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Research Article

Multilevel Barriers to Access Health and HIV Care Among African, Caribbean, and Black Men and Youths in Ottawa, Ontario: A Qualitative Study

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Abstract

Background: Ontario is home to the largest proportion of African, Caribbean, and Black (ACB) people living in Canada. This group isdisproportionately affected by the HIV pandemic. However, there is limited evidence on how multilevel barriersintersect and mutually reinforce each other to restrict access to health and HIV care. This paper examines multilevel barriers to access health and HIV carebased on the lived experiences of ACB people in Ottawa and Ontario.

Method: We conducted community based qualitative study with self-identified ACB men aged 16 and over, living in Ottawa. Our approach is informed by intersectionality theory and Socio-Ecological Model (SEM). A purposive sampling technique was used to recruit participants. We conducted six Focus Group Discussions and 16 In-depth Interviews. Sixty-three people participated in this study. N Vivo software was used for data management and thematic analysis.

Results: Six major themes were identified including barriers to access health and HIV care among heterosexual ACB men in Ottawa and Ontario, which is the focus of this paper. This theme is discussed through three sub-themes:(1)individual level low economic, knowledge,and racial identity;(2) community-level lack of culturally responsive services, few community leaders and lack of neighbourhood resources;and (3) system-level embedded discriminatory policies and practices, anti-*Black racism*, and traumasand legacies of *colonialism*.

Conclusion: Addressing health inequality and enhancing the accessibility and provision of healthcare for ACB populations in Ontario is critical for their health and well-being. An inter sectionality lens and SEM should be given priority to guide understanding of the causes of inequities and the complex ways multilevel barriers to access healthcare relates, intersects, and mutually reinforces one another. Multiple level strategies with strong emphasis at a systemic level, and culturally appropriate approaches are crucial to address barriers while enhancing collaboration among multilevel stakeholders including heterosexual ACB men's and ACB organizations.

Keywords: Multilevel barriers; Healthcare access; African; Caribbean; Black men; Heterosexual; Ottawa/Ontario

Abbreviations

ACB: African, Caribbean and Black; AIDS: Acquired Immuno Deficiency Syndrome; FGDs: Focus Group Discussions; HIV: Human Immuno Virus; IDI: Individual In-Depth Interviews; SEM: Socio Ecological Model; PHA: People Living with HIV/AIDs

Background

In North America, the Human Immunodeficiency Virus (HIV) pandemic has evolved over the past four decades. It is now concentrated in socially marginalized communities, and is endemic in the poorer sections of society [1]. WhileCanada has not seen a decrease in new HIV infections in recent years the long-standing systemic and social inequities have put many racialized people at increased risk of getting sick and dying [2]. Despite ongoing efforts, Canada has not seen a decrease in new HIV infections in recent years and further work is needed to meet all of the United Nations Programme on HIV/AIDS (UNAIDS)90-90-90 targets [3]. The 2020 data from the Public Health Agency of Canada reveals that the number of new HIV cases in Canada has increased by 25.3% since 2014 [3,4]. The African, Caribbean, and Black (ACB) population in Canada represents over 25% of new HIV diagnoses, despite the fact that ACB constitute less than 5% of Canada's population [5]. We argue that despite Ontario being home to the largest proportion of ACB living in Canada (52.4%) [6], their disproportionate vulnerability to HIV is not well documented [7].

Despite the achievements in HIV treatment and care in North

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America, HIV is still an issue of concern as it is disproportionately impacting socially marginalized communities, including ACB [1]. These disproportionately impacted marginalized groups include Black (African-Americans, Canadians of African and Caribbean descent) and other sexual and gender minorities. While ACB made up only 13% of the United States' (US) population, they accounted for 43% of HIV-related deaths in 2018 [8]. In the US Acquired Immune Deficiency Syndrome (AIDS) is the third leading cause of death among Black men and women between ages 35 to 44 [1]. HIV-related deaths are decreasing in the US, however the number of cases are up in Canada [9].

