stakeholders in Canada to engage heterosexual ACB men in the design and implementation of policies aimed at addressing their vulnerability to HIV infection. Furthermore, service providers attending to the HIV needs of ACBs must be

conscious about ACB men's concern about discrimination and racism at service centres.

5.1. Introduction

In Canada, African, Caribbean and Black (ACB) men have one of the highest HIV prevalence rates and compared to others, may be more vulnerable to HIV (Husbands et al., 2013; Public Health Agency of Canada, 2014b). For instance, recent data from the Public Health Agency of Canada (PHAC) suggests ACBs are 12.5% more likely to be infected with HIV relative to people in the general population. Furthermore, ACBs represent over 25% of new HIV diagnoses, although they constitute less than 5% of Canada's population (Haddad et al., 2018). Mostly through heterosexual exposures, the ACB community also accounted for 17.9% of all new infections in 2017 (Haddad et al., 2018). Within the ACB community however, heterosexual ACB men are emerging as a vulnerable group who are yet to get the attention of health policy stakeholders including AIDS Service Organizations (ASOs) (Husbands et al., 2017). It is therefore not surprising that Remis et al. (2012) reported that as of 2009, heterosexual ACB men represented 60% of all ACBs infected through heterosexual exposures in Canada. In Ontario, specifically, ACB men accounted for 17% of all new diagnoses spanning 2015-2016.

While earlier studies prioritized behavioral factors, including those associated with the endorsement of traditional masculinities to explain the high HIV prevalence among heterosexual ACB men (Courtenay, 2000b, 2000a; Higgins et al., 2010), others have pointed to the overarching role of structural factors. Within Canada, structural factors constitute the social, economic, political, and environmental influencers beyond individuals' control, but shape quality of health and access to health care (Gupta, Parkhurst, Ogden, Aggleton, & Mahal, 2008; Viruell-Fuentes, Miranda, &

Abdulrahim, 2012). Therefore, the influence of these factors necessitates understanding the health of heterosexual ACB men through the social determinants of health framework where their risk of HIV infection is conceptualized beyond sexual exposures (Marmot, Friel, Bell, Houweling, & Taylor, 2008). For instance, social identity, including race, may have persisted as a barrier to accessing quality health care in the context of North America, including, Canada where the health care needs of racial minorities may not be mainstreamed into the health care delivery system (Lebrun & Dubay, 2010). A report on health inequities in Southwestern Ontario, Canada, revealed that ethno-racial minorities face additional challenges in accessing health care (Human Environments Analysis Laboratory, 2016). In Toronto, Gardezi and colleagues (Gardezi et al., 2008) also found that racism inhibits ACBs from adequately responding to their HIV health needs. In this regard, it is possible heterosexual ACB men face unique social and structural barriers in accessing health care services, including HIV services such as testing, counseling, information and treatment (Husbands et al., 2017; Konkor, Antabe, et al., 2020).

Furthermore, being stereotyped as ‘active transmitters’ of HIV can potentially exclude them as specific targets of health policies and further discourage them from seeking preventive health care (Essien, Meshack, Peters, Ogunbade, & Osemene, 2005; Husbands et al., 2017). Thus, though the literature acknowledges low levels of HIV awareness and limited use of preventive health services among heterosexual ACB men, this is framed as behavioral, emanating from their endorsement of traditional masculinities (Husbands et al., 2013; Remis et al., 2012). Hence, this study as part of an Ontario based research (weSpeak) sought to understand barriers to heterosexual ACB men’s access to HIV preventive health services with two main objectives. First, to situate heterosexual ACB men’s access to HIV-related services

within broader structural factors including social, economic, political, and environmental factors in Canada. Second, to understand how the intersection of race and sexuality informs heterosexual ACB men's access to HIV-related services.

5.1.1. Discourses on Preventive Health Care among Heterosexual ACB men

Although people of African, Caribbean and Black descent constitute distinct social groups with varying social experiences and interactions, they are placed in one broad social category as part of this study based on their observed predisposition to HIV infection through heterosexual contacts. Additionally, the framing of their high HIV prevalence takes a similar tangent as it is attributed to behavioral factors (Husbands et al., 2017; Konkor, Antabe, et al., 2020). Furthermore, race in this study is operationalized as a social and relational trait that informs and engenders an individual's social positioning and interactions, including access to social services such as preventive health care. Generally, access to health care spaces such as hospitals and clinics, is linked to positive and desirable health outcomes, including the acquisition of factual knowledge on disease transmission. For HIV researchers and scholars, preventive health care is useful in reducing new infections among high-risk populations, including heterosexual ACB men (Bowleg & Raj, 2012).

Additionally, increased visits and interaction with health professionals are known to improve health literacy and related health behaviors (Anfaara, Atuoye, Mkandawire, & Luginaah, 2018). According to Burns et al. (Burns et al., 2008), frequent visits to health facilities provide clinicians the opportunity to test, counsel and engage individuals and groups at high risk of HIV infection. In the United States, Swenson et al. (2012) observed that, among African-American adolescents, those with regular access to preventive health care were more likely to have tested for, and be knowledgeable about, HIV (transmission) compared to peers who do not have access.

Thus, to achieve the Joint United Nations Programme on HIV and AIDS (UNAIDS) 90-90-90 target by 2020, health facilities are also incorporating education, screening and counseling services as part of their core preventive health care mandates (Sidibé, Loures, & Samb, 2016; UNAIDS, 2017b). Given the organization of these health care services, it has been argued that frequent visits by heterosexual ACB men will offer them the opportunity to test for their HIV serostatus and improve their overall HIV awareness. At these health facilities, individuals who test positive will receive counselling on treatment including antiretroviral and dietary options which ensure HIV seropositive individuals live their normal lives after diagnoses (Moyer, 2013). The suppression of viral loads through treatments also limits the probability of transmitting the virus during sexual intercourse (UNAIDS, 2017b). For people who test negative, acquiring information about HIV transmission is useful for behavioral changes that reduce the risk of infection (Bentley et al., 1998).

Although structural factors have persisted as determinants of health for racial minorities, discourses on ACB's underutilization of HIV-related preventive health care have mostly been devoid of structural contexts and intersections of marginalization. The predominant narrative has been that, ACB men are socialized to hold and practice traditional notions of masculinity that encourage risky sexual behaviors in their community (Bowleg et al., 2011). These masculine practices, however, tend to be associated with limited use of preventive health services, having concurrent multiple sexual partners, non-use of condoms and a general disinterest in health (Bowleg et al., 2011). These scholars argue that traditional masculine ideas pervasive in the ACB community have also entrenched heteronormative discourses and gender stereotypes, resulting in preventive health care being constructed as feminine (Courtenay, 2000b). In this regard, heterosexual ACB men only resort to

curative and medical emergencies when their health conditions worsen or are in advanced stages (Moyer, 2013). However, in Ontario, Husbands et al. (2017) observed that Black heterosexual men might be aware of their heightened vulnerability but face some structural barriers in accessing services. For instance, despite Canada's claim to universal health coverage, poor health outcomes among Blacks are linked to socio-economic status, housing conditions, and employment status, among others (Shamara Baidooobonso et al., 2012). Particularly for recent immigrants of color, navigating structural barriers to overcome financial and economic challenges to improve health may be daunting (Lebrun & Dubay, 2010).

Consequently, Husbands et al. (2014) and Remis et al. (2012) posited that because of structural risk factors, ACBs may be disproportionately exposed to HIV infection but are still missing in current HIV policies in Canada. To help understand increasing heterosexual HIV transmission among ACB men, this paper explores their everyday challenges in accessing preventive health care, particularly HIV-related services in London Ontario, Canada.

5.2. Theoretical Context

This study is informed by the intersectionality theory. Building on the understanding that people's social positioning influences their health outcomes, intersectionality theory departs from the biomedical understanding of health disparities. It theorizes that experiences of health disparities, particularly for oppressed and underprivileged populations including ACB people, can be explained by the intersections of their social vulnerabilities and identities (Simien, 2007; Viruell-Fuentes et al., 2012). Accordingly, this intersection of varied forms of

oppression and discrimination becomes the ‘new normal,’ making it difficult to disentangle multilayered axes of oppression into individual factors, as these factors act in unison to predispose marginalized groups to poor health. Thus, for heterosexual ACB men, limited economic participation, lower socio-economic status, higher rates of incarceration, stereotyping and general discrimination are reflective of the intersection of their social identities, resulting in their disproportionate burden of HIV infections (Viruell-Fuentes et al., 2012). Invariably, heterosexual ACB men are over-represented in the burden of HIV in Canada, and are also more likely to suffer other poor health outcomes, including hypertension and cardiovascular complications (Wang & Kwak, 2015). Conscious of the heterogeneity of the lived experiences of oppressed populations, intersectionality theory recognises varying realities based on race, gender, class and sexuality (Simien, 2007).

Furthermore, intersectionality theory posits that people’s social positioning, including the quality of their health and health care access, is influenced by an interaction between their power and privilege relative to others (Asante, Jackson, & Balaji, 2011; Kimberle Crenshaw, 1991; Doyal, 2002). In this regard, heterosexual ACB men’s heightened vulnerability to HIV infection could also be situated within their limited power to influence or propose health policies that are specific to their health needs. ACB people’s limited power also implies that they are unable to counter existing narratives about their increased vulnerability to HIV and poor health, which may be working to exclude them from health care facilities. While there is a general discourse about a monolithic masculinity and a problematic socialization process that feminizes preventive health care, evidence suggests the quality of ACB men’s general health and vulnerability to other diseases may also be influenced by existing structural

factors predicated on multiple, intersecting identities (Husbands et al., 2017; Konkor, Antabe, et al., 2020).

Therefore, limiting ACB men's HIV vulnerability to only behavioral risk factors is problematic as it excludes persistent systemic and structural barriers in ACB people's daily encounters. It also fails to account for how these behavioral factors overlap with other lived realities such as racism, stereotypes, discrimination, poverty, and general social oppression that predisposes heterosexual men to heightened HIV risk (Baidooobonso et al., 2013, 2012; Frohlich et al., 2006; Szekeres, 2008). For instance, Paradies, Truong, and Priest (2013) revealed that experiences of racism from health care personnel are associated with reduced use of health services by racial minorities. Consequently, Nazroo (2003) also observed that racial disparities in health quality are underpinned by racism, as racial minority populations continue to face several intersecting forms of discrimination and oppression which impact their health.

To understand and proffer tested policy suggestions in addressing the HIV prevalence in ACB communities, particularly among heterosexual ACB men, it is imperative to go beyond conceptualizing vulnerability as an individual level sexual exposure, to embrace a broader scope that targets the disadvantaged position of heterosexual ACB men due to the intersection of their social identities. This broader scope will also help better situate structural factors, including social, economic, political, and environmental conditions that expose racialized people to disproportionate poor health. This will help provide counter-narratives about their poor health, which continues to center on their behavioral characteristics (Nazroo, 2003). Furthermore, through an intersectional perspective, narratives about how micro-level characteristics may have aided in the spread of HIV are discounted, such as lack of personal competence and self-esteem in the ACB community. These

narratives neglect the situational nature of people's lives as well as the influence of socio-environmental factors, including access to resources and the quality of the immediate environment on population health (Doyal, 2002). Thus, the concept of HIV vulnerability and access to health care is situated within a multidimensional and intersectional network of social identities underpinning ACBs increased risk to HIV infection and their associated adaptations.

5.3. Study Context

London is located in the Southwestern part of Ontario, Canada (See Figure 2). The 2016 population census estimated the total population of the city at 383,822. London was also named as one of the fastest-growing cities in Canada in 2019 by Statistics Canada. The traditional manufacturing economic base of the city is giving way to a vibrant emerging service sector. Thus, the expanding service base of the city continues to attract people to the city culminating into an overall population growth rate of 3.9% which is relatively higher than other mid-sized cities in Ontario (Blais, 2015). Currently, London is the 6th and 15th most populous city in the province of Ontario and Canada respectively. The city's population is becoming racially diverse with data from the 2016 census estimating that people of ACB descent constitute 2.6% of the city's population, with ACB men making up the majority (i.e. 51.3%).

Compared to other cities in the province, London has one of the highest rates of infectious diseases including hepatitis B and HIV. For instance, although by close of 2016, new diagnoses of HIV and hepatitis B were 4.9 and 30 persons per every 100,000 respectively at the provincial level, figures recorded in the city of London were 13.5 and 39 persons per every 100,000 for HIV and hepatitis B respectively. To

address these disturbing trends of infections in the city, a medical emergency was declared by The Middlesex London Health Unit. The immediate response was among other things, to increase the supply of needles to injection drug users (IDUs). Further, safe spaces were created across the city to help supervise safer injections. Although The Middlesex London Health Unit admits it is yet to fully unravel why London experiences a unique trajectory of HIV infection relative to the rest of Ontario where infections are indeed reducing, attention seemed focused on only IDUs (Butler, 2017). Therefore what was not clear in this program was whether this attention is in tandem with emerging evidence of HIV risk and vulnerability, as heterosexual infections particularly among heterosexual ACB men are rising (Public Health Agency of Canada, 2014b). For instance, the Ontario Ministry of Health and Long-Term Care reported that 18% of people living with HIV/AIDS (PLHA) and 29% of new infections in the province are through heterosexual contacts, which puts the ACB community at increased risk.

Although access to primary health care in London has improved over the years, a 2016 report suggests that vulnerable and marginalized populations in the city experience barriers in accessing health care (Human Environments Analysis Laboratory, 2016). Ethno-cultural and racial minority populations, given the precarious nature of their jobs, alluded to the timing of appointments as a barrier as it tends to conflict with their work schedules making it difficult to discuss their health-related needs with medical practitioners (Human Environments Analysis Laboratory, 2016). In an earlier study on health equity and access in London, some members of the ACB community emphasized the challenges they faced in the city's health care system, thus compelling them to resort to seeking health care outside the city (Shamara Baidobonso et al., 2012). Furthermore, limited engagement with

vulnerable ACB communities in the city might have heightened their risk to infection given the lack of information and provision of culturally sensitive health services (Shamara Baidoobonso et al., 2013). Thus, to understand the HIV threats to the ACB population in the city of London, Baidoobonso et al. (2013) called for a more structurally focused approach where HIV risk and vulnerability can be situated in the social determinants of health framework.

5.4. Methods

5.4.1. *The weSpeak study*

This study is informed by findings from an exploratory study conducted in London and Toronto dubbed 'iSpeak' (2011-2013), which sought to examine HIV preventive health care needs and treatment challenges of all ACBs of varying genders and sexual orientation. Currently implemented in four cities (London, Windsor, Ottawa, Toronto) in Ontario, this larger study sought to understand HIV vulnerability and resilience among heterosexual ACB men. The focus on heterosexual ACB men's HIV-related health needs and challenges became necessary as evidence suggested devastating impacts of rising heterosexual HIV infection among this population. To further situate their degree of vulnerability, the research focused on access to both primary and preventive health care, particularly HIV-related services. Other markers of vulnerability including sexual practices and condom use, as well as beliefs and constructs of masculinity and how it relates to ACB men's health care access were discussed. Given the study's perspectives on intersectionality and the social determinants of health, the research also focused on the influence of economic participation, housing and lived experiences of racism, and how these informed

ACBs' access and willingness to use preventive health care services. Challenges associated with accessing social services and other systemic barriers that may be impacting their use of preventive health care services were also discussed.

Furthermore, discussions also centred on resilience trajectories of heterosexual ACB men as they navigate everyday challenges amidst their increasing HIV vulnerability. Thus, existing community resources that have aided members of this community in building resilience were discussed during focus groups and in-depth interview sessions. Data collection spanned from February 2016 to April 2017. The study received ethics approval from the University of Western Ontario's Non-Medical Research Ethics Board (NMREB) in 2015.

5.4.2. Participant Recruitment

The study recruited heterosexual ACB men from varying ethno-cultural, socioeconomic, immigration and HIV serostatus backgrounds. This was to help capture the heterogeneity of the lived experiences of members of the ACB community in London, Ontario. Given that ACBs are below 3% of the city's estimated population, initial contacts with study participants were through the distribution of flyers and posted notices in spaces frequently used or visited by the target population in the city. These included Black barbering salons, churches, mosques, restaurants and activities organised during Black History month. Through the leadership of Black ethno-cultural groups based on country of origins in Africa or the Caribbean, members who were interested in the study contacted the research coordinator through email or phone for initial screening and subsequent participation in the study. Notices were also posted at some selected hospitals and health facilities asking interested persons to contact the research team.