In Canada, HIV overwhelmingly affects already marginalized groups and communities such as men who have sex with men, people who inject drugs, and racialized populations, including Indigenous people [9]. Evidence released in late 2019 by the Public Health Agency of Canada indicated that there were 2,561 HIV diagnoses in 2018, which was an 8% increase from the previous year and which represented an overall increase of 9% in the last decade [9]. In 2018, the prevalence of HIV among heterosexuals accounted for 33.4% of all people with HIV in Canada. Additionally, ACB men have one of the highest HIV prevalence rates in Canada and, compared to others, they might be more vulnerable to HIV [10].

The devastating impact of health inequalities has been exacerbated during the COVID-19 pandemic, but this issue is by no means new. The disproportionate effect of HIV on ACB and Indigenous people in Canada is largely due to the systemic health disparities that exist which act as a barrier to care [9]. In Ontario, like the rest of Canada, HIV is concentrated in minority populations: Gay, bisexual, and other men who have sex with men (GBMSM), Black communities, Indigenous communities, People Who Inject Drugs (PWID), and at-risk women, in particular Tran's women [11].

HIV transmission is, therefore, a biological event that is entirely dependent on social context and behavioral practices. It has been shown in the literature that HIV transmission is a function of four concomitant interrelated multilevel factors local HIV prevalence, individual behaviors, biological factors, and social conditions [1]. The unmet needs for the health care of ACB people in Ontariomay are caused by racial and ethnic inequality that is reinforced by systemic barriers and anti-Black racism in the health care system [12-14].

Extensive research has been conducted on the barriers minority groups face to receiving health and HIV care [12-14]. However, there is limited granular analysis of heterosexual ACB men's lived experiences and perspectives as to how the multilevel barriers intersect and mutually reinforce each other to negatively affect access to health and HIV care particularly in Ottawa and Ontario. This paper aimed to examine the multilevel barriers to accessing equitable health and HIV care to inform policy interventions that reduce ACB health/HIV outcome inequalities in Ottawa and Ontario. We conducted a community based qualitative study to investigate heterosexual ACB men's vulnerability and resilience while engaging in HIV/AIDS programming in Ottawa in a project nicknamed 'weSpeak'. weSpeak was a five-year community based participatory research program with a goal of reducing HIV vulnerabilities and promoting resilience through active engagement of self-identified heterosexual ACB men in community HIV responses. In this article, we report on one of the major themes emerging from the weSpeak qualitative study that is barriers to access health and HIV care. These barriers are presented under three sub-themes (1) individual level; (2) community level; and (3) system and societal level. Our findings are relevant for various public health actors and professionals interested in addressing the multilevel barriers to access health and HIV care among ACB in Ontario guided by an intersectionality lens and the Socio-Ecological Model (SEM).

Theoretical Framework

The weSpeak research was supported by the principles of intersectionality theory that posits that the intersection of individual's social and political identities tends to expose them to either privilege or experiences of marginalization [15]. In this regard, experiences of poor health outcomes by oppressed and underprivileged populations, including ACB men, can be explained by the intersections of their social and political identities [16]. According to intersectionality theory, limiting ACB men's HIV vulnerability solely to their behavioral attributes may be problematic. This is because it excludes persistent systemic and structural barriers in their daily encounters and how these encounters overlap with other lived realities such as racism, stereotypes, discrimination, poverty, and general social oppression in predisposing them to HIV. We used SEM [17] to inform the description of the multiple levels of determinants of ACB men's to access health and HIV care.

Methods and Materials

Reporting

It is being reported in accordance with the reporting guidance provided in the Standards for Reporting Qualitative Research (SRQR), see file 1.

Study Design and Settings

We used descriptive qualitative methods informed by community-based participatory research to explore the perspective of men in the ACB community. Individual In-Depth Interviews (IDIs) and Focus Group Discussions (FGDs) were used to collect the data. The qualitative data collection took place between June 2016 and April 2017 with self-identified ACB men in Ottawa, Ontario.

The weSpeak study team included a broad range of stakeholders with demonstrated expertise and experience in healthcare, research, program and policy development, and advocacy with ACB communities in Ontario. The research team for the weSpeak study consisted of experienced male ACB members, community-based academic researchers and service providers. Participant recruitment and data collection was conducted by trained research assistants who had lived experience with ACB, qualitative research experience, and a university degree. The analysis was conducted by the study's leadership, including Josephine Etowa, the Principal Investigator, AG and DK (both of whom were the research coordinators at different times in the research process), and the authors of this manuscript.

Context: Research Project Description of the weSpeak Study

This manuscript reports some findings of the weSpeak qualitative study of the Ottawa site. weSpeak was a five-year research program with a goal of reducing HIV vulnerabilities and promoting resilience

through active engagement of self-identified heterosexual ACB men in community HIV responses.

weSpeak was implemented in four cities (London, Windsor, Ottawa, and Toronto) in Ontario to understand HIV vulnerability and resilience among heterosexual ACB men and youth (age 16 and over). The focus on heterosexual ACB men's HIV-related health needs and challenges became necessary as evidence suggested that there were devastating impacts of rising HIV infection among heterosexuals in 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. Given the intersectional and social determinants of the health care perspective of the study, the research also focused on the influence of the lived experiences of racism and how these experiences informed ACB men's access and willingness to use preventive health care services. The study was launched in 2015 with funding from the Ontario HIV Treatment Network (OHTN) and the Canada Institute of Health Research (CIHR).

Recruitment: Sampling Strategy

Purposive sampling and the snowball technique were used to recruit different groups of participants to ensure maximum variation [18]. According to Patton [19], *this kind of sampling technique is widely used* in qualitative research for the identification and selection of information-rich *cases* for the *most effective use* of resources.

Study Population Characteristics

The study's participants were self-identified ACB men and youth who live in Ottawa, Ontario.

Eligibility criteria for participation in the FGDs and IDIs included individuals self-identifying as heterosexual ACB males (including transmen who identify as heterosexual), and who were at least 16 years old, ACB men and youth People living with HIV (PHAs), or non-PHA including service providers, who were able to communicate in English or French, and who resided in Ottawa. Data collection was preceded by a community engagement campaign.

Data Collection

Data were collected using FGD and IDIs as guides, at a mutually convenient time and place. FGDs lasted 60 minutes to 90 minutes, on average, and IDIs, lasted 45 minutes to 90 minutes, on average. At the beginning of each FGD and IDI, the research coordinator briefly described the purpose of the study for the participants.The FGDs explored heterosexual ACB men's perspectives on their HIV vulnerabilities, as well as strategies to engage our target population in community HIV responses. The IDIs drew from insights and critical issues that emerged from FGDs. The participants were enabled to discuss issues related to vulnerability, relationships, sex/*sexuality*, and other sensitive or personal issues that could not be effectively captured from FGDs. The FGDs and IDIsalso assessed how vulnerability, resilience, heterosexuality, and masculinity emerged in everyday experiences. All responses were audio recorded, and hand-written field notes were taken during data collection to capture any non-verbal cues.

Data Analysis

We followed Braun and Clarke's [20] six step thematic analysis. SEM and the intersectionality lens guided the data analysis and interpretation. This is in keeping with the understanding that social identities and inequities such as gender, heterosexuality, unemployment, and racism, overlap and simultaneously interact with individual, community, and structural level factors to deter access to health care and reduce opportunities [16,21]. In order to address the HIV and health needs of the ACB sub-population, it is important to understand the multilevel layers of factors that influence access and utilization of health services. These theoretical perspectives informed coding and interpretation of key patterns in the raw data, to understand the factors that influence access to health and HIV care for ACB heterosexual men in Ottawa.