Additionally, the Regional HIV/AIDS Connections (RHAC) posted notices about the study on its premises. Prospective participants who contacted the research coordinator were screened and those who were 16 years or older, spoke English or French, lived in London, self-identified as heterosexual ACB men, and gave consent to be interviewed in either an individual in-depth or a focus group setting were recruited. For service providers who participated in the study, eligibility was based on at least five years of experience in directly providing HIV-related services to clients in their organizations. In line with our ethics protocol, all participants who met the inclusion criteria for the study were made to sign a consent form.

5.4.3. Focus groups and in-depth interviews

Focus group discussions (FG) with an average of 5 participants per group lasted between 60-90 minutes while in-depth interviews (IDI) spanned between 45-60 minutes. With the consent of participants, all focus group discussions and in-depth interviews were audio-recorded. The interviewer, with the help of a field notebook, also recorded emotions and gestures that could not be audio-recorded but were deemed useful in data analysis and interpretation. Prior to each interview session, study participants were informed about their right to not be recorded, quoted or participate in the research. For focus groups, ACB men were put into similar age cohorts to ensure resonance especially as discussions also aimed to capture sexual practices (Baxter & Eyles, 1997; Kitzinger, 1994; Rice & Ezzy, 1999). Although participants from the focus groups were invited to take part in-depth interviews, all participants who were finally selected for the in-depth interviews were not part of the focus groups.

The emerging themes from the FG which were further discussed during the IDIs include: specific barriers to accessing preventive health care and treatment

services from health care providers, sexual risk taking and susceptibility to HIV infection, knowledge of the availability of preventive health services in ACB communities and their interaction with health care providers. Prior to each interview session, participants were assured pseudonyms will be used in research publications or public presentation of study findings. Participants were also informed about their right to leave the interview whenever they wished to do so. To cover the cost of transportation each participant was given an honorarium of CAD\$ 20 as interviews took place at designated places that were safe for both participants and the interviewer. The sociodemographic characteristics of the research participants are provided in Tables 1 and 2.

5.4.4. *Data analysis*

Audio-recordings were transcribed verbatim and exported into NVivo, a qualitative data analysis software. To get a holistic understanding that also captured varied experiences affecting ACB men's access to health care especially preventive health care, all transcripts from in-depth interviews and focus groups (including those of the service providers) were analyzed together. Based on the theoretical underpinnings of how intersecting social identities influence heterosexual ACB men's access to health care, the authors employed a mixed inductive-deductive thematic approach to data analysis. With this approach, the process of our theme identification was partly driven by our theoretical perspectives of intersectionality and social determinants of health. As researchers, we were cognizant of how heterosexual ACB men as a marginalized group are socially and structurally positioned to suffer poor health outcomes.

The remainder of the theme identification, through the inductive lenses, was then driven by the data (Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006).

Therefore, all four members of the weSpeak research team in London, Ontario, used this approach to identify emerging themes relating to health care access and other systemic barriers to accessing preventive health care among heterosexual ACB men. For this type of analysis, the transcripts were read through severally and thoroughly by team members to familiarize themselves with the content and emerging themes. This was followed by a line-by-line coding in reference to our specific research objectives (Merriam & Tisdell, 2015; Wong et al., 2019). Coded transcripts were exchanged among the research team members to ensure consistency and verify if selected codes represented the identified themes. A seasoned qualitative researcher in the research institution with years of experience in qualitative research went through the coded transcripts and assigned themes.

5.5. Results

In all, thirty-seven (37) participants took part in this study made up of four focus groups and thirteen in-depth interviews. There was one focus group for service providers (N=7) and three others for 16-24 (N=5), 25-38 (N=5), and 39+ (N=7) age cohorts. Service providers included the Regional HIV/AIDS Connections; Middlesex Health Unit, London InterCommunity Health Centre (LIHC) Options Testing Clinic and LUSO. Community services discussed the type and availability of services at their facilities, including those designed for the specific needs of heterosexual ACB men. Discussions further centered on cultural competence of service delivery and the implementation of programs to attract heterosexual ACB men for HIV testing or counseling.

Service providers shared their experiences in serving heterosexual ACB men and possible challenges they faced in carrying out their work, including difficulties in establishing trust and delivering culturally competent services. Additionally, service providers discussed ways they could fully engage members of the ACB community and extend available testing services. ACB men discussed issues relating to HIV vulnerability and access to preventive health care, particularly HIV-related services. Emerging from these discussions were the everyday lived experiences of heterosexual ACB men—including accessing employment opportunities, housing and social services, and encounters with racism—and how these affect access to and utilization of preventive health services.

Findings revealed the persistence of structural factors that limit heterosexual ACB men's access to preventive health care services. Interview with participants revealed limited awareness of HIV risks and service availability, disconnection with health care spaces, and issues of stigma both within and outside the ACB community which prevent heterosexual ACB men from openly discussing their vulnerability, testing for HIV and seeking treatment. Furthermore, systemic everyday challenges hindered access to and quality of social services received by ACB men which (in)directly affected their utilization of HIV services. Emergent themes signified the existence of structural barriers that work to significantly reduce heterosexual ACB men's visits to preventive health care spaces.

5.5.1. Low Awareness of HIV Risks and Service Availability

Some heterosexual ACB men were unaware of their elevated HIV risks. This resulted from lingering misconceptions that heterosexuals may be immune to contracting HIV. For instance, given misconceptions about HIV being a 'gay disease,'

some heterosexual ACB men presumed they had a lower risk of getting infected. A participant in a focus group remarked:

I would like to say that most times, most black men, are kind of uneducated on how AIDS is transmitted. Just because I am not a heroin junky does not mean that I won't get it from having sex with a woman. Just because I am not gay doesn't mean that I won't get it from having sex with a woman, and that's what we need to remember [FG, 39+ years]

Some subgroups of ACB men, especially recent immigrants, are at increased risk of HIV infection as they may not be aware that HIV exists as a public health issue in their new destination of Canada. This was noted by a participant when he stated:

There are just things that they [recent immigrants] do not know. They may come from an area where there is a little bit of AIDS, but they haven't talked about it. They never really talked about it there. But then you come here, and AIDS still here, but you are just ignorant to that fact, so you might want to have a little fun with a couple of ladies, you are an ignorant immigrant, a little ignorant [IDI, 25-38 years]

Some heterosexual ACB men who required preventive health services did not know of these services' existence in their respective communities and London as a whole. This may imply a disconnection between institutions mandated to inform and reduce new HIV infections and ACB men. Commenting on this, a research participant stated:

I feel that not many people have access to what they need. I know there are places they give out condoms, treatments, and stuff. There are sexual clinics I have been to one before, where they will give you pills if you have contracted an STI or an STD. But not many people know about that, and when they are vulnerable and having sexual intercourse with multiple partners, then they do not know that they have it, so they are just transferring it to whoever they are having sex with [IDI, 25-38 years]

Low awareness about the availability of HIV-related health services and where to locate these services works to reduce the number of ACB men visiting these facilities to test or seek treatment for HIV. This also implies that ACB men may not be getting

the needed information useful in positioning themselves to reduce their exposure to the virus. A participant noted the importance of information dissemination in reducing new infections among ACB men.

I think that what we need in terms of how we should better prepare ourselves for HIV is information. I think we touched on it already. We need the information. It could come through school, it could come through services, it could come through pamphlets, but just general awareness as my colleague said about the causes [FG, 16-24 years]

According to this participant, unlimited access to HIV information, testing, and treatment services may be indispensable to position ACB men to respond to their HIV vulnerability adequately.

5.5.2. *A Disconnect with HIV Service Spaces*

ACB men who were aware of the existence of HIV preventive health care services bemoaned their disconnection with these spaces. They stated that they were not represented in the staffing at these institutions. A participant, commenting on the low usage of preventive health care by ACB men, reported:

I think it has to be in the activity, the narrow mindedness because there are many linear thinkers in the fields [ASOs]. And I think those are some of the things that need to be addressed so that they can talk to anybody. And again, in the employment, is to have a reflectiveness of the diversity [IDI, 39+ years]

Being unrepresented in staffing at ASOs makes ACB men feel alienated from these spaces. Further, the lack of cultural competence in service delivery was identified to reduce their visits to ASOs. The lack of culturally competent and sensitive services at ASOs was reported by a service provider (SP) as he stated:

I think from a cultural lens, I will suggest that it's kind of walking a mile in my shoes. Right now, at our organization, for example, she talks about doing outreach, and I'm the department head of HIV, but I'm just a non-ACB guy, and she is a female. I wonder the impact of speaking to the community being

not as connected. I think that if it was a strong black man presenting information, I think that might land on different ears. It might land a little differently than if it is it coming from myself or her despite our best efforts [SP, 39+ years]

These lapses at service provider sites may dissuade ACB men from testing for their HIV status or seeking treatment in these spaces. An HIV positive ACB man reported challenges he faces at provider sites when attempting to access services:

I went in there, had a bit of an issue with those folks, and I asked to get a referral to another HIV clinic in order to get the medical help that I need. They told me that they wouldn't give me a referral. I asked for a second opinion. They told me that I couldn't even get a second opinion. They told me that all I had to do was go down to some other medical spot, tell them that I have HIV and that they would take care of my needs [IDI, 39+ years]

Based on these lapses at provider sites, participants commented on how ASOs can position themselves to improve services for heterosexual ACB men. Another HIV seropositive participant remarked:

As far as ASOs are concerned, I would like to see, especially when it goes down to dealing with people that are HIV positive. You can't really call them mentors, but the people we go to for help and whatnot. I would generally like to see a good split right down the middle between heterosexual and people that are not heterosexual [IDI, 39+ years]

The quote from this participant may suggest that services in these health spaces may not be tailored towards the needs of the heterosexual population as he calls for increased representation of heterosexual people in the delivery of services.

5.5.3. Stigma Within and Outside the Community

Experiences of stigma both within and outside the ACB community may create barriers to accessing preventive health services. Participants referred to stigma outside the community as comments and actions from non-ACB people which

stereotype them as automatic carriers of the virus. Stigma within the community was in reference to the negative discourses and blame by other ACB people around how people become infected. For some ACB people, the social environment may be hostile to people living with HIV, which affects the willingness to test or use services in ASOs. A research participant commented:

Someone raised in that type of environment [with high HIV stigma], why would they ever want to tell anyone that they contracted HIV at a point. They probably wouldn't even have been tested necessarily in general. And it is like so if you found yourself in a situation like that now and there are cultural stigmas around having HIV, and you realize there is nothing you can do about it, it is not so crazy to see that individuals will continue to go on and act as they normally would and that only furthers the spread of the virus in general [IDI, 25-38 years]

Misconceptions about HIV directly aids in the spread of the virus, as people are discouraged from undergoing testing. ACBs living with the virus feel restrained from openly disclosing their status and/or seeking treatment. For ACBs with transnational ties in Africa and the Caribbean, fears about one's HIV positive status filtering back home further impedes their willingness to test.

Someone who had experienced testing for example before they came to Canada, they know what the situation is like in their country say in Africa, so they will have a very different view than someone from here. There is all this judgement. I know everybody in the community I don't want anybody in my community to know that I'm HIV positive [SP, 39+ years]

Outside the ACB community, experiencing stigma from non-ACB persons due to stereotypes about Africans/Blacks being carriers tends to discourage testing. ACB men feel stereotyped when links are drawn between their race, sexuality, and HIV prevalence in Canada. For instance, a participant in a focus group discussion observed:

I feel like it is the stigma thing. I feel because of the susceptibility of people getting HIV in countries and continents like Africa, that same stigma is

put somewhat onto us. So, it is a social norm for anyone to say HIV or AIDS you automatically think of an ACB person, which is not fair, and I feel that there's also a mental stigma to it as well [FG, 16-24 years]

Other ACB men shared similar stigma experiences indicating that such stereotypes affected their social relations and interactions with non-ACB members of their community. A participant in an in-depth interview remarked:

But you know if there are general perceptions that black men are of a higher likelihood, or of a higher percentage to have contracted HIV, then when I am out here in London, in a small concentration of black people, the way people perceive me might be based on those statistics, based on those perceived realities. People will feel threatened to interact with me even on threat of me potentially having that virus purely from just me being black [IDI, 16-24years]

Accordingly, ACB men admitted to the realities of their higher vulnerability.

However, they noted that the stigma associated with these realities also served as a barrier to using health services.

5.5.4. Systemic Policy Neglect

Systemic policy neglect of the health and social needs of the ACB community may be partly responsible for their low patronage of preventive health care services.

In the comment below, a service provider elucidated how the ACB community, regardless of their higher vulnerability, may not constitute a priority group for specific policy targets:

I am probably looking at it from a much more macro perspective. I'm just wondering whether the political systems, the government, in essence, are putting out the kinds of money that need to be put out there to address some of the issues. Now there are many people who I always look at in terms of voting powers. Certain segments of the community don't get a lot of economic action from the government because they in terms of their voting power, are fairly limited to make changes. They don't necessarily put out the kinds of funds that are needed to address some of those concerns [SP, 39+ years]

ACB men also alluded to lack of funding for social and health programs within the ACB community in London that could potentially increase awareness and access to HIV preventive health care. However, in the quote below, participants agreed that other vulnerable groups continue to receive funding for health-related programs, while they do not:

Just some more focused social programs directed at that (HIV programs). It is always social programs, that is all what we need. The funding runs out for us in our social programs, but other communities have tons of money. [IDI, 25-38 years]

A lack of funding from the government for HIV services for heterosexual ACB men could be due to its attention to other groups that are politically mobilized. A service provider underscored why heterosexual ACB men's HIV vulnerabilities may have escaped health policy attention:

In my role we like to think that we deal with health equity. We like to think that we are targeting those populations that most need it, but the reality is that sometimes we go with the biggest which means that we are targeting the public. Even though we have statistics that say this population [heterosexual ACB men] that needs very specific targeting, but it is really only 5% of the population. So, are we really going to spend our campaign dollars on 5% of the population? So, when you are making those choices again, it comes down to funding and which again comes in to political. Are we spending those dollars on those vulnerable populations and often the answer is no [SP, 39+ years]

While political and health policy stakeholders, including service providers, may be aware of the heightened risk of HIV infection among heterosexual ACB men, their low numbers (i.e., less than 3% of the city's population) may not engender political interest in their health needs.

5.6. Discussion

As part of weSpeak, an Ontario-based study on HIV vulnerability and

resilience among heterosexual ACB men, this study sought to understand the broader context of heterosexual ACB men's access to preventive health care, specifically HIV-related services, by exploring their everyday challenges in accessing these services amidst their HIV vulnerability. The findings show that ACB men face substantial daily structural challenges in their attempts to access HIV-related health services in London. This may be contrary to earlier assertions that heterosexual ACB men's HIV vulnerability is explained by behavioral characteristics that work to keep them away from preventive health care services (Moyer, 2013). Our findings also demonstrate that a multiplicity of factors—including a disconnect with health care services given the absence of culturally competent services, heightened stereotypes that stigmatize heterosexual ACBs and a systemic neglect—act as structural barriers to prevent them from easily accessing preventive health care.

Furthermore, it emerged that ACB men's limited awareness of their risk of infection is underscored by their inability to access information on HIV in their communities as they tend to be alienated from ASOs. This is especially the case for recent ACB immigrants from regions with higher HIV prevalence as they may not perceive any risk of HIV infection when they arrive in Canada (Shamara Baidoo-Boonso et al., 2013). While members of the ACB community show urgency in their desire to get timely access to information on HIV and related services, they find themselves in a conundrum as they are disconnected from sources of HIV information as well as testing and treatment services. This revelation, as observed by other researchers such as Husbands et al. (2000), has worrying implications for reducing new infections as ASOs and other preventive health care facilities may not be targeting the vulnerable ACB population with the much-needed information.