All FGDs and IDIs audio files were transcribed verbatim, and the typed versions were edited for analytical clarity. All French audio-recorded interviews were transcribed into English. Verbatim transcription was done by listening to audio-recorded material and was carried out by two research assistants.

We used NVivo software for data management and analysis, and conducted thematic analysis guided by the six-step process of Braun and Clarke [20]. The analysis included development of a coding framework informed by questions from the interview guides and a systematic approach that involved (1) familiarization with the data; (2) generating initial codes; (3) developing a coding tree to guide the coding of transcripts; (4) identifying themes; (5) reviewing, defining, and naming themes; (6) interpreting the narratives and stories; and (7) producing the report —a concise, coherent, logical, and non-repetitive account supported by vivid examples [22]. These iterative processes, which are typical of qualitative analysis, ensure that to gain new insights, preliminary themes and interpretations are tested and revised upon further data collection. During data analysis, preconceptions and assumptions were challenged, and a consensus was reached in terms of the data's interpretation. Thematic analysis was considered an appropriate modality for this study as it is participatory, accessible, and enhances collaborative data analysis and interpretation [20]. The qualitative working group composed of investigators and research staff, refined, defined, and named specific themes. Finally, we developed the qualitative report using vivid, compelling quotes of the participants to convey key ideas and issues to the audience [18].

Trustworthiness of data

Several measures were taken throughout the research process to establish the credibility of the data. Validation strategies used by Creswell and Pothwere employed [18]. These strategies included member-checking, peer debriefing, external auditing, and triangulation. It is important to ensure the assessment of fit between constructed realities of the informants and the reconstruction attributed to them. Peer-debriefing among members occurred during our regular qualitative workgroup meetings, to analyse data and discuss themes as they emerged [23]. Other measures taken to assure the trustworthiness of the research findings included designing the project to be led primarily by ACB community members, academics, researchers, and community members. The study team was organized at two levels prior to the actual study start up to involve community members, researchers, and policymakers' perspectives.

Team one was organized as a local advisory committee composed of volunteer heterosexual ACB community members and leaders to give

feedback on the planning, data collection, knowledge translation, and creation of the final report of the study. They met quarterly to review the process and ensure the community's perspective was respected. The second team encompassed the Principal Investigator, Co-Investigators, and community collaborators along with the academic researcher and knowledge use and policymaking experiences. This team met every month and led the overall administrative and technical process of the study. They provided a detailed critical review of the data collection process, the categories deriving process, and the decision-making process throughout. All of the research teams have experience in conducting and consulting qualitative research. Theassigned research coordinators have graduate level education and assistants have university level education, and both have significant experience in ACB community work and community-based research. Next, the team developed and pre-tested the interview guide. Following this the data were collected from diverse study participants recruited from different settings that have relevant experience. These processes facilitated meaningful engagement of the people being studied and ensured that the findings presented in this study are truly grounded in the realities of the individuals being studied.

Ethical Considerations

Prior to the commencement of the study, we obtained ethical clearance from Ottawa Public Health and the University of Ottawa's Research Ethics Board (REB). During data collection and analysis, we obtained informed written consent and assured participants of the confidentiality of their data. Participants were informed of their right to withdraw their consent at any time. Participants were also provided with the contact details of the University of Ottawa and Ottawa Public Health Ethics Committee for onward reporting of any possible ethical concerns and complaints. All respondents were informed of the right to refuse to answer any question posed by the interviewer and that they could withdraw from the study prior to having approved the interview transcript. Written consent was obtained from all participants after orientation. All interviews and discussions were recorded after obtaining the participants' permission. Anonymity was maintained throughout.

All typed records were kept on a password-protected computer and a back-up drive.