Given Canada's claim to universal health care and improved access to health

information, the finding that HIV transmission misconceptions persist among the vulnerable and structurally exposed ACB population due to structural barriers in accessing HIV-related information and testing services is an antithesis to this claim. This observation, however, may not be too surprising as Martin and colleagues (2018) allude to systemic and structural failures in adequately addressing the health vulnerabilities of racial minorities in Canada. In this sense, despite the Public Health Agency of Canada's admonition that increasing heterosexual infection disproportionately affects the ACB community (Public Health Agency of Canada, 2014b), heterosexual ACB men still lack sufficient awareness and readily available opportunities to test. Within the context of Canada, immense policy attention – and prioritization of men who have sex with men (MSM) and IDUs – aimed at behavioral change in the form of safer sex, increasing access to HIV testing and treatment, and the introduction of needle distribution programs across provinces resulted in substantial drops in new infections among this population (Krentz & Gill, 2009; Leonard et al., 2008; Ontario Advisory Committee on HIV/AIDS, 2016). Therefore, rising heterosexual infections may be suggestive of a structural deficiency in dealing with an equally vulnerable population. In line with earlier studies such as Husbands et al. (2013), one can argue that the intersection of ACB men's race, gender and sexuality informs stereotypes and narratives about a self-inflicted HIV vulnerability that may be excluding them from Canada's health policies.

The disconnect between heterosexual ACB men and preventive health care institutions arises due to a lack of culturally competent services and ACB representation by way of staffing in preventive health care institutions. Invariably, these concerns do not only lead to feelings of alienation from services, but ACBs are also discouraged from sharing their experiences of vulnerability with the

predominantly non-ACB staff as personal health disclosures tend to occur in environments of established trust (Mayer et al., 2015). Given the increasing cultural diversity of the Canadian population, it has been argued elsewhere that a corresponding diversity in the healthcare workforce will improve health access for medically underserved populations, increase research on the health needs of racial minorities, while ensuring minorities are also adequately represented in future health policies (Cohen, Gabriel, & Terrell, 2002). According to Betancourt et al. (2019), this can be achieved by recruiting minorities into health systems, providing interpreter services and tailoring health materials in languages that are sensitive and appropriate to minority populations. Furthermore, the importance of racial representation in health spaces has been posited by Zambrana et al. (2000) to engender feelings of empathy, cultural competence and sensitivity for racial minorities. It has further been observed that willingness to disclose sensitive information by patients to health professionals may be predicated on similarities in social category including sexual orientation and race (Pierre, 2012). The current under-representation of ACBs in staffing at ASOs amidst evidence of their rising infection may also reflect the structural complacency in understanding the needs of this vulnerable population and mainstreaming their needs into the health service delivery system. In this regard, the revelation that service providers are unable to provide culturally competent services even for ACB men living with HIV implies a non-alignment of preventive health services to specific needs of vulnerable ACB men (Husbands et al., 2017).

The persistence of stigma within and outside the ACB community remains one of the greatest structural barriers in addressing HIV/AIDS in Canada (Shamara Baidoobonso et al., 2012). Among exposed populations including ACBs, stigma arises in the community due to misconceptions fraught in misinformation about the etiology

of the virus, and how it is transmitted. In Toronto, Newman et al. (2008) report similar findings as some ACBs believe contracting HIV is a result of moral impropriety including risky and indiscriminate sexual adventures. Therefore, for fear of being stigmatized and ostracized, HIV positive ACBs are discouraged from openly disclosing their HIV status and may experience challenges in making the needed lifestyle adjustment with potential implications for the continuous transmission of the virus in the ACB community. In preventing accidental disclosure of their HIV serostatus to their community, particularly for those living in a transnational space, ACBs are reluctant to seek treatment or follow a strict medication regime when they test positive. Intersected with gender and race, the discourses of heterosexual ACB men as active transmitters of HIV in the context of North America including Canada as observed by Miller (2005) may have distanced members of this community from actively being engaged in seeking preventive health care (see Geary, 2014). Earlier findings by Loutfy et al. (2012), that the intersection of race, ethnicity and gender play an important role in experiences of HIV-related stigma in Ontario, led to the call for differently targeted approaches for specific racial minority groups (particularly ACBs) in reducing HIV-related stigma, instead of a generalized approach. They further emphasised addressing racial and sexist discourses that in/directly expose marginalized populations to HIV vulnerability.

Despite discourses which privilege HIV vulnerability among heterosexual ACB men as behavioral, structural factors, as posited by Hankivsky and Christoffersen (2008), persist in preventing ACB men from accessing preventive health services. The absence of structural support for social programs in ACB communities leads to poor community mobilization in sensitizing community members on their heightened risk to HIV infection. Policy has continued to focus on other at risk groups, which have

witnessed a drastic decline in new infection rates over the last two decades. At the same time, heterosexual infections, particularly among heterosexual ACBs, are rising (see Peter & Bobinski, 2008) which speaks to policy mismatch and the further marginalization of a vulnerable group. This may persist, as heterosexual ACB men, as a marginalized group, do not have the political mobilization and lobbying prowess to adequately engage and draw policy attention to their social and health vulnerabilities.

5.7. Conclusion

Findings in this study suggest that Canada's progress in maintaining HIV prevalence below endemic levels was achieved through increased access to information and preventive health services. However, racial minority groups still report endemic HIV prevalence rates. The conundrum of higher HIV prevalence among heterosexual ACB men and limited access to information, testing and treatment exposes a structural deficit and complacency that may be worsening HIV vulnerabilities for an already structurally marginalized population. To reduce new infections among this population, there is the need for policy to shift from narratives about ACBs' avoidance of preventive health services and rather focus on overarching structural factors that may be predisposing this population to new HIV infections.

While it is worthwhile to encourage HIV testing among this population, testing services should take an integrative approach where HIV information sessions are held prior to testing, to help people acquire factual knowledge about HIV transmission. This may be particularly useful as Bond et al. (2015) observe among ACB men in the US that HIV testing does not always translate into accurate knowledge of HIV transmission, and in some cases may even be considered as prevention. Given the

commitment of heterosexual ACB men to seek HIV-related information and testing services, it is important to engage them through frequent community outreach by ASOs. Building trust between preventive health service providers and the ACB community is essential for promoting ACB men's access to services that are useful in reducing HIV prevalence in the community.

5.8. References

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CHAPTER SIX

6.0. BLACK HETEROSEXUAL MEN RESILIENCE IN TIMES OF HIV ADVERSITY: FINDINGS FROM THE weSPEAK STUDY

Abstract

In Canada, heterosexual African, Caribbean and Black (ACB) men suffer a disproportionate burden of HIV infection. Consequently, studies have examined the underlying contributors to this disparity through the nexus of behavioral and structural factors. While findings from these studies have been useful, their use of deficit and risk models only expand our knowledge of why ACB men are more vulnerable to HIV infection. Thus far, there is a dearth of knowledge on how heterosexual ACB men mobilize protective assets to promote their resilience towards HIV infection. This study as part an Ontario-based project called weSpeak, examined how ACB men acquire protective assets to build their resilience to HIV. We analyzed three focus group discussions (n=17) and 13 in-depth interviews that were conducted with ACB men. Findings showed that ACB men mostly relied on personal coping strategies including sexual abstinence to avoid HIV infection. Interpersonal resources such as family, friends and religious communities were an important link in the chain of ACB men's resilience trajectories. ACB men bemoaned their lack of access to essential institutional resources such as health services. There is an urgent need for HIV policy stakeholders to engage the community in the design of intervention programs. Additionally, addressing their socioeconomic disadvantages will increase their capacity to respond to HIV.

6.1. Introduction

A low HIV prevalence rate of 0.2% in Canada tends to mask the realities of HIV infection in the country (Lee, Plitt, Fenton, Preiksaitis, & Singh, 2011). For instance, studies have reported higher concentration of the HIV epidemic among sexual and racial minorities whose HIV prevalence rates are at par with that of HIV endemic low-income countries (Bird, Lemstra, Rogers, & Moraros, 2016). In particular, people of African, Caribbean and Black (ACB) descent in Canada are overburdened with HIV. Evidence suggests that, while ACB people make up less than 5% of Canada's population, they constitute 20% of persons living with HIV and are also 12.5% more likely to be infected compared to others in the general population. Despite the disproportionate burden of HIV experienced by ACB communities, the allocation of resources to address these vulnerabilities may not be specifically targeted at heterosexual ACB men, which makes them particularly more vulnerable to new infections (Haddad et al., 2018; Husbands et al., 2014). Specifically, in Ontario, they also accounted for 17% of all HIV diagnoses and are further incriminated as subjecting ACB women to HIV risk (Remis et al., 2012; Tharao & Massaquoi, 1999).

As critiqued by Husbands et al. (2019), HIV studies have relied on behaviorist perspectives that focus on explaining how ACB men's behavior has resulted in the disproportionately high prevalence of the disease. Consequently, the question of which assets are critical for building resilience to preventing HIV infection and how these assets are mobilized is less known in the Canadian context. In this paper, the term "resilience to HIV" refers to ACB men's activities that help them prevent or reduce their vulnerability to HIV and/or help those living with HIV to cope with their HIV positive status. In general, traditional masculine expectations deter all men from seeking health services and support, which are deemed a sign of weakness or feminine

traits (Springer & Mouzon, 2011; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). ACB men face additional challenges related to systemic barriers of racialized stigma and discrimination that may particularly impact how they acquire assets to build resilience to prevent HIV infection. While all men demonstrate masculinities to a varying degree, ACB men's sexual practices are mostly interpreted out of context or decontextualize to produce stereotypes about their masculinities that further create barriers to access resources (Geary, 2014; Gilbert et al., 2017).

However, the prioritization of behavioral factors as main contributors to ACB men's risk of HIV infection projected the perceptions that HIV among ACB men risk is 'self-inflicted' (Husbands et al., 2017). However, in situating their HIV risk within a structural context, other scholars (Baidooobonso et al., 2016; Husbands et al., 2017, 2013; Konkor, Lawson, et al., 2020) have called for a re-examination of ACB men as active agents who, with appropriate support and resources, can address their risk to HIV infection. Indeed, earlier studies in Ontario, Canada have observed that ACB men were aware of their risk of HIV infection and, therefore, were proactive in meeting their own health needs and making the necessary adjustments and choices to avoid HIV infection (Gardezi et al., 2008; Husbands et al., 2014). Despite this evidence, studies continue to use deficit and risk models that only explain the disproportionate burden of HIV among Black men (and women). For those using resilience and asset-based approaches, the focus has been on how ACBs living with HIV cope and overcome the stress associated with their diagnosis. This study is part of a research project called weSpeak, which focuses on HIV vulnerability and resilience among heterosexual ACB men in Ontario. weSpeak also seeks to engage stakeholders in critical dialogue through innovative and community-based approaches to address high HIV prevalence among ACBs in Ontario. Consequently, this study

examined how resilience emerges among heterosexual ACB men and how they may be positioning themselves to acquire protective assets to build resilience to prevent HIV in London, Ontario. Findings from this study could be crucial in contributing to reform health policies on HIV service provision that leverages existing ACB men's resilience mechanisms and assets to address their health needs and reduce new HIV infections.

6.1.1. ACB Men and Resilience to HIV

Resilience is differently defined but generally connotes an individual or a community's ability to bounce back from adversity (Diprose, 2014). It may also be defined to constitute the protective assets at the disposal of individuals that cushion and equip them with the capacity to recover from adversity (De Santis, Florom-Smith, Vermeesch, Barroso, & DeLeon, 2013; Diprose, 2014). In its earliest application, resilience was linked to people's innate qualities, including 'hardiness' 'social competence' 'self-control' which made them 'naturally' adapted to overcome temporary setbacks (Leadbeater, Marshall, & Banister, 2007; Theron, Mabitsela, & Esterhuizen, 2009). However, the broader conceptualization of resilience not only recognizes the innate qualities but also includes its intersection with socio-environmental factors and any supportive resources that can help individuals to gain protective assets to be able to thrive within adversity (De Santis & DeLeon, 2013; Wood, Ntaote, & Theron, 2012). Therefore, while HIV prevention constitutes recommended programs specifically targeted at reducing HIV spread, HIV resilience connotes a spectrum of resources inclusive of access to these recommended HIV prevention programs as well as other intrapersonal, interpersonal, and institutional resources (De Santis et al., 2013; Fishbein, 2000).

In the context of the HIV epidemic, an individual's ability to avoid infection is based on their accumulated protective assets arising from their access to and the quality of resources in their sociocultural environment. Among ACB men for instance, studies have suggested their predisposition to infection may be due to low awareness and uptake of HIV testing and treatment (Bowleg & Raj, 2012; Bowleg et al., 2011). In this regard, making the necessary behavioral adjustments to avoid infection among ACB men may largely be limited to their understanding of how the virus is contracted or transmitted (Baidoobonso et al., 2016). Emphasizing the role of information in HIV resilience, the Ontario Advisory Committee on HIV/AIDS (Ontario Advisory Committee on HIV/AIDS, 2016) posits that declining HIV prevalence among high-risk groups including men who have sex with men (MSM), and injection drug users (IDU) is attributable to policies that intensified information dissemination to these populations. This is because unhindered access to relevant HIV information equips individuals with the requisite knowledge to avoid infection (Antabe et al., 2020; Sano et al., 2016). Similar arguments are made for the frequent use of HIV-related health services, where those with easy access are able to accumulate protective assets to build resilience. Concomitantly, such users of preventive health services are mostly exposed to factual information and are then able to make the right decisions such as testing to know their HIV serostatus and when positive, can access counselling and treatment which further builds resilience (Anfaara et al., 2018). In Canada, while ACB men represent a key constituency of groups at increased risk of infection, they are the least visible group in AIDS Service Organizations (ASO) and health care spaces, and this could be linked to their inability to get factual information (Lasser, Himmelstein, & Woolhandler, 2006).

Overcoming adversity also involves having a strong network of family, friends, interpersonal resources within existing social and cultural structures to buffer individuals' resilience (De Santis, 2008; Diprose, 2014; Hoy et al., 2008; Theron & Malindi, 2010). The existence of social and cultural support systems that prioritize HIV testing, treatment, and access to information may engender individuals in these support systems to make the necessary adjustments to build resilience to HIV infection (Isler, Eng, Maman, Adimora, & Weiner, 2014). In this regard, ACBs sociocultural and social network characteristics are sometimes evoked to explain why they may be more vulnerable to new infections. For instance, HIV stigma, limited access to preventive health care spaces, homophobia, and a socialization process that seems to endorse traditional masculinities are theorized to prevent heterosexual ACB men from accumulating enough protective assets against HIV (Bowleg, 2004; Bowleg et al., 2011). It is further suggested that, relative to other groups, ACB men do not readily discuss their sexual and health vulnerabilities, and this may prevent them from engaging in practices known to be useful in accumulating protective assets in fighting HIV adversity (Bond et al., 2009; Hammond, Matthews, Mohottige, Agyemang, & Corbie-Smith, 2010).

Unfortunately, most discussions about ACB men's HIV risk are bereft of structural contexts despite the overarching role of these structural factors in defining individuals and communities' capacities to acquire protective assets in the face of HIV adversity (De Santis, 2008; Theron et al., 2009). For instance, Husbands et al. (2017) argued that heterosexual ACB men were aware of their HIV risk but were not engaged by ASOs. Thus, ACB men are left wandering within the health care policy spectrum, which is expected to provide them health services that would support their resilience to HIV. Amidst inherent challenges, what we do not fully understand is how

heterosexual ACB men are responding to their HIV vulnerabilities beyond the frequent behavioral connotations. Very few studies have interrogated ACB community's health production practices and how they may be mobilizing protective assets for building resilience to HIV. Therefore, this study examined resilience trajectories and practices of ACB men within the context of contributing to health policy literature on HIV resilience. In particular, the findings will improve our understanding of the protective assets, characteristics and mobilization dynamics in ACB communities and their potential for designing HIV-related health policy.

6.2. Study Context

London, Ontario has a population of 383,822 according to the 2016 population census of Canada. It is noted as one of the fastest growing cities in Ontario and Canada. It is the 6th and 15th largest city in Ontario and Canada respectively. The city's policy to attract people with diverse cultural and racial backgrounds, together with its strong economic base ensures the continued growth and the increasing racial diversity for London. As of 2016, ACBs constituted 2.6% of the city's total population, which is relatively higher than similar size cities in Canada (Statistics Canada, 2017).