Results and Discussion

Sociodemographic Characteristics of Study Participants

Sixty-three people participated in this study. We conducted six FGDs (47ACB heterosexual men and youth participated) and 16 IDIs. The sociodemographic characteristics of the participants are presented in Table 1: In terms of language, French speakers equalled 21 (33%) and English speakers equalled 42 (67%); of these, 15 (27%) were PHA and 48 (73%) were non-PHAs as detailed in table 1 below.

The thematic analysis of qualitative data generated six major themes including (1) Multilevel barriers to access health and HIV care; (2) Black identity; (3) heterosexuality; (4) resilience; (5) love; and (6) vulnerability.

This manuscript reports on the theme of multilevel barriers to access health and HIV care among heterosexual ACB men in Ottawa, Ontario. The study's findings show how barriers to access health and HIV care can occur at three levels. The sub-themes emerging from barriers to access health and HIV care are individual, community, and systemic.

Table 1: Sociodemographic characteristics of the participants.

	FGDs	IDIs	Total	Percent
Ethno-racial background				
Black Africa	34	11	45	71.4
Caribbean	4	3	7	11.1
Black	5	2	7	11.1
Others (non-Black service providers)	4	0	4	6.3
Total	**47**	**16**	**63**	**100.0**
Age				
16–24	16	4	20	31.7
25–34	5	3	8	12.7
35–49	11	3	14	22.2
50+	11	6	17	27.0
Others	4	0	4	6.3
Total	**47**	**16**	**63**	**100.0**
Education (highest level achieved)				
Less than High School	1	1	2	3.2
High School	3	13	16	25.4
Post secondary/College	28	11	39	61.9
University	1	1	2	3.2
Others	4	0	4	6.3
Total	**37**	**26**	**63**	**100.0**

Individual Level

The first level examines individual factors that influence health-seeking behaviors of heterosexual ACB men and youth. According to our data, these include low economic status or lack offinancial security, low access to gainful employment, limited access to knowledge/information, and racial/ethnic identity. We found that ACB people who have low income have no motivation to pursue health care goals because their primary focus is on fulfilling basic needs such as food as one participant elaborates:

> They say an empty stomach has no ears. For me to feel comfortable, my basic needs have to be fulfilled. I cannot think of anything else when I lack the money to buy milk for my child. That's the primary problem that bothers me the most. …My reasoning is limited to my stomach, that's what must first be resolved to evolve. [25+, Adult Non-PHA, 026].

From the perspective of the above participant, when ACB people are worried about how to feed their family members, they are unable to prioritize seeking health or HIV care.

Our findings also show that ACB men and youths with lower socioeconomic status have limited access to supports necessary for good health. For example, the excerpt below from a PHA illustrates how providing a person with access to medication when they lack the ability to maintain a balanced diet is not enough:

> First of all, medications, because if we do not have medication,

the infection is going to keep spreading. Second, one must have a balanced diet. And to have a balanced diet, one must have the means, because if you cannot afford balanced food, such as organic foods… People living with HIV are not like everyone else when it comes to health needs. If you don't check what you eat and drink, your system will be affected. However, to have a balanced diet like you must have the means. The need for medication goes together with the need for appropriate food and especially the medicines we take; they are very strong drugs. You have to eat well. Apart from that, you have to have ways to do sports, that means to have access to gyms, because the drugs we take, they affect our system. [25+, Adult PHA 035].

Our data, therefore, shows that due to ACB people's social economic status it is very important for them to be healthy. Apart from issues related to people's ability to eat healthy and nutritious foods, a good income is important because it provides them with the necessary mental stability for them to keep track of what they eat and drink. We found out that our participants who were immigrants struggled to obtain professional jobs because their credentials were not recognized in the Canadian job market. They settled for minimum wage jobs, which are hardly enough to pay their bills. Although maintaining a balanced diet is important, circumstances dictate that is not prioritized. Our findings confirm how factors at the individual level affect health care for ACB men and youth.

Community Level

The second level highlights the surroundings or neighborhood situations that influence ACB community health and HIV care. This includes a lack of culturally responsive services. Our analysis reveals that some ACB people who are newcomers to Canada have limited access to relevant supports at a community level. Consequently, ACB people struggle to navigate community systems and resources, which renders them vulnerable poor health status. For instance, one participant commented:

...some of them need education and language depending on where they are coming from, access to social services or community services. There are people who don't even know that they qualify for certain income benefits. They have no idea that they qualify for certain programs, whether it's EI, so. [25+, Adult Non-PHA 023].

Some ACB people with low-income status are not aware of the available resources because there is a general assumption by the public actors that everyone knows where to go.

Additionally, we found that there is lack of ACB community-based interventions to address these barriers. For example, participants expressed a need for a setting where ACB people can freely, comfortably, and warmly relate, visit, and integrate. Building a culturally responsive and inclusive social environment can be effective in terms of enabling ACB people to access health information and services, and become more confident in advocating for themselves and their families. For example, one participant said:

Maybe we need a Black focussed HIV-AIDS resource center. That's how people would feel welcome, would feel accepted, would be able to relate to each other. …that may reduce the number of infections. OK, we need more centers which are geared towards (silence…) [building] a cultural or ethnic based community, like the Chinese community, they have their own community centers. I believe the Somalis, which is a group,… [that] can have African, Caribbean community center. I think people would feel more welcome to go and get services compared to…because there is the issue of feelings, there is some tension, ACB men may feel they don't belong to go to centers where most of the staff don't reflect their culture. They want to go to places where they can see staff that they can relate to. [25+, Adult Non-PHA 024].

As one of the participants stated, it is important to have in place ACB community health development interventions to optimize health and economic literacy. The findings suggest that some ACB men and youth may not be comfortable to access health and HIV care services from facilities where they do not feel welcome or where their needs are not acknowledged and addressed.

Another participant, quoted below, described the need for ACB space for health education and experience sharing opportunities:

I mentioned community support. Arabs people for instance, when there is a newcomer and there is a community member who has an enterprise, that person would hire the newcomer until he finds something better. I think we should find ways to guide the newcomers give them orientation and find them some jobs to start with while they are in the process of finding a better job [16–24, Youth Non-PHA 056].

Empowerment of community knowledge and lived experience is considered as a strategy to stop the pandemic, and reduce the impact of HIV, and inequalities in health outcomes:

Let's say the epidemic…it hits the community, community…able to do something and then next time...people are better prepared to deal with it, but all that comes from education and experience. So, if people would share their experiences just like we just stay right now with the best of the community in mind that would change us. [FGD 02, 25+, Adult Non-PHA].

Promote…something that would pertain to Black values for example. You know what?...you are helping us, you are helping yourself, and now, we are gonna help you back. It is like a shared environment. I got your back you got mine. Then it goes around and shows the Black community that we are actually there to..., we actually care about the Black community…. [16–24, Youth Non-PHA 055].

According to our findings, ACB men and youth health and HIV care depends on community efforts to empower them to support themselves.

Our study findings further show that there is limited access to health and HIV-related information among ACB people as one of the participants observed:

really...invest in education about how it's [HIV] transmitted and how it destroys the community…not striking fear into it, but educate people, like getting them to be responsible for those actions, right and understanding that those actions are like permanent because HIV is obviously not curable. [16–24, Youth Non-PHA 033].

A similar view was expressed by another participant as follows:

Keep spreading the news, continue awareness activities, and ask the people who finance research to do more. Don't let your guard down otherwise a community. An entire part of the society could be

wiped out by this disease if they do not seriously invest efforts in this. [25+, Adult Non-PHA 027].

Based on our study findings, availability of ACB focussed community efforts, or lack there of, has consequences for health outcomes of ACB men and youth in Ontario.