London has one of the highest prevalence rates for infectious diseases, such as hepatitis B virus (HBV) and HIV. Evidence from both the Public Health Agency of Canada and the London-Middlesex Health Unit—the local body responsible for administering and managing health care in the city—places residents of London at heightened risk of infection. HIV infection rates in London nearly doubled over a decade from 5.9 cases per 100,000 in 2005 to 9 per 100,000 in 2015 (Spalding, 2016).

Similar trends were recorded for hepatitis C infections which was found to be higher than the reported incidence for the province of Ontario. These disturbing trends of infection led the London-Middlesex Health Unit to declare a ‘medical emergency’ in 2016 as part of strategies to reduce new infections in the city. The main strategy was to increase supply of needles and create safer spaces for supervised and safe injection as injection drug users were observed to be disproportionately infected. Missing from this initiative, however, is a strategy for addressing worsening heterosexual transmission which represents close to 90% of all HIV diagnoses in the ACB community (Haddad et al., 2018). Despite heterosexual ACB men constituting one of the key HIV risk groups, there is no specific policy aimed at reducing new infections among them.

Although access to primary health care in London has improved over the years, a 2016 report suggested some populations in the city experienced barriers in accessing health care (Human Environments Analysis Laboratory, 2016). Ethnocultural and racial minority populations including ACBs continue to face challenges in the access and utilization of health care services likely made worse by their poor socioeconomic status (Human Environments Analysis Laboratory, 2016). In an earlier study on health equity and access in London, some members of the ACB community also emphasized the challenges they face in the city’s health care system, thus compelling them to resort to seeking health care outside the city (Baidoobonso et al., 2012). To understand the HIV needs of ACB population in London, Baidoobonso and colleagues (Baidoobonso et al., 2013) called for a more structurally focused approach where HIV risk, vulnerability and resilience can be situated in the structural determinants of health.

6.3. Methods

This study forms part of the weSpeak research project implemented in four Ontario cities – London, Windsor, Ottawa and Toronto – between 2015 and 2020 to understand heterosexual ACB men’s HIV vulnerabilities and resilience. The present study focuses on how heterosexual ACB men in London position themselves and mobilise protective assets to overcome HIV adversity. In addressing this research objective, we examined the activities and practices ACB men employed to reduce their risk to HIV infection. Of interest was how ACB men defined and perceived resilience in their everyday lives. We sought to understand existing strategies and protective assets or resources, as well as the methods in which these resources are mobilised to build resilience to HIV. Participants also identified experiences that were debilitating to their ability to build resilience to HIV. Ethics for the study was approved by the Western Non-Medical Research Ethics Board (NMREB) in 2015.

6.3.1. Participant Recruitment

Participant recruitment for focus groups (FG) and in-depth interviews (IDI) took place between the February of 2016 and April 2017. To understand the varied experiences and resilience trajectories and practices of heterosexual ACB men in London, Ontario, recruitment was carefully designed and rolled-out to interview participants from varying backgrounds – socioeconomic, geopolitical, ethno-cultural, immigration and HIV serostatus. To qualify to participate in the research, the prospective participants self identified as heterosexual ACB men, aged 16 or older, spoke English or French, and lived in London. Given that the targeted participants were a hard-to-reach population, the study employed a five-pronged approach in the recruitment. First, the study identified ACB men’s common spaces including Black barbering salons, churches, mosques and African-Caribbean restaurants where project

notices and flyers were available. Individuals interested in the research made initial contacts with the research coordinator for recruitment in the study. Second, the leadership of ethno-racial groups including those from sub-Saharan Africa (SSA) and the Caribbean were contacted and informed about the purpose of the research. The leaders then informed their membership about the research were invited to contact the research coordinator for additional information and to be screened for their eligibility to participate in the study. Third, notices were posted at the spaces of health service providers including the Regional HIV/AIDS Connection (RHAC) and some selected hospitals in London for prospective participants to contact the researchers. Fourth, recruitment also took place during community activities and events that brought members of the ACB community together. For instance, researchers were present at activities marking Black History Month and a health fair organized for racial minorities by the RHAC. Research assistants also randomly spoke to ACB men they met on the streets about the research. Interested individuals contacted the research coordinator for initial screening on their eligibility to participate. All selected participants who met the eligibility criteria signed a consent form to participate in the study. Demographic details of participants are provided in Table 1.

6.3.2. In-depth Interviews and Focus Groups

Individuals interested in the study were invited to participate in either in FG or an IDI. For FGs, participants were organized into three different groups based on their age as that ensured resonance among group members (Baxter & Eyles, 1997; Kitziinger, 1994). To delve further into, and unpack nuances emerging from themes in the three FGs, there were additional thirteen (13) IDIs for heterosexual ACB men. This was useful in providing depth and contextualizing findings from FGs. It was also useful to use this medium to discuss views that may not be amenable to a group

setting. Overall, FGs lasted between 60-90 minutes while IDIs lasted between 45-60 minutes. Sessions for both FGs and IDIs began with individuals giving both verbal and written consent to be audio-recorded. Participants were informed that their identities would be confidential and protected. Participants were made aware of their right to have the recorder switched-off at any point in the interview or not to answer any question if they did not want to and to withdraw from the study at any time if they chose to do so. The interviewer kept a field notebook where important gestures and emotions were recorded during the interviews to assist during data analysis, interpretation and presentation of findings. FGs were held at the Regional HIV/AIDS Connections (RHAC), while IDIs took place at spaces identified by participants as safe and appropriate for the interview.

Guided by a checklist of questions, participants in both FGs and IDIs discussed how they acquire protective assets to build HIV resilience. They first discussed their understanding of resilience and how the concept informs their efforts to avoid getting infected. Specifically, they linked the concept of resilience to their everyday lived experiences in the City of London, Ontario. They identified existing resources in coping with HIV adversity, including individual protective assets and those at the interpersonal level. They further discussed the role of institutional resources in building individual and community resilience to HIV. The core questions that guided the discussions included the following: 1) how are ACB men accessing information and health services related HIV?; 2) what specific activities or programs target ACB men in an attempt to keep them informed about available community resources; 3) what resources are available for those who test seropositive for HIV?; and 4) what challenges do ACB men face, and how do these challenges impede their ability to acquire protective assets to build resilience to HIV? Overall, three (3) focus

groups involving individuals in age categories 16-24 (n=5), 25-38 (n=5), and 39 and older (n=7), and thirteen (13) in-depth interviews with individuals aged between 16 and 67 were conducted.

6.3.3. *Data analysis*

All audio recordings from the interview sessions were transcribed verbatim by research assistants under the guidance of the research coordinator. The transcripts were then exported into NVivo, a qualitative software for analysis. We employed a mixed inductive-deductive thematic coding, where the process of theme identification was informed by our theoretical constructs and the data (Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006). Team members read the transcripts to become familiar with them before proceeding to code and identifying themes related to our research objectives. To ensure consistency in coding among three team members, coded transcripts were exchanged between team members to crosscheck and verify that the coded discussions were representative of their assigned themes and were consistent with other transcripts. Some of the research co-PIs with extensive qualitative research experience were given copies of the coded transcripts for their independent review. These strategies improved rigor in the analysis and results of the study.

6.4. Results

The analyses revealed several themes on how ACB men cope and thrive through HIV adversity. These themes were tied to participants' conceptualization and understanding of resilience and the means available to acquire protective assets to build resilience to HIV. We found that heterosexual ACB men used internal (or

personal) and external resources to build resilience to HIV. While internal resources were expressed in individual characteristics such as an openness to discuss one's vulnerability, external ones were primarily defined by interaction with family members and friends.

We found that religion was an important platform employed in mobilizing both internal and external resources. Religious groups and teachings provided a sense of community and an important medium for ACB men to discuss their vulnerabilities and acquire protective assets. This notwithstanding, several structural dynamics impede the process of building resilience among this community. Heterosexual ACB men draw on their everyday experiences to propose ways to improve their resilience to HIV. The next section presents details of these findings. Each of the key findings is supported with direct quotes to provide context for further clarity. At the end of each quote, the participant's age and whether they took part in a focus group discussion or in-depth interview are provided.

6.4.1. Participant's conception of resilience

Participants explained that HIV-related resilience generally encompasses internal resources or personal protective assets that position them to freely discuss and share their feeling of vulnerability with family and acquaintances. However, there was a recognition that internal resources or personal protective assets of resilience need to be supported by external resources in the social environment to adequately address HIV adversity as captured in the following quote:

We have innate determination, it is given, we have that. But it needs to be formed into resilience with respect to adverse circumstances and adverse environments. And with diseases like HIV/AIDS, our resilience has to be formed, so we channel our resilience into positive ways to get through something like HIV [FG, 32 years]

Experiences of adversity in the past provide participants with the ability to identify support systems in overcoming the impact of HIV. As observed by a participant (age 40) in an in-depth interview, *“I feel that for everybody you must hit the bottom, rock bottom to realize who's your friend, who's around, what you can do so when you're right back to the top you know how to deal with it.”* Yet, for other participants, resilience to HIV meant access to HIV information and testing for ACB men.

You can build resilience, you know, get tested, learn about HIV, know your status, those types of things. It protects yourself. So, we [ACB men] should be getting ourselves tested as a priority [IDI, 35 years]

Participants also conceptualized resilience to encompass the use of condoms during sexual intercourse. Akwasi, a 45-year-old Caribbean, summarised what he perceived to constitute the most important HIV resilience for ACB men *“Somebody don't have sex because they don't want to have children, but the condom is the umbrella of resilience for black men.”*

ACB men perceived acceptance of risk to HIV infection as foundational to acquiring protective assets to build resilience to HIV. Therefore, making them informed about their risk to HIV infection could compel them to identify resources and mediums that can be used to acquire protective assets against HIV infection.

Acceptance is the fact that as an African Canadian Black man, I am in fact vulnerable to HIV. As well, if I don't utilize [HIV] information, I become more vulnerable [FG, 29 years]

6.4.2. Individual Intrinsic Resilience and Coping Mechanisms

Heterosexual ACB men employed several individual intrinsic strategies and initiatives to avoid being infected. These included sexual abstinence, as highlighted in the following quote:

I feel right now in this very moment, I am 100 percent not vulnerable to HIV because of choices such as sexual abstinence [IDI, 25 years]

The strategy of sexual abstinence was reported by recent ACB immigrants to Canada.

A 32-year-old recent immigrant to London affirmed abstinence as a resilience tool,

“you know, ever since I got to Canada, I have not had sex with anybody [for fear of getting infected with HIV]. And that's almost a year now. I don't rush things. I always

want to be sure what I do.” For those that may not be abstaining from sex, limiting sexual activities to one partner, preferably in stable relationships, positioned them to reduce their vulnerability and be resilient to HIV infections.

Most of the sex I have had comes in an actual relationship. And you think that doesn't really seem like it means much in reducing risk of HIV infection, but one, it reduces the number of partners you have; and two, it usually puts space in between your partner's partners [IDI, 40 years]

For some participants with transnational ties, communicating with contacts in origin countries was important to overcoming HIV adversity:

I often bring up some issues...personal stuff like my health and things like this [HIV vulnerability], there isn't anything that my sisters don't know. I also have with my cousin's husband, who is in Jamaica, I talk with. I have other friends outside Canada I speak with. So, I have a fair network of people [FG, 67 years]

Despite the role of community network in building resilience, our findings also revealed that issues relating to trust and HIV stigma discourage some heterosexual ACB men from freely discussing their HIV vulnerabilities and thereby resorting to individualized mediums in dealing with adversity.

I guess when I'm feeling vulnerable, I just like to listen to music. I know a lot of people might want to speak to someone about it, but again with a lot of the stigmas around HIV, a lot of people are afraid to talk to someone about it. I used to play sports a lot to help myself deal with those type of things when I'm stressed [IDI, 25 years]

Individuals without such strong intrinsic capacity may find themselves in challenging circumstances where their risk is heightened. For instance, those with difficulties discussing their vulnerability with others may want to suppress and overcome adversity by using illicit substances, making them somewhat vulnerable to infection.

6.4.3. Resilience through community

Emerging from the findings was the revelation that the larger ACB community plays an essential role in helping ACB men acquire protective assets to build resilience to HIV by providing a sense of community and support. Building social networks within the community keeps participants informed about issues, including where to get help that may not be available within the community and immediate environment.

The thing I realized in society being a Canadian and growing up in this society is that it depends on who you know to succeed. So, if you are not accessing different social networks out there, then you are not in the know, and if you are not in the know-how, can you benefit or grow as a person? In the last 5 years, I had to be vulnerable and put myself in to share with somebody what I want to do. And they are like why don't you go to this agency over here, so I go to those agencies. They say well, we could do this for you, but how about if you go to that agency over there and the next you know, I've got this great big social network because I allowed myself to be a little vulnerable, which was very hard for me to do [FG, 57 years]

While some ACB men may shy away from building a network in the ACB community, it is considered a necessary resource in London, which has a small population of Black people. This point was captured in the remarks of a 57-year-old participant in one of the FGs.

When it comes to your community, you don't think about interacting with them; you have to put in the effort. It is the same with drawing support of the black community, you have to try because you are not going to go to the grocery store and see 20 black people, and 5 of them you know.

This recognition among ACB men may encourage a sense of common vulnerability and, therefore, the need to mobilize protective resources in small networks of ACB people in the study context. Improving connection and networking in the ACB community as a protective asset against adversity was echoed by another participant in an IDI.

I find it is beneficial to our brothers and sisters to say, like, hey, you know what? I'm going to get vulnerable; it's like give a little to get a little. I will be vulnerable why don't you share your struggles with me? I will share mine with you [IDI, 25 years]

Another participant also stated the benefits of keeping such social networks, especially when they cannot rely on their immediate family to discuss their vulnerabilities.

That's where it starts, actually exposing or revealing that side of you that you're vulnerable to somebody who you trust. Probably you can not reveal that to your wife because she might cut your throat. You can probably tell a pastor or have a conversation with a near friend who has values and gets his perspective and his advice. You find some way to get help and don't just say OK I don't have any help [FG, 39 years]

The sharing of experiences, vulnerabilities, and mobilization of protective assets among ACB men sometimes occurred through virtual communities such as social media. It emerged in FGs that some community members use YouTube channels, Facebook, and WhatsApp groups to share messages, discuss information specific to the community, and provide support and opportunities with members.

6.4.4. Spirituality and religion as sources of resilience

Participants identified religious beliefs as a valuable resource to their resilience trajectories. Many suggested that religious teachings and spirituality for those going through vulnerable times positioned them to overcome adversity. They also believed

that those who heed teachings on sexual abstinence and sex outside stable relationships tend to reduce their exposure to HIV, as indicated in the comment below.

From a spiritual perspective, I said I was Christian. If someone's in a situation where they are very spiritual, premarital sex is probably not something that's encouraged. But if someone was very spiritual, I suppose they would be discouraged from having that premarital sex, to begin with [IDI, 25 years]

Most participants agreed that while religious teachings may not directly touch on HIV, applying these messages to their everyday lives helps them protect themselves and build resilience to HIV. A 57-year-old participant in an in-depth interview remarked, *“Well if you are a religious person, then depending on your religion, you shouldn't be practicing polygamy. So, you should be only dedicating yourself to one woman, not cheating on her, and that will decrease any possibilities of [getting] HIV.”* Preaching empathy and sexual abstinence, and the importance of healthy living may encourage individuals to protect themselves from HIV.

In addition, churches, mosques, and religious groups are able to offer emotional support to members in overcoming challenges such as substance abuse that would have heightened their vulnerability to HIV. By so doing, religious groups serve as important platforms in building resilience against HIV.

I got baptized and dedicated my life to the Lord. And it was always a struggle. It's like forget about all my old life [drug addiction and sex with multiple partners], this is my new life, this is who I am, this is my identity, this is what I have been waiting for...it [had] been 8 months ago I gave up everything of my old life [IDI, 25 years]

For a city like London with a relatively small degree of racial diversity, Black churches are crucial in bringing the ACB community together to fight adversity or provide support to members in times of adversity. This was observed in a quote below:

When I look at this, I still see that the church is a sort pillar of the community... that sort of props the community up must be the starting point. I go back to churches because they seem to be the pillar. I mean, everybody seems to get there [FG, 40 years].

Thus, the church remains an important medium for addressing some of the social issues that predispose ACB men to a heightened risk of HIV infection.

6.4.5. Resilience for ACB men living with HIV

Some participants, namely ACBs living with HIV, used health and institutional services to accumulate protective assets in their resilience trajectories. For instance, a participant living with HIV recounted in an in-depth interview on how the help he received from various agencies supported the process of accepting his HIV status and initiating treatment.

I experienced other people who liked the service when they first came, I was really distant from a lot of people, it was something that I never wanted to get myself into. And I went to this location on a retreat, and I never forget it, a men's retreat, and it really opened up my eyes [IDI 45 years]

ACB men receiving these services over time tend to develop trust and establish friendships with service providers, helping them overcome stress and depression associated with living with HIV. In more extreme situations, individuals are able to acquire mental health services from health providers. Another seropositive participant recounted his experience in an interview:

Because of the way I was infected, there is a psychological component to it. It can bring out mental issues to the surface. And I think that for the longest time before I was infected, I was an angry individual. And I was an angry individual probably for about 8 years until I went and got help for post-traumatic stress disorder [through the agency] [IDI, 32 years]

Overcoming some of the challenges of living with HIV for this participant was through referral services, which helped him adjust to living with HIV. Through this, the participant could come to terms with his HIV status and continue with medication. The observation that health institutions' medication allowed ACB men living with

HIV to have healthy lives makes institutional resources foundational to their process of building resilience against HIV. A participant living with HIV in an interview provided the following comment:

I look at it this way, but a kind of a benefit from having HIV is that our health is monitored, it's incredibly monitored. So, when you're going, and you're doing your blood work every three months, you can find out or know of the possible things coming down the tube [IDI, 45 years]

While services offered by ASOs emerged as important for ACBs living with HIV, it appeared that most ACB men who were HIV negative or unaware of their HIV serostatus were not connected to these services. Even in most cases, they did not know where these organizations were located or the services they provided.

6.4.6. Strategies to improve ACB men's resilience

Participants proposed activities and ways the ACB community could be assisted to acquire protective assets to fight the HIV adversity. These proposed activities mainly focused on improving their connection to ASOs, which will be useful in accessing information and other valuable resources such as testing that can build their capacity to respond to HIV. This was emphasized by a recent ACB immigrant during an in-depth interview:

I was talking about understanding the realities of the virus. I think a lot of people [ACB men], including myself, have no knowledge around how you can contract the virus and ways in which once contracted, you could treat the virus [IDI, 25 years]

Connecting ACB men to ASOs will not only inform them about HIV transmission, but this may also encourage HIV testing and treatment for those living with the virus. It became apparent from the interviews that testing also has an added potential of promoting collective resilience in ACB communities as observed by a 40-year-old in

an in-depth interview *“I think you have to hit bottom, rock bottom to realize who is your friend, who is around, what can you do so when you are right back to the top you know how to deal with it.”* To ensure increased testing among ACB men, participants suggested the use of innovative ways to disseminate information about HIV to the community. For instance, virtual platforms, including social media and other community platforms such as churches, mosques, community leaderships, and entertainment figures, can improve HIV information and knowledge in the community. A participant in a FG commented:

People are so influenced by the media. Everyone's searching their phones these days...let's have HIV information here, let's have awareness information there, and let's just pump it out like that [FG, 25 years]

Another participant emphasized the strategy of increasing HIV information dissemination using prominent entertainment figures known in the community. In a FG, a 25-year-old participant had this to say: *“Because I do videos myself, I find that when there is a famous person in a video, people watch. For example, if Eminem is talking about HIV and the vulnerabilities, boom, you got like 10 million people following instantly”*. This may also require the political mobilization of Black leaders and the community to put pressure on the state to be more proactive to the health needs of the ACB community.

Furthermore, structural barriers appeared prominent in interviews and FGs as the core reason explaining ACB men’s difficulties drawing on protective resources to improve resilience against HIV. It was stated that reducing the social and economic vulnerabilities of ACB can help build resilience. A participant noted:

On a broader scale, it is important to lessen the stratification of society. Basically, improve social economic standards for the poor in society, which by and large are made up of Blacks and the black community, and then, we can actually go to school and learn instead of just having information thrown at us

when we can't concentrate because stuff at home is just messed up [FG, 32 years]

A 45-year-old immigrant echoed the need for improved access to social services and a just system for the ACB community as a pathway to acquiring protective assets to build resilience. *“We need access to decent educational facilities, better schools, better home environments, and less incarceration of our people.”* Additionally, they acknowledged the need for community mobilization around a shared leadership to make demands from the state and other stakeholders on resources to help build resilience to HIV in the ACB community. In an FG, a participant noted:

We need more black leaders, we need people to really get out there and go hard, because if you don't see a thousand black faces who are looking at you like what are you going to do for us? Then you're not going to do anything, you're going to be like yeah guess what, there's actually 15 000 black people in London, and you only see 15 in a given day if you really look hard. Then you don't give a damn about black people [IDI, 35 years]

In the perspective of ACB men, strategies that take a holistic approach to build resilience to HIV will have to consider their socioeconomic vulnerabilities based on the social structuring in Canada and an unfair justice system. The mobilization of the community to demand more from stakeholders will also ensure they are adequately positioned to become more resilient to HIV in Canada.

6.5. Discussion

In Canada, ACB men continue to suffer a disproportionate burden of HIV. While studies have expanded our knowledge of the nexus of behavioral and structural factors that predispose this population to HIV vulnerability, we know little about how they mobilize protective assets to face and manage HIV adversity. For populations at high-risk of HIV infection, increasing both their internal and external resilience is

necessary to enable them to withstand HIV vulnerabilities. In the context of this study, participants defined resilience to encompass personal protective assets, family, friends and social networks. This study found several strategies employed by heterosexual ACB men to cope with and manage HIV adversity in London, Ontario. While institutional resources emerged as essential to empowering ACB men to build resilience to HIV, only those living with HIV were in touch with these resources. Importantly, the local religious communities emerged as important facilitators providing protective assets for ACB men's resilience against HIV risk. Furthermore, although ACB men defined resilience to encompass their connection to ASOs, they were not engaged by these organizations, which appeared detrimental to their resilience against HIV.

ACB men's personal understanding of key constituents of resilience influenced their definition and situatedness of resilience to HIV at the intersection of personal protective assets, community, and institutional resources. However, this conceptualization is influenced by the social environment and individuals' ability to mobilize protective assets in the fight against adversity. This is consistent with Wood et al.'s (2012) view that resilience is a multidimensional concept that transcends individual intrapersonal qualities to embrace the quality of resources within their social environment in responding to adversity. The importance of accurate information for building resilience, as revealed in this study, is consistent with Frye et al. (2012), who found access to HIV information and testing to be key strategies in addressing HIV among Blacks in the United States. In Canada, Mitra et al. (2006) also revealed access to HIV information was a key strategy to improve HIV testing and resilience among migrant women from HIV endemic countries.

Employing individual strategies such as abstinence from sexual intercourse and limiting sexual activities to just one partner in a stable relationship was another major pathway for building resilience to HIV among ACB men. Importantly, some of these practices were linked to spirituality and religiosity which emphasized sexual abstinence and discouraged partner concurrency. While monogamy and abstinence's link to spirituality and religiosity has been found to help reduce HIV vulnerability among individuals (Jonsen, Stryker, & Council, 1993), other studies such as Isler et al. (2014) have opined that HIV risk as constructed and preached by religious beliefs, expectations and doctrines may not be a realistic strategy for reducing HIV risk among individuals and targeted populations. This may be emanating from the observation that religious-backed messages and construction of HIV risk may sometimes be pegged as a moral call rather than being emphasized as an activity that is useful for reducing one's risk to HIV (Husbands, Nakamwa, Tharao, Greenspan, & Calzavara, 2020; Nunn et al., 2012). In this regard, despite attempts by religious denominations to be part of efforts to reduce ACB men's exposure to HIV, those perceived not to be practicing abstinence or revealed to be HIV positive may face judgment and moral condemnation which depletes their capacity to be resilient to HIV. As suggested by Bryant-Davis et al. (2016) and Bradley et al. (2018), given the importance of Black religious denominations as integral parts of ACB communities, their messages on HIV should promote a non-judgmental and non-stigmatizing understanding of HIV risks. Thus, introducing stigma reduction messages as part of religious messages will help promote resilience among ACB men in their respective communities. Furthermore, churches, mosques, and religious organizations should provide teaching and social support that enable ACB men to choose value-guided living that influences their sexual decision-making. This strategy may be more

effective in promoting ACB men's resilience against HIV as it will encourage access to accurate and inclusive information on safer sex, HIV prevention, testing, and treatment. Overall, as found in this study, the use of sexual abstinence as an HIV resilience tool and strategy seems to discount earlier narratives attributing heightened HIV vulnerability among ACB men to their poor investment in HIV resilience strategies (El-Bassel, Caldeira, Ruglass, & Gilbert, 2009). The finding also supports Husbands et al.'s (2017) observation that narratives about ACB men employing sexual performance to demonstrate masculinities is not supported by evidence in the context of ACB communities in Canada.

Religious communities such as churches also served as a reliable source of interpersonal assets for the resilience trajectories of ACB men. Through teachings and emphasis on spirituality, ACB PLWHAs and those going through tough times were given a glimpse of hope. This has been found to be effective in developing positive adaptive coping mechanism to overcome HIV adversity (Arrey, Bilsen, Lacor, & Deschepper, 2016; Brito & Seidl, 2019). In North America, Black churches have mobilized the ACB community to fight adversity, including Jim Crow, and they remain important spaces for resisting structural oppression, racism and discrimination (Barber, 2015; Pattillo-McCoy, 1998). Although some studies implicate Black churches for their complacency in responding to high HIV prevalence in their communities, they remain important pillars and rallying points for ACBs in drawing strength to fight HIV. More recently, Black churches may have taken up the challenge of becoming more proactive about HIV as they organize voluntary counseling and testing services and providing emotional and psychological support to members (Isler et al., 2014; Williams, Pichon, Latkin, & Davey-Rothwell, 2014).

Sharing experiences of vulnerability with friends, family, and community members gave ACB men confidence as they were reassured of their strengths in overcoming adversity. Among persons living with HIV, this has remained an important resilience strategy to cope and overcome challenges associated with living with the virus (Coursaris & Liu, 2009; Mo & Coulson, 2014). However, Diprose (2014) suggested that prioritizing individuals' and communities' internal qualities to overcome adversity follows a neoliberal ideology where affected individuals and communities are expected to overcome adversity with little or no state involvement. This may be true as ACB men demonstrate high levels of resilience which helps them overcome HIV adversity despite their limited access to important institutional and social resources.

In London, Ontario, where ACBs constitute less than 3% of the city's population, building social networks with other ACBs facilitated access to support from the ACB community in times of adversity. While Theron and Malindi (2010) have argued that intrapersonal assets enable vulnerable persons to identify role models to overcome adversity, ACB men in London also used links to the ACB community to navigate protective asset-building in the city. ACB men's networking transcended to transnational and virtual communities where they drew strengths to overcome HIV adversity. Given the evidence that heterosexual ACB men may be disconnected from asset-building in state resources in Canada (Husbands et al., 2013), it is not surprising these non-institutionalized resilient strategies are used to aid them to overcome HIV adversity. Among persons living with HIV, virtual communities have emerged as an essential platform promoting adaptive approaches to HIV (Coursaris & Liu, 2009; Mo & Coulson, 2014). Furthermore, the finding that ACB men were resorting to transnational and virtual communities as part of their resilience trajectories is aligned

with Drushel's (2013) suggestion that the vulnerable use these channels to circumvent inaccessible traditional and official sources of HIV information and support.

To improve the resilience of ACB men to HIV, it is important that ASOs and other institutions mandated to provide HIV services engage the ACB community through innovative strategies. For instance, promoting resilience in high-risk populations will require the involvement of community and religious leadership and other role models to make outreach campaigns more effective (Isler et al., 2014; Jeffries, Sutton, & Eke, 2017; Theron & Malindi, 2010). Importantly, ACB men in the study underscored the urgency of addressing structural barriers and discrimination which limits their access to socioeconomic and health resources, leading to the depletion of the protective assets needed to overcome HIV in the community. Thus, improved economic and educational opportunities in ACB communities can translate into higher HIV awareness, frequent visits to preventive health care spaces, and utilization of services at ASOs (Baidooobonso, 2013b; Husbands et al., 2014). Such improvement will directly build ACB men's HIV resilience and empower them with protective assets to adequately respond to HIV in their community. Thus, the removal of structural barriers will facilitate this community's connectivity with HIV information and testing services leading to the use of services that strengthen ACB men's resilience to overcome their current HIV adversity.

6.6. Conclusion

Findings from this study revealed the use of several strategies to mobilize protective assets and resilience against HIV among heterosexual ACB men. ACB men mostly relied on personal and intrapersonal protective assets with little involvement of

ASOs in building resilience to HIV – demonstrating their aptitude and resolve to overcome HIV in the community. Given that ACB men understand and desire a connection to ASOs, information, and testing services in mobilizing protective assets to cope and overcome HIV, there is an urgent need for policy stakeholders to design HIV intervention and information dissemination programs that engage the community. Beyond testing and information sharing, a holistic approach to supporting ACB men's resilience to HIV in Canada is needed, where poor health outcomes in this community are situated within the structural determinants of health. In this regard, it is necessary to address the problem of social structuring which limits ACB men's access to socioeconomic and health resources, thus exacerbating their vulnerability to HIV. Overall, these findings demonstrate that ACB men have been investing in resilience aimed at curtailing new HIV infections within their communities. With improved collaboration with ASOs and other stakeholders, ACB men are poised to overturn high HIV prevalence in their community.

6.7. References

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CHAPTER SEVEN

7.0. SUMMARY AND CONCLUSIONS

7.1. Introduction

In this chapter, I provide a summary of the major findings of this dissertation. I discuss how by addressing the three interconnected research objectives, the study contributes to explaining the overarching research question of the thesis. The chapter also highlights why this study situates ACB men's HIV risk within subjective epistemologies. I conclude by focusing on the theoretical, methodological, and policy contributions of the thesis and the direction for future research.

7.2. Revisiting the Research Problem

Globally, Canada has one of the lowest HIV prevalence rates of 0.02% within the general population (Lee et al., 2011). In 2017, the national diagnoses rate was also reported as 6.5 per every 100 000 (Haddad et al., 2019). Despite this low national prevalence rate, the realities of HIV are different for people of African, Caribbean, and Black (ACB) descent, as they accounted for 25.3% of HIV cases in 2017, although they constituted less than 5% of Canada's population at the time. Unlike other racial groups, heterosexual infections, as noted by the Public Health Agency of Canada (2014), account for close to 90% of all HIV cases in the ACB community.

The evidence further suggests ACB men are becoming overly exposed to new HIV infections in the community. Mostly through heterosexual contacts, ACB men constituted 17% of all new HIV cases among men in Canada and 16.5% in Ontario (Haddad et al., 2018). This supports Remis, Swantee, and Liu (2012) call for

increased attention to heterosexual ACB men, given that they made up 60% of ACB people living with HIV in Canada. Of further concern is the revelation that half of ACB men living with HIV are unaware of their HIV status compared to only one-third of ACB women (Baidooobonso, 2013b; Remis et al., 2012).

Despite mounting evidence suggesting heterosexual ACB men require policy engagement to understand their health needs, specifically regarding HIV, they remain missing in health policy interventions. This poses a conundrum as ACB men's risk of HIV persists with little to no engagement by health policy stakeholders to address their vulnerability. In unpacking this conundrum, it has been opined in both the US and Canada that the perception and construction of HIV risk – by popular and scholarly discourses – as mostly behavioral and arising from sexual impropriety, plays a role in ACB men's neglect in HIV policy spaces (Geary, 2014; Miller, 2005). Therefore, in these scholarly propositions and narratives, heterosexual ACB men are framed as culprits rather than victims.

In this dissertation, I argue that examining heterosexual ACB men's risk to HIV infection has mostly been bereft of the role of structural factors. This argument is in line with emerging scholarship suggesting that people's social identities, positions, and hierarchies are indispensable to their quality of health (see Solar and Irwin 2010; Lopez and Gadsden 2016; Richmond and Big-canoe 2013). Therefore, in Chapter 1, I contextualized the need to go beyond the biomedical/behaviorist paradigm to unpack HIV vulnerability and resilience at the nexus of behavioral and structural factors. I also advocate for the need to give heterosexual ACB men the platform to represent themselves in framing their HIV exposure and resilience building capacities.