Systemic Level

The third level looks at the extensive social system-wide factors that prevented or posed challenges for ACB heterosexual men and youth in accessing resources and opportunities to be safe and healthy. These include systemic and embedded discriminatory policy and practice, anti-*Black racism* and trauma and legacies *of colonialism, which* are manifested in the day-to-day *policies and practices,* have directly or indirectly impacted ACB people's health.

Systemic and embedded discriminatory policy and practice: Our study participants lamented that their academic credentials from outside of Canada — especially from Black majority countries — are not recognized in Canada. When most ACB men arrive in Canada, they are confronted with a dilemma of choosing between social assistance, a survival job, and taking an educational loan without a guarantee for gainful employment after graduation. That not withstanding, those who get educational loans are required to re-pay within the assigned period. Therefore, there is downgrading of ACB credentials and minimum wage employment. One participant recalled:

it is very difficult,...I work with so many people who are underemployed and they have highly qualified skills and they come here and all they have to do is to work in a warehouse even if you get that, that is great. It is very difficult for people to make a living. I know some people who are struggling but they don't want to be on Ontario OW [Ontario Works or Social Assistance]…because of the stigma. A well-educated man with a Master's degree going on a what is it?… OW, you don't want to talk about it. [FGD 03, Adult 25+, [4] Service Providers].

The systemic discrimination and racism experienced by ACB men and youth in Canada impacts on their socio-economic statuses as individuals, which in turn dictates the quality of their health outcomes. As noted earlier, for a man who is struggling to feed his family, maintaining a balanced diet is a luxury out of his reach. They are likely working the maximum number of shifts to pay their bills and may not have time for health and HIV care visits.

A youth participant living with HIV explained:

So if you are ACB, in Canada it is pretty challenging.... When you are basically a Doctor in Africa and you come here it does not happen that way, they want you to restart the whole process. They want you to restart and pay money to them [16–24, Youth PHA 037].

ACB participants perceived this as an example of systemic discrimination which indirectly impacts on their health.

Furthermore, our study findings revealed that ACB voices are absent from the policy dialogue table and where ACB-specific health and related issues are discussed and determined.

ACB men mentioned that they experience low financial mobility and get stuck in inconsequential employment compared with their education and experience. They do not have an equal chance of being hired or promoted in their professions because their credentials are considered inferior. Consequently, ACB voices are missing in ACB-specific health and HIV-related discussions. The study participants noted that the system seems racist and discriminatory:

To work, first they will give you the opportunity to work. You just arrive, even if you have a degree (Well, you do not have Canadian experience. So Canadian experience how am I gonna get it?). Then you'll find yourself stuck or do other things or go back to school, but school, it is not easy. You have to take loans. You see, this is the system; it is about business. When you take the loan six months after you finish, you have to start paying even if you do not have a job yet. The debt already begins; the problems begin as well. This is the system. …The system is set in such a way that there is a category of people who have to stay at a certain level. [25+, Adult Non-PHA 026].

Anti-Black racism and colorism: Our findings show that anti-Black racism may be hindering ACB men's access to health services. For example, the lack of enough HIV interventions is demonstrative of the lack of value placed on ACB lives, as this is the most vulnerable group to the disease. As one respondent comment:

I think HIV is still linked to Black skin...first, it is a disease for poor people and because Africa is still considered the continent where there is a lot of poverty, a Black man is supposed to have HIV and then a White person, because he is White and because he lives in a developed country this disease is not always attached to him. When we see HIV, it is with the Black person, with poverty, with discrimination, I think that's what happens. [25+, Adult PHA 035].

Some of our study participants mentioned that they must work harder to prove themselves in the workplace to overcome the stereotype that they are generally incompetent. The statements of interviewed participants suggest that targeted evidence organization is important:

They like to tell us being a Black man in this world you do extra. If a White man gets an A, you have to try to get an A+ and then more, probably like, imagine you are trying to get a job, the White man is going to have a connection somehow and you gotta get almost like three times better to get recognized. [FGD 04, 16–24 Youth PHA].