Underpinned by the larger framework of the social determinants of health, and specifically drawing on Intersectionality and Critical Race theories (CRT), I sought to

explore an in-depth understanding of ACB men's HIV vulnerability and resilience.

This was done by addressing the following three research objectives:

1. To explain how masculinity ideas and practices as behavioral characteristics influence heterosexual ACB men's perceived risk and response to HIV.
2. To explain potential barriers to heterosexual ACB men's access to preventive health services.
3. To examine how heterosexual ACB men may be acquiring assets to build resilience to HIV infections.

These three objectives were achieved using a qualitative methodology, involving in-depth interviews and focus group discussions.

In the next sections, I discuss in detail how my stated research objectives were addressed by summarizing the findings from the three interconnected manuscripts in this dissertation.

7.3. How the research objectives were achieved

7.3.1. Research Objective 1: Explain how masculinity ideas and practices as behavioral characteristics influence heterosexual ACB men's perceived risk and response to HIV.

This objective was addressed in Chapter 4. Findings revealed fluid ideas and practices of masculinity among heterosexual ACB men in navigating their HIV risk. Thus, while younger cohorts of heterosexual ACB men tended to endorse and sometimes practice masculinity as sexual performance, this was in the broader context of a quest for an 'authentic' Black identity and a sense of belonging. These masculinities were tied to embodying and acting out these stereotypes and

expectations in their respective communities. Interestingly, most heterosexual ACB men did not subscribe to these traditional masculinity ideas as they were aware of the debilitating effect of these stereotypes and its implications for their health and HIV vulnerability. For many heterosexual ACB men, acting ‘manly’ did not preclude them from taking care of themselves and prioritizing their health to enable them to perform their duties as fathers, husbands and family men.

They further demonstrated masculinities that allowed them to discuss their feelings of vulnerability with families, friends and other ACB men; which they deemed empowering in overcoming and managing adversity, including HIV. Consistent with earlier findings by Husbands et al. (2017) in Ontario, heterosexual ACB men – contrary to perceptions that practices of traditional masculinity are endemic and linked to their high rates of infections – practiced resourceful masculinities. By this they prioritized their health needs that helped them to avoid HIV infection. Indeed, it can be argued that the few ACB men who endorsed traditional masculinities did so within the historical context of their experiences of structural violence in the North American society, where they are positioned and expected to demonstrate their masculinities within defined and stereotyped outlets (see Malebranche et al. 2009).

7.3.2. Objective 2: Explain potential barriers to heterosexual ACB men’s access to preventive health services

This research objective was addressed in Chapter 5 using an in-depth approach. Our analysis of the findings showed that ACB men’s underutilization of preventive health services was because of several intersecting structural barriers, and not solely due to their behavioral characteristics. Overall, heterosexual ACB men appeared disconnected from AIDS Service Organizations (ASOs) and remained

unaware of where these institutions and services were in the city. Some participants were not aware that in Canada, the ACB community, and specifically, heterosexual ACB men were comparatively at higher risk of being infected with HIV. This lack of information from the perspective of ACB men may be because the institutions mandated to furnish and engage them with such information were not targeting them.

Thus, while ACB men were willing to access information and test for their HIV serostatus, knowing which organizations and services to visit and engage proved challenging. Furthermore, among those aware of HIV services, HIV stigma in the larger London community and within the ACB communities emerged as a major barrier to visiting these HIV service spaces. Within the city, negative stereotypes about HIV being of African origin and being spread by ACB men made some participants feel judged as automatic carriers of the virus. This engendered discomfort and worked to discourage them from visiting HIV services. Their disconnection to service spaces was further compounded by their observed lack of representation in preventive health care facilities.

Within the ACB community itself, misconceptions that people visiting these services spaces are HIV positive, with the risk of such information filtering back into the ACB community or back home for those with transnational ties, could have turned some people away from these services. Misconceptions about the virus's etiology and how people get infected also seemed to have given some ACB men a sense of immunity that discouraged their visits to HIV service outlets. Heterosexual ACB men further bemoaned the systemic neglect of their health needs as a community. They reported that they were not effectively mobilized in drawing the attention of political and policy stakeholders to prioritize ACB men's health requirements – particularly given the evidence of their increased risk of infection. These challenges have been

observed by earlier scholarship (e.g., Baidooobonso et al. 2016; Baidooobonso 2013; Mbuagbaw et al. 2020; Husbands et al. 2020), which focused on ACB communities in Canada and called for increased policy attention to address ACB men's HIV needs.

7.3.3. *Objective 3: Examine how heterosexual ACB men may be acquiring assets to build resilience to HIV infections.*

To document the resilience trajectories of ACB men to HIV, research objective 3 set out to examine the sources of assets that help ACB men build their capacity to be resilient to HIV. Broadly, the findings showed that ACB men demonstrated resilience in managing their adversity to HIV. They identified several resources used as strategic assets in building their capacity to be resilient to HIV. For instance, some ACB men relied on personal coping strategies such as sexual abstinence. Abstinence as a personal protective asset, was also linked to religiosity and spirituality. Interpersonal resources – identified as family, friends, and the larger ACB community – were also mentioned as important assets to building resilience. ACB men relied on these interpersonal resources in discussing their feelings of vulnerability and navigating networks to find resources within the city.

Aside from the larger ACB community, religious communities also served as important sources of resilience for ACB men. While for some ACB men, religious messages were linked to sexual abstinence, for others, religious communities were sources of support, healing, and a second chance when they experienced challenges or felt vulnerable. Thus, although religious communities have been blamed for their complacency/inaction regarding the spread of the virus in the community, participants identified them as assets that positioned them to build their capacity to be resilient to HIV. This observation is generally consistent with Nunn et al. (2012) and Husbands et al. (2020), who observed religious denominations as important pillars in helping ACB

communities deal with challenges and manage adversity in the context of North America. For participants living with HIV, counseling and other related services were very useful in positioning them to overcome their everyday challenges of living with the virus.

However, while resilience is captured by the literature to encompass intrapersonal, interpersonal, and other resources at the community level (including institutional support services), only heterosexual ACB men living with HIV linked their protective assets to these institutional resources. Other ACB men were seemingly disconnected from these assets, emphasizing an earlier observation by Baidooobonso et al. (2010) that ACB communities need more connections to these services to improve their overall health outcomes.

7.4. How the three manuscripts integrate

Although the three manuscripts addressed different research objectives, all of them helped answer the main research question: *what are the HIV vulnerabilities and resilience strategies of heterosexual ACB men in London, Ontario?* To answer this research question, the research used an intensive approach to gain in-depth understanding of the phenomenon under study. Findings from the manuscripts provided a glimpse into the overarching role of structural factors in ACB men's vulnerability to HIV infection in London, Ontario. For instance, findings in Chapter 4 revealed that some ACB men's endorsement of traditional masculinity is within the context of influences and expectations that arise from the history and place of ACB people in North America. The internalization and performance of stereotypes, despite

the associated health and HIV risks, reflect how structural aggression and expectations of masculinity persist for ACB men.

In answering the overall research questions, the manuscripts (Chapters 4, 5, and 6) emphasized the fact that ACB men were disconnected from institutions providing services that were essential for reducing vulnerability and helping them build their capacity to be resilient to HIV. In this regard, ACB men's poor use of preventive health services may be partly due to their poor access to information about their increased risk to HIV infection. The disconnection with important institutions providing HIV-related services does not only have an implication on HIV testing and treatment for ACBs, but it directly debilitates their capacity to build resilience given the vital role of information and institutional support services in preparing individuals and communities to overcome adversity. Thus, ACB men's disconnection to institutional support services could be disproportionately exposing them to HIV, relative to other high-risk groups whose increased interactions with these institutions play a key role in the substantial decline of HIV prevalence within these groups.

Overall, ACB men's health needs, including their access to HIV-related services, have not been a priority for health policymakers and institutions. Service providers did not have specific services or interventions targeted at heterosexual ACB men. Most providers also lacked cultural competence in serving heterosexual ACB men visiting the ASOs. Indeed, within institutions that may be at the frontline of testing, treatment and counseling – the Regional HIV/AIDS Connections (RHAC) – heterosexual ACB men were not adequately represented in their staffing, thus missing an important opportunity to make the larger heterosexual ACB community feel connected to these institutions.

7.5. Research Contributions

This dissertation makes important theoretical, methodological, and policy contributions surrounding heterosexual ACB men's vulnerability to HIV and strategies for building resilience. In this subsection, I expand on each of these contributions.

7.5.1. Theoretical Contributions

This dissertation expands our understanding of the social determinants of health framework by specifically drawing on Intersectionality theory and Critical Race theory. Specifically, as propounded by Kimberlé Crenshaw (1989), the focus of intersectionality theory was to unpack how multiple social and political identities of an individual and, by extension, a group of people can subject them to experiences of discrimination or privilege. While Intersectionality theory has been used in research focusing on the health outcomes of ACBs and ACB communities in general (see Bowleg 2012; Lewis et al. 2017; Griffith, Ellis, and Allen 2013), this dissertation is among the first to extend its use to examine HIV vulnerability and resilience trajectories among heterosexual ACB men in Canada.

In extending the Intersectionality theory's frontiers, I have shown in Chapters 4, 5 and 6, that heterosexual ACB men are prone to HIV vulnerability based on social and political identities such as race, gender, sexual orientation, immigration and socioeconomic status. Thus, while HIV risk among racial minority populations such as ACB men is mostly constructed as behavioral, this dissertation emphasizes the importance of structural predictors of HIV exposure. A key contribution of this dissertation includes the use of Intersectionality theory to deconstruct and unpack the intricately intertwined social identities of ACB men, and the manner in which this increases their risk of HIV exposure. Consequently, although a heterosexual and male

gender status constitutively position individuals to receive power and privilege (Bruce, 2015; Case, Hensley, & Anderson, 2014; Jackson, 2006), when these identities are intersected with other identities such as race, socioeconomic position, class, and immigration status, ACB men become more susceptible to poor health outcomes including HIV. This suggests the intersecting social identities of heterosexual ACB men in Canada engender stereotyped and stigmatized identities that strip them of their access to important health resources to reduce their risk and exposure to HIV. Consequently, for ACB men in the weSpeak study, their social identities have created a 'new normal,' which shapes the way that they experience the health care system.

Furthermore, in this dissertation, I extended CRT's application by countering superficial narratives and discourses about heterosexual ACB men's risk to HIV infection. Thus, I highlighted how the framing of their HIV risk might be rooted in racial stereotypes and masculinity expectations in North America (see Chapters 4 and 5). Accordingly, I argue that among the study population, higher HIV prevalence rates reflect the realities of living in an unequal society characterized by structural racism where the HIV health needs of ACB people do not receive political and policy attention. Although Canada may have worked over the years to reduce individual and overt experiences of racism, the issue may be more structural given the organization of the health care system which creates a hierarchy and varying experiences of utilization based on race (Nickel, Lee, Chateau, & Paillé, 2018; Reading & Greenwood, 2015; Richmond & Big-canoe, 2013). Together with other raced-based disadvantages such as unemployment, poor housing, low health insurance coverage, stigma, and stereotypes, ACB men's risk of HIV is shaped by Canada's racially hierarchical society which impacts access to health resources. The findings expanded

in this thesis also further deepened the applicability of SDH as a theoretical lens for unpacking HIV vulnerabilities among racial minorities.

7.5.2. *Methodological Contributions*

This study also makes very important methodological contributions to ACB men's HIV risks and their resilience trajectories in the context of North America. Firstly, this dissertation's use of a qualitative approach is among the few to explore the HIV risks of ACB men beyond the biomedical and epidemiological approaches where recommendations have focused on behavioral change. Furthermore, their use of standardized and universalized tools assume the heterogeneity of study subjects across racial and social groups with regards to HIV risk (Auerbach, Gerritsen, Dallabetta, Morrison, & Garnett, 2020; Weinhardt, Forsyth, Carey, Jaworski, & Durant, 1998). In contrast, the use of qualitative methods in this dissertation emphasized the situatedness of HIV risk and the role of contextual factors in further exposing the already vulnerable ACB population to HIV.

Another key contribution to the methodological richness of understanding the drivers of HIV infection and high HIV prevalence rates among heterosexual ACB men is the use of an asset-based approach in this thesis. Previous studies have tended to use a deficit approach where factors perceived to be resulting in ACB men's risks are emphasized for policy attention. Unintendedly, ACB men in such studies, appear passive to HIV risk, potentially downplaying their agency and resilience strategies and trajectories in the face of HIV adversity. In Chapter 6 therefore, I employed an asset-based approach to scrutinize the strategies and sources of assets that build the capacity of ACB men to reduce their risk to HIV infection. By focusing on their sources of protective assets, it will become easier for policy makers to improve and escalate these protective assets to the policy level. While few studies have used this asset-

based approach, it has been limited to how people living with HIV overcome the everyday challenges associated with being HIV seropositive (see Dale et al. 2014; Brewer et al. 2020). This leaves a gap in how resilience emerges among high-risk populations who are unaware of their HIV status or are HIV negative. Using an asset-based method, this dissertation contributes towards closing this existing gap.

In addition, a methodological contribution of this dissertation is the approach employed in recruiting ACB men as study participants. Given that participants have hitherto been described as a ‘hard to reach population,’ the recruitment strategies outlined in Chapter 3 and the individual manuscripts will be useful to future studies focused on a similar population. Finally, my position in relation to the research participants and the research community may also serve as methodological contribution. Where it is difficult to gain access to a ‘hard-to-reach’ research community such as this one, it would be advisable to include in the research team people who identify or share similar characteristics with the study community. I benefitted from this and consider it a methodological contribution. For instance, as described in chapter 3 my positionality afforded me an insider privilege. Our shared identities became a medium to establishing trust with research participants, that ensured easy entry into the research community. Based on these shared identities with participants, interview sessions became safe spaces where participants were comfortable enough to open-up about their HIV vulnerability as well as their resilience strategies. My positionality was not only useful in connecting and recruiting participants but also in collecting rich and varied data, analysing, contextualizing and interpreting of the data which was useful for the success of this thesis.

7.6. Policy Implications

This study has some practical implications for HIV policy making in London, Ontario, and Canada in general. Firstly, the dissertation's findings underscore the need for focused policy attention on heterosexual ACB men, given their increased structural risk to HIV infection. The study provides evidence supporting the fact that ACB men as a high-risk group need increased research and policy attention to craft interventions and services to reduce their exposure to HIV. Thus far, only a few studies in the context of London have focused on heterosexual ACB men's HIV risk. Notable among these are two earlier studies from the quantitative phase of the weSpeak study (see Konkor, Antabe, et al. 2020; Konkor, Lawson, et al. 2020), which also highlighted similar findings about the precarity of ACB men's structural exposure to HIV. Therefore, to effectively engage ACB men to reduce their vulnerability and build their capacity to be resilient to HIV, more research is needed to unpack the contextual factors shaping their HIV exposure.

Secondly, the findings suggest a lack of prioritization by policy stakeholders and service providers on the HIV needs of ACB men. Currently, there may be a two-tiered disconnection of ACB men from important institutions offering HIV-related services. In the first tier, the ASOs are not making enough effort to reach and engage ACB men with needed information to improve their utilization of HIV services such as testing and treatment. In the second tier, the few ACB men who attempt to access these services report a lack of cultural competence, stereotypes, and stigmatization as factors that discourage their use of these health facilities. In this regard, it is prudent and, indeed urgent to hasten a structural response which could be achieved if ACB men's HIV risk is seen as a medical emergency, requiring immediate action. For this to be effective, planning and engagement with the ACB community is necessary, with

a focus on centering ACB men's needs and concerns into mainstream health policy in London.

Thirdly, evidence from this dissertation presents a counter-narrative to the persistence of behavioral risk factors as influencers of ACB men's HIV risk trajectories. The revelation that indeed, members of this population are willing to engage with health policy stakeholders and ASOs presents an opportunity to involve them in designing community responses to HIV. Given that ACB men identify assets at the community level to be indispensable to their capacity to be resilient to HIV, policy makers could leverage these strategies and include ACB women and leadership of Black religious denominations in critical dialogue on holistic ways ACB men can be positioned to reduce their HIV risk.

Finally, policy makers and stakeholders can leverage the progressive alternate masculinity beliefs and practices of ACB men, as revealed in this dissertation. For instance, the finding that ACB men consider taking care of their health as an important constituent of masculinity is an opportunity to explore and promote healthy behaviors, including HIV testing as part of 'manly behaviors.' Furthermore, the knowledge that resilience practices for ACB men include discussing their vulnerability with other ACB men emphasizes the need to increase their representation in the staffing of ASOs to provide a bridge to the ACB community. Additionally, it will be useful for the political mobilization of ACBs and their communities in demanding more from policy makers to address their poor health/HIV outcomes.

7.7. Study Limitations

Despite its theoretical, methodological, and policy contributions, there are some noteworthy limitations of this dissertation. Firstly, although the use of a qualitative approach offered the opportunity to examine in depth the HIV vulnerability and resilience trajectories among the study population, inherent in the use of the qualitative approach is the fact that study findings are limited to the context of London, Ontario (see Lincoln, Lynham, and Guba 2011; Biber-Hesse Nagy and Leavy 2004). Therefore, while the dissertation enriches our understanding of how ACB men become exposed to HIV, the implementation of these findings may not be readily extendable to ACB men in other parts of Canada.

Secondly, lumping the experiences of all heterosexual ACB men in this study may suggest they are a homogenous group with similar experiences of HIV exposure. However, they constitute distinct social groups whose social identities may engender different social interactions and realities that directly impact their everyday lived experiences and interactions with Canada's health care system (Mbuagbaw, Tharao, Husbands, Nelson, Aden, Arnold, Baidoobonso, Dabone, Dryden, et al., 2020). For instance, identifying as an African may be associated with unique experiences of social realities of discrimination, stigma and stereotyping, that may differently impact health outcomes relative to a Black Caribbean (Seaton, Caldwell, Sellers, & Jackson, 2008; Smith, 2020). Furthermore, although race was operationalized as a social and relational trait that informs an individual's social positioning, interactions, and access to social services, evidence suggests differences in Black people's social relations and interactions based on skin tone (Margaret Hunter, 2007). Specifically, in Canada, Veenstra (2011) found that dark-skinned Black people reported poor health outcomes relative to their light-skinned colleagues. In this regard, skin tone may influence how

ACB men experience exposure to HIV, but this complexity has not been captured in this dissertation.

Thirdly, findings in this dissertation may not be exhaustive of all the intersections of vulnerabilities that predispose heterosexual ACB men to HIV. Given the understanding that the lived experiences of oppressed populations are at the intersection of several social and political identities (Kimberlé Crenshaw, 1989; Simien, 2007), it may be far-fetched to assume the factors of vulnerability and resilience for heterosexual ACB men in this dissertation are exhaustive of all the factors that predispose them to increased risk of HIV infection in the context of London. For instance, the role of an individual's educational attainment is a powerful medium to health behaviors and navigating structural challenges for overall health improvement. Nonetheless, this factor was less addressed in this dissertation.

7.8. Directions for future research

Based on the dissertation's limitations and positioning of its findings in the general HIV literature, I provide potential areas for future research to reduce ACB men's vulnerability to HIV and build their capacity to be resilient. First, to have a broader assessment of ACB men's vulnerability and resilience trajectories, it may be prudent for future research to examine the perspectives of ACB women and ACB community and religious leaders, as they emerged as a vital chain and critical assets to resilience trajectories of ACB men. Findings from such studies will be a useful complement to the revelations in this study in developing a holistic intervention strategy to reduce ACB men's HIV vulnerability. This is particularly important in line with earlier research that highlighted the need for a more community-based approach

to addressing the health needs of ACB men involving all community stakeholders (Plescia, Herrick, & Chavis, 2008).

Furthermore, the observation that ACB men's social interactions could vary based on their perceived or ascribed socio-ethnic identities, such as African or Caribbean (Mbuagbaw et al., 2020), calls for future studies to examine potential differences in HIV exposure along the lines of these social identities. Similarly, it will be prudent for future studies to understand the role of 'colorism' in ACB men's social interactions and how this impacts the ways they access essential resources, including health services.

Finally, given the finding that some ACB men are unaware of their high-risk of HIV infection and where to locate HIV services, future studies could have a more pragmatic approach where (through the research process) ACB men could be informed about these services. For instance, after each interview session, there could be debriefing exercises where ACB men are engaged in an information session on HIV risk, directing interested participants to available resources for testing and treatment services. There could also be opportunities for ACB men to be provided with self-testing kits after each interview session. This would be a useful strategy for linking the research process to HIV information dissemination in the ACB community.

7.9. Conclusion

In this dissertation, I examined HIV vulnerability and resilience among heterosexual ACB men in the context of London, Ontario. With evidence that heterosexual infections are rising relative to other major routes of HIV infection in Canada, members of this population are particularly at risk, especially as HIV health

policies have not mainstreamed their needs. Given Canada's commitment to ensuring health equity and universal health access, it remains paradoxical that ACB men who are at high risk of infection remain in the peripheral of HIV policy-making and service delivery in the country. Given that this dissertation's findings and that of previous studies discount behavioral risk factors as underlying ACB men's heightened HIV vulnerability, it is crucial to re-evaluate narratives and discourses in policy spaces that continuously privilege these accounts. Additionally, there is the need to begin examining how the hierarchical structuring of Canadian society and its health care system act as social pathogens that adversely impact the health outcomes of ACB men. A community-based engagement and dialogue to understand the HIV/health needs of ACB men are indispensable in promoting health equity in Canada.

7.10. References

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APPENDICES

Appendix A: Ethics Approval



**Western
Research**

Research Ethics

Western University Health Sciences Research Ethics Board
NMREB Full Board Initial Approval Notice

Principal Investigator: Dr. Isaac Lugemash
Department & Institution: Social Science Geography, Western University

NMREB File Number: 106833
Study Title: weSpeak: Straight Black Men Building Resilience to HIV in Ontario
Sponsor: Canadian Institutes of Health Research

NMREB Initial Approval Date: August 27, 2015
NMREB Expiry Date: August 27, 2016

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Recruitment Items	Appendix 22 London_Recruitment Flyer Phase 2 (ACB men) Jun 2 2015	20150602
Instruments	Appendix 21 London_weSpeak (Main) Survey Phase 2 (ACB men) Jun 1 2015	20150602
Other	Appendix 20 London_weSpeak participant contact form (All participants) Jun 1 2015	20150602
Other	Appendix 18 London_Focus Group Interview Guide Phase 1 (Community Stakeholders) Jun 2 2015	20150602
Instruments	Appendix 17 London_Demographic and Health Practices Survey Phase 1 (ACB Men) Jun 2 2015	20150602
Other	Appendix 16B London_Individual Interview Guide Phase 1 (ACB men_attended focus groups) Jun 1 2015	20150602
Other	Appendix 16A London_Individual Interview Guide (ACB men_no focus groups) Jun 2 2015	20150602
Letter of Information & Consent	Appendix 14 London_Individual Interview Consent Form Phase 1 (ACB men) Jun 2 2015.docx	20150602
Other	Appendix 6_London weSpeak project summary Jun 1 2015	20150601
Other	Appendix 5_London weSpeak Website Template (new) Jun 1 2015	20150601
Recruitment Items	Appendix 3_London Recruitment Flyer Phase 1 (ACB men non-HIV specific) Jun 1	20150601
Recruitment Items	Appendix 4_London Recruitment Flyer Phase 1 (community stakeholders) Jun 1 2015	20150531
Recruitment Items	Appendix 9_London Scripts for recruiting ACB men_all phases Jun 1 2015	20150601
Instruments	Appendix 8_London Focus Group Ground Rules Jun 1 2015	20150601
Other	Appendix 28 London_Description of Concept Mapping Overall Guide Phase 3 (All participants) June 2.docx	20150602
Other	Appendix 29 London_Online Concept Mapping Survey Phase 3(Community Stakeholders) Jun 2 2015.docx	20150602
Recruitment Items	Appendix 30 London_weSpeak Recruitment Flyer Phase 3 Concept Mapping (ACB men) Jun 2 2015.docx	20150602
Recruitment Items	Appendix 31 London_weSpeak Recruitment Flyer Phase 3 Concept Mapping (Community Stakeholders) Jun 2 2015.docx	20150602
Other	Appendix 32 London_Community Resources all Phases (All participants) Jun 2 2015.docx	20150602
Recruitment Items	Appendix 2 London Recruitment Flyer Phase 1 (HIV+ ACB men) Jun 2 2015	20150602
Other	Appendix 7 London_List of community agencies for outreach Jun 2 2015.docx	20150601
Recruitment Items	Appendix 10 London_a.b.c_Participant Screening Tool (ACB men) Jun 2 2015	20150602
Recruitment Items	Appendix 11 London_a.b.c_Participant Screening Tool (community stakeholders) Jun 2 2015	20150602
Instruments	Appendix 19 London_Demographic Survey Phase 1 (Community Stakeholders) Jun 2 2015	20150601
Revised Western University Protocol		20150730
Revised Letter of Information & Consent	Appendix 24 London_weSpeak_E-Survey Consent Form Phase 2 (ACB men)	20150730
Revised Letter of Information & Consent	Appendix 25 London_Concept Mapping Focus Group Consent Form (ACB Men)	20150730
Revised Letter of Information & Consent	Appendix 12 London Focus Group consent form Phase 1 (each men)	20150730
Revised Letter of Information & Consent	Appendix 13 London Focus Group consent form Phase 1 (Community Stakeholders)	20150730
Other	Appendix 11 London_Research Design and Methods Jul 30 2015	20150730
Recruitment Items	Appendix 15 London_Focus Group Interview Guide Phase 1 (ACB men)	20150730
Revised Letter of Information & Consent	Appendix 27 London_weSpeak_Concept Mapping FG Consent Form (Community Stakeholders)	20150730
Revised Letter of Information & Consent	Appendix 23 London_weSpeak_Paper Survey Consent Form Phase 2 (ACB men)	20150730
Revised Letter of Information & Consent	Appendix 26 London_weSpeak_Pre-Concept Mapping Online Survey Consent Form (Community Stakeholders)	20150730

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the above named study, as of the NMREB Initial Approval Date noted above.

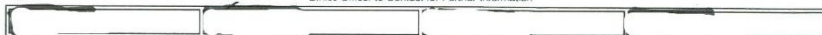
NMREB approval for this study remains valid until the NMREB Expiry Date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario.

Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 0000941.

Ethics Officer to Contact for Further Information



This is an official document. Please retain the original in your files.

Appendix B: In-Depth Interview Guide (ACB Men: HIV-, or HIV+)

1. Introduction:

- a. Welcome participants
- b. Obtain informed consent

2. I would like to explore your perspectives on HIV and heterosexual African, Caribbean and Black (ACB) men.

- (a) When you hear the topic - HIV and straight (heterosexual) ACB men – what comes to your mind?
- (b) Interviewer takes notes of what the participant has said and follow-up, and invite participant to say more: Please elaborate on each of the ideas you have just mentioned.

3. Explore participant's perspectives on the connection between heterosexuality and masculinity:

As you are aware, this study focuses on reducing the HIV vulnerabilities and promoting resilience among heterosexual ACB men. Before we talk about HIV vulnerabilities, I would like to explore something that has not been explored much in research. I would like to hear your perspectives on:

- (a) What does it mean to be straight (heterosexual)?
- (b) What does it mean to be straight and an ACB man?

Probes:

- How do you define being straight? (E.g., feelings of attraction, cultural norms, sexual and gender practices – sexual behaviours, sexual relationships, intimacy, etc.)
- How do you think ACB men's understandings of heterosexuality (being straight) differ from other men, for example, White men or non-Black men in Ontario?
- Based on what you see or experience in the community, what are the different ways that ACB men practice being straight (i.e., different ACB men may define being straight differently and also interact differently with women and men in different contexts)?

- (c) What does it mean to be manly (masculine)?
- (d) What does it mean to be manly (masculine) and being an ACB man?

Probes: Encourage participant to provide specific examples based on their own lived experiences or community stories.

- (e) How do **the ways that ACB men are expected to be manly or fulfill their role as a man** affect you as an ACB man:
 - your sense of identity, social status (**prestige or reputation**) and wellbeing?

- your relationships with women (hetero-social/opposite-sex friendship, hetero-social/opposite-sex social intimacy, and hetero-sexual/opposite-sex sexual intimacy, etc.)?
- your relationships with other men (homo-social/same-sex friendship, homo-social/same-sex social intimacy, and homo-sexual/same-sex sexual intimacy, etc.)?

Probes: Encourage participant to provide specific examples based on their own lived experiences or community stories.

If participant cannot think or is hesitant in providing a personal example, invite him to respond to the following statement by saying: “In Canada society and in the community, we often hear many discourses about Black men’s sexualities. I would like to hear your response to the following statements:

- Black men can’t turn down sex
- Real Black men have multiple sex partners concurrently

Note: For interviews with HIV+ ACB men, ask the following additional questions:

- How does living with HIV affect your sense of identity as a straight (heterosexual) ACB men?
- How does living with HIV affect your sexual decision-making?
Probes: explore challenges and resilience

4. Now, I would like to explore your ideas about HIV vulnerabilities among heterosexual ACB men.

- (a) In general, vulnerability means being at increased risk of harm, and/or having a less capacity to protect oneself from harm because of biological (**physical or related to the body**), psychological (**related to the mind or mentality**), social, political, cultural, spiritual and environmental (**built environment or physical surroundings**) conditions.
- (b) What comes to your mind when you hear the topic HIV and straight ACB men?
- (c) What contributes to HIV vulnerabilities among straight ACB men?
- (d) How do some of these factors affect you personally? (Explore participant’s own perception of personal HIV vulnerabilities.)
- (e) How do ACB men express their vulnerability or vulnerable feelings? What discourages ACB men from openly addressing their vulnerability (e.g., stigma, negative experiences, etc.)?
- (f) How do you address your vulnerable feelings? When and with whom would it be okay for you to talk about your vulnerability? How do men’s interactions with each other facilitate (**encourage or promote**) or discourage openness about their vulnerability?

Probes:

- Invite participant to talk about HIV and straight ACB in terms of biological (**physical or related to the body**), psychological (**related to**

the mind or mentality), social, political, cultural, spiritual and environmental (**built environment or physical surroundings**) sources of vulnerability; and encourage him to provide specific examples based on his own lived experiences or community stories.

- Invite participant to share his own experience of HIV vulnerabilities and what supported him to be resilient; for example, peer pressure vs. peer support; stress and coping; power negotiation, etc.
- Explore with participant **how** his experience may differ from other straight ACB men based on their different life contexts and lived experiences (e.g., age, citizenship and/or immigration/settlement experiences, connection to ACB communities, etc.)

5. Explore individual, group and collective resilience among heterosexual ACB men:

We have talked quite a bit on HIV vulnerabilities. I would like to hear your thoughts about individual and collective resilience among straight ACB men. There is not one agreed definition on resilience. In general resilience has been defined as the ability of individuals and communities to bounce back when they are faced with challenges and adversities (**challenges or hard times**). Another definition of resilience focuses more on what supports people to be well: (a) Individuals know how to obtain resources that they need to be well; and (b) individuals' social environments (e.g., family, school, work, community, society) provide them with resources that meet their physical, social, economic, cultural, and spiritual needs.”

- (a) Based on these ideas on resilience, what do you think is needed to promote resilience among straight ACB men particularly to reduce their HIV vulnerabilities and improve their health and well-being?
- (b) What will promote your resilience?

Probes:

- Explore how the participant copes with adversity – what kind of strategies, narratives, networks, and resources does he draw on to address adversity?
- Also explore resilience in the contexts of family, social networks, ACB communities, and society.

6. Explore participants' perspectives on existing social and structural barriers and pathways for heterosexual ACB men to access culturally safe and coherent resources that address HIV vulnerabilities and promote resilience.

- a. What do you think are the HIV and health related priority needs of straight ACB men?
- b. What are your experiences in accessing HIV-related health and social services?
- c. What can be done to improve HIV services and programming for straight ACB men? What about policy or government responses towards HIV in the ACB communities?

Probes:

- Explore the roles of both HIV and non-HIV services in addressing HIV vulnerabilities of heterosexual ACB men;
- Explore the participant's awareness of existing services and resources
- Encourage participant's to express new and creative ideas

7. Interviewer summarizes the interview, and invite participants to provide additional comments.

Appendix C: Focus Group Interview Guide (ACB Men)

1. Introduction:

- a. Welcome participants
- b. Obtain informed consent
- c. Review ground rules / guiding principles for group interaction (Appendix 8)
- d. Facilitator posts the key topics to be discussed to guide the focus group processes

2. Explore participants' perspectives on HIV and heterosexual ACB men:

- a. Provide each participant with a small piece of paper, and invite the participants to write down: "*Three things that come to mind when you hear the topic HIV and straight (heterosexual) ACB men.*" (Facilitator posts this pre-written statement on flip chart to enhance participation.) After a couple of minutes, invite participants to submit their responses into a basket and facilitator saves these responses to guide the discussion later on. Facilitator: "Thank you for all your responses. We will come back to this list in a few moments."

3. Explore participants' perspectives on the connection between heterosexuality and masculinity:

Facilitator: "As you are aware, this study focuses on reducing the HIV vulnerabilities and promoting resilience among heterosexual ACB men. Before we go on to discuss HIV vulnerabilities, we would like to explore with you something that has not been explored much in research, that is, heterosexual ACB men's perspectives on:

- a. What does it mean to be straight (heterosexual)?
 - What are the cultural norms that you are aware of? (probes – feelings of attraction sexual practices relationships and intimacy, etc.)
- b. What does it mean to be straight and an ACB man?
 - How is the meaning different from other straight men? How do you think ACB men's understandings of heterosexuality (or being straight) differ from those of non-ACB men?
 - What are the different ways that ACB men practice being straight? Can you think of some examples? (probes: interaction with other men, interaction with women, etc.)
- c. What does it mean to be manly (masculine)? How do you define being manly?
 - What are the cultural norms that define manliness or being masculine?
 - What does it mean to be manly and an ACB man? How is it different than manliness among non-ACB men?
- d. **How do you define manliness? Who or what shapes how you or other ACB men define manliness? How?**
 - What are examples of ways that ACB men are expected to be manly or fulfill their role as a man? Who imposes these expectations on ACB men?
 - How does economic successes affect how ACB men's identity as men? What about social successes?

- How do the ways ACB men are expected to be manly or fulfill their role as a man affect ACB men's relationships with women (hetero-social/opposite-sex friendship, hetero-social/opposite-sex intimacy, and hetero-sexual/ opposite-sex sexual intimacy, etc.)?
- How do the ways ACB men are expected to be manly or fulfill their role as a man affect ACB men's relationships with other men (homo-social/same-sex friendship, and homo-sexual/ same-sex intimacy, etc.)
- Encourage participants to provide specific examples based on their own lived experiences or community stories. If participants could not think of examples of cultural norms or expectations, use the following statements to promote discussion by asking – “What is your response to the following statements?”
 - Men are expected to provide for their families or girlfriends.
 - If a Black man turns down sex from a woman, he must be gay.
 - Real men have multiple sexual partners concurrently.
- e. How do you feel about the ways you are expected to be manly or fulfill your role as a man that you are experiencing in your life right now? How would you like to change these roles and expectations?

- **NOTE:** For FG with HIV+ ACB men, ask an additional question – How does living with HIV affect your sense of identity as a straight ACB men?

4. Explore HIV vulnerabilities among heterosexual ACB men:

- a. Facilitator: “Thank you for sharing your insights and stories about being straight ACB men. Now, we would like to focus on HIV vulnerabilities. Before we invite you to share, we will share with you a definition of ‘vulnerability’ and perhaps it will help us with our discussion.”
- b. Co-facilitator posts definition: “Vulnerability is often defined as being at increased risk of harm, and/or having a decreased capacity to protect oneself from harm because of biological, psychological, social, political, cultural, economic, spiritual, and/or environmental conditions.”
- c. Facilitator reads out the posted definition and encourages participants to add their ideas to the written definition on vulnerability. Then, facilitator post the recorded list of participants responses on the “Three things that come to mind when you hear the topic HIV and heterosexual ACB men” (taken at the beginning of the focus group) to guide the group discussion on the HIV vulnerabilities of heterosexual ACB men by:
 - engaging participants in categorizing their responses in terms of biological (physical or related to the body), psychological (related to the mind or mentality), social, political, cultural, spiritual and environmental (built environment or physical surroundings) sources of vulnerability;
 - “As I read out each of these items that you have written out, let me know which category you would like me to put them in.”
 - going through each category and inviting participants to elaborate on their perspectives and encouraging them to give specific examples based on their own lived experiences or community stories.
 - “You have collectively identified many sources of vulnerabilities among ACB men, I would now like to hear examples of how these

vulnerabilities play out in your everyday life. What are some examples of these different sources of vulnerabilities?”

- “How do these sources of vulnerabilities affect different groups of ACB men?” (Probes: young men, immigrants and refugees, older men, etc.)
- What do ACB men do with their sense of their vulnerability/feelings.
 - What discourages ACB men from openly addressing their vulnerability (e.g., stigma, negative experiences, etc.)?
 - When and with whom is it okay for ACB men to disclose their vulnerability?
 - How do men’s interactions with each other facilitate (encourage, promote) or discourage openness about their vulnerability?
- Engaging participants to make linkages and connections of the different sources of vulnerability to their lived experiences (e.g., gender expectations and condom use).

5. Explore individual, group and collective resilience among heterosexual ACB men:

- a. Facilitator: “We have discussed quite a bit on HIV vulnerabilities. We would like to take some time to hear your perspectives about individual and collective resilience among heterosexual ACB men. When you hear the term resilience, what comes to mind?”
- b. Facilitator: “Thank you for these thoughtful ideas on resilience. There is not one agreed definition on resilience. In general resilience has been defined as the ability of individuals and communities to bounce back when they are faced with challenges and adversities (challenges or hard times). Another definition of resilience focuses more on what supports people to be well; for example, individuals knowing how to obtain resources that they need to be well; and individuals having supportive social environments (e.g., family, school, work, community, society) that provide them with resources that meet their physical, social, economic, cultural, and spiritual needs.” [Co-facilitator posts pre-written definitions]
- c. Facilitator: “Based on your understanding of resilience and these definitions, what do you think is needed to promote resilience among heterosexual ACB men to reduce their HIV vulnerability and improve their health and well-being?”
- d. How do ACB men cope with adversity – what kind of strategies, narratives, networks, and resources do they draw on to address adversity? [Probes: family, social networks, ACB communities, and society]

6. Explore participants’ perspectives on existing social and structural barriers and pathways for heterosexual ACB men to access culturally safe and coherent resources that address HIV vulnerabilities and promote resilience.

- d. What are heterosexual ACB men’s HIV and health-related needs and priorities?
- e. What are the experiences of you and your peers (other heterosexual ACB men they know) in accessing HIV-related health and social services?
- f. What can be done to improve HIV services and programming for ACB men? What about policy or government responses towards HIV in the ACB communities?
 - What roles do both HIV and non-HIV services play in addressing HIV vulnerabilities of straight ACB men;

- What are the existing services and resources available to address HIV vulnerabilities among straight ACB men?
- How do you think we can improve HIV programming and services for straight ACB men and communities?

7. Facilitators summarize focus group discussion, and invite participants to provide additional comments.

Appendix D: Focus Group Interview Guide (Service Providers)

1. Introduction:

- a. Welcome participants
- b. Obtain informed consent
- c. Review ground rules / guiding principles for group interaction (Appendix 8)

2. Facilitator: **“In this study, we are interested in hearing from service providers about their perspectives and experiences in addressing HIV vulnerabilities and promoting resilience among self-identified ACB men. We know that “vulnerability” may have different meanings for different people.”**

- a. Provide each participant with a small piece of paper, and invite the participants to write down: *“Three things that come to mind when you hear the topic HIV and straight (heterosexual) ACB men.”* (Facilitator posts this pre-written statement on flip chart to enhance participation.) After a couple of minutes, invite participants to submit their responses into a basket. Facilitators post the responses up on the wall guide the discussion and review the responses with participants.
- b. Facilitator: **“Thank you for sharing your perspectives of the HIV vulnerabilities of heterosexual ACB men. We have prepared a definition on vulnerability to help further our discussion. Let us see how similar or different your perspectives are from this definition.”** Co-facilitator posts definition: **“Vulnerability is often defined as being at increased risk of harm, and/or having a decreased capacity to protect oneself from harm because of biological (physical or related to the body), psychological (related to the mind or mentality), social, political, cultural, spiritual and environmental (built environment or physical surroundings) conditions.”**
- c. Facilitator invites participants to share their understanding of HIV vulnerabilities among straight (heterosexual) ACB men.
- d. **“Based on your experience in working with the ACB communities, how common are these vulnerabilities among straight ACB men?”** Co-facilitator records participants’ perspectives.”
- e. **“Based on this definition, can you think of anything else about the HIV vulnerabilities of straight (heterosexual) ACB men?”**

Probes:

- Facilitator guides participants to explore HIV vulnerabilities at the individual and community level in terms of social, political, cultural, economic and environmental sources of vulnerability.

3. Facilitator invites participants to share their experiences and perspectives in working with heterosexual ACB men:

- a. “What types of programs/services do you or does your organization provide to address the HIV vulnerabilities of ACB communities in general? What about the HIV vulnerabilities of heterosexual ACB men?”
- b. “Based on our discussion, what other types of programs/services do you think are needed to address the HIV vulnerabilities of heterosexual ACB men?”
- c. Facilitator: “Another key aspect of our study is about promoting resilience among heterosexual ACB men. In many ways, resilience and vulnerability are inter-related. When you hear the term resilience, what comes to mind?” Co-facilitator records participants’ responses on flip chart.
- d. “Based on your experience in working with, or your knowledge about straight (heterosexual) ACB men, what is your impression about resilience of heterosexual ACB men?”

Probes:

- What are the characteristics of resilience among heterosexual ACB men?
- What kind of strategies (harmful or safe) have you observed among ACB men in terms of how they cope with vulnerability? What strategies do you think have worked and which ones have not?
- What promotes resilience and reduces HIV vulnerability among heterosexual ACB men?”

4. Facilitator: “Thank you for these thoughtful ideas on resilience. We have also prepared a definition on resilience to further help guide our discussion.”

- a. Facilitator: “There is not one agreed definition on resilience. In general resilience has been defined as the ability of individuals and communities to bounce back when they are faced with challenges and adversities (**challenges or hard times**). Another definition of resilience focuses more on what supports people to be well:
 - i. Individuals know how to obtain resources that they need to be well; and
 - ii. Individuals’ social environments (e.g., family, school, work, community, society) provide them with resources that meet their physical, social, economic, cultural, and spiritual needs.”

5. Co-facilitator posts the pre-written definitions. Facilitator explores the current practices of participants and their organizations:

- a. Does your organization have specific programs/services geared towards ACB men?”

- b. “Based on your ideas on resilience and these definitions, how does your work or the work of your organization fit with promoting resilience and reducing the HIV vulnerabilities of heterosexual ACB men?”
- c. “What are the challenges and barriers that you and/or your organization have encountered in providing programming and services to reduce the HIV vulnerabilities and promote the resilience of heterosexual ACB men?”
- d. “What are the facilitators that have supported you and/or your organization in providing programming and services to reduce the HIV vulnerabilities and promote the resilience of heterosexual ACB men?”
- e. “What other strategies do you think are needed to reduce the HIV vulnerabilities and promote resilience among heterosexual ACB men?”

6. Facilitator explores with participants their previous and current engagement of heterosexual ACB men in community HIV responses.

- a. Facilitator: “Our previous research and community consultation suggested that it is important to engage heterosexual ACB men in community HIV responses. To what extent and how have you and/or your organization engaged heterosexual ACB men in addressing their HIV vulnerabilities and promoting their resilience?”

Probes:

- Explore in terms of different levels of engagement -programming, policy, organization leadership, and community mobilization, etc.
- “What are some of the challenges that you and/or your organization have encountered in engaging heterosexual ACB men in addressing their HIV vulnerabilities and promoting their resilience?”
- “What are some of the strategies that you and/or your organization have used to meaningfully and effectively engage ACB men in addressing their HIV vulnerabilities and promoting their resilience?”
- “What would support you and your organization in engaging heterosexual ACB men in addressing their HIV vulnerabilities and also for them to take part in HIV responses in the ACB community?”

7. Facilitators summarize focus group discussion, and invite participants to provide additional comments.

Appendix E: Curriculum Vitae

Roger Antabe

EDUCATION

Sept. 2016-

PhD Candidate, University of Western Ontario

Thesis: *HIV vulnerability and resilience among heterosexual African, Caribbean and Black men in London Ontario, Canada*

Academic Advisors: Dr. Isaac Luginaah and Dr. Godwin Arku

August 2016

Master of Arts, University of Western Ontario, Canada

Thesis Title: *Environment and Health Perceptions in the Vicinity of Surface Mining Concessions in the Upper West Region of Ghana.*

Academic Advisors: Dr. Isaac Luginaah and Dr. Godwin Arku

May 2007

**Bachelor of Arts, Geography and Resource Development
University of Ghana**

Thesis Title: *Economic Empowerment of Women in the Techiman Municipality of Ghana*

Academic Advisor: Prof. John Nabila

May 2005

Certificate, International Water Management

Technology.

University of Ghana/Norwegian University of Science and

TEACHING EXPERIENCE

Sept 2014-May 2020

Teaching Assistant, University of Western Ontario

Fall 2019

Ontario

Lecturer, Department of Geography University of Western

Course Title: Geography South of the Sahara (Geog 2030A)

SELECTED PUBLICATONS

1. **Antabe, R.**, Sano, Y., Luginaah, I. (2020) HIV Misconceptions among Married Women in Malawi: The Role of Household Decision-Making Autonomy. *Journal of Public Health*, 1-8
2. **Antabe, R.**, Kansanga, M., Sano, Y., Kyeremeh, E., Galaa, Y. (2020) Utilization of Breast Cancer Screening in Kenya: What are the Determinants? *BMC Health Services Research*, 20 (1), 1-9
3. **Antabe, R.**, Sano, Y., Anfaara, W. F., Luginaah, I. (2020) Reducing HIV misconceptions among females and males in Malawi: are we making progress? *AIDS Care*, 1-5.
4. Konkor, I., Lawson, S. E., **Antabe, R.**, McIntosh, M., Husbands, W., Wong, J., & Luginaah, I. (2020) An intersectional approach to HIV vulnerabilities

and testing among heterosexual ACB men in London, Ontario: results from the weSpeak study *Journal of Racial and Ethnic Health Disparities*, 1-10

5. Konkor, I., **Antabe, R.**, McIntosh, M., Mkandawire, P., Lawson, S. E., Husbands, W., Wong, J., and Luginaah, I. (2020) Knowledge of Sexual Partner's HIV Serostatus and Condom Use Behaviour among Heterosexual men of African Descent in London, Ontario. *Ethnicity and Health*, 1-13
6. **Antabe, R.**, Atuoye, K. N., Kuuire, Z. V., Sano, Y., Arku, G., & Luginaah, I. (2019) To move or not to move: community members' reaction to surface mining in the Upper West Region of Ghana. *Society and Natural Resources*, 1-18
7. **Antabe R.**, Atuoye K. N., Sano Y., Kuuire V. Z., Galaa S. Z., & Luginaah I. (2019) Health insurance enrolment in in the Upper West region of Ghana: Does food security matter? *International Journal of Health Planning and Management*, 34(4), 1621-1632
8. **Antabe, R.**, Sano, Y., Anfaara, F.W., Kansanga, M., Chai, X., & Luginaah, I. (2019) Antenatal care utilization among circumcised women in Kenya: Some evidence from the 2014 Kenya Demographic and Health Survey: *Sexuality and Culture*, 1-13
9. **Antabe, R.**, Atuoye, K. N., Kuuire, V. Z., Sano, Y., Arku, G., & Luginaah, I. (2017) Community health impacts of surface mining in the Upper West Region of Ghana: The roles of mining odours and dust. *Human and Ecological Risk Assessment: An International Journal*, 23(4), 798-813

AWARDS

Nov 2019	PSAC Graduate Teaching Assistant Research Contribution Scholarship CAD\$ 500
2016-2020	Western Graduate Research Scholarship (WGRS) CAD\$ 128000
2014-2016	Western Graduate Research Scholarship (WGRS) CAD\$ 54000