Legacies of colonization and slavery: Many men expressed similar opinions and described the hardships ACB people face and the impact of distal structural barriers. Such barriers are generally beyond the individual or community's control and are the causes of unjust life situations for ACB people. Explicit references were made by participants to the adverse effects of the enslavement of ACB people and ongoing neocolonialism:

As a Black man, I don't even think that economically, there is an expectation to be successful or to be economically stable. I feel like there is actually downward pressure, you are supposed to be on the lower-income level.... It is extremely easy to see a person from another race, a person of a majority in the position that you want. If you want to be a CEO of a big tech company, you see Mark, you see Merry Pages you see all these people, but the first Black person CEO of a tech company you see is…Nicholas Julien the role models are not there. In other races and other situations there are actually people that you could see that are pulling you. I feel like with Black people you

actually getting pushed down in certain things. [FG 02, Adult 25+, Non-PHA 008-019].

From the perspective of the aforementioned participant, ACB people are worried about the limitedrole models or lack seeing role models in the leadership due to the sustaining *legacy* and trauma of *colonialism.*

Discussion and Implications

In Ontario, racialized populations are disproportionately represented in lower socioeconomic categories [11]. These dynamics are tied to long histories of colonization, racism, structural inequality, and social exclusion. For example, Black people make up a notable proportion of people living with HIV in the province [24-26]. In addition to being hard-hit by HIV, ACB people experience other factors that complicate health outcomes, such as racism, unemployment, and immigration status [25,27]. In Ontario, despite an abundance of health research documenting inequalities among racialized populations, limited research has focused on multilevel barriers intersectionality and reinforcement of barriers toaccess health and HIV services among heterosexual ACB men and youth.

The findings show that there is intersectionality and reinforcement of barriers of how men's health was shaped by individual, community, and societal/systemic factors.These determinants include an individual's low economic status/financial security, employment access, knowledge and racial/ethnic identity, the community's lack of culturally responsive service and limited number of community leaders/champions and lack of neighbourhood resources to help people navigate the system can render people vulnerable to poor health outcomes. System wide and embedded discriminatory policies and practices as well as anti-*Black racism,* trauma, and legacies *of colonialism.*

Our study highlighted the importance the intersectionality lens and SEM to analyze and better understand the causes of inequities and the complex ways in which access to healthcare relates, intersects, and mutually reinforces one another among heterosexual ACB men in Ottawa and Ontario. Intersectionality refers to understanding the prejudices and inequities experienced by individuals and exploring the interconnectedness of social identities such as race, gender, and class [28]. In this study, heterosexual ACB men and youth mentioned that they have multilevel barriers to access health and HIV care. The intersections of these experiences inhibit access to social and health services [29]. As these interacting factors are tied to poverty, discrimination, inequality and other social conditions facilitate HIV transmission by influencing local HIV prevalence as well as an individual's risk behaviors [1]. Health inequities along sociodemographic lines are complex and call for multiple level strategies at a systemic level.

There was a lot of overlap among the results, individual and systemic barriers, and the literature review. Participants described persistent systemic inequities impacting the health and wellness of ACB people in general and heterosexual ACB men and youth relative to the general population in Ottawa and Ontario. Although many ACB people come to Canada with extensive skills and knowledge, they find it difficult to obtain professional employment because they lack the mandatory Canadian education and experience. Our findings revealed that ACB people who have low incomes have no motivation to pursue health care goals or their situation does not allow for this because their primary goal is to sustain their life and family needs through 'survival jobs.' As a result, they experience low financial mobility and get stuck in irrelevant areas of service compared with their education and experience. They are, therefore, unable to support themselves and to contribute to their household [30] and protect their good health and safety [24]. For instance, educational achievement, related work experience, and subjective perceptions of social status and social class are considered based on Canadian standards [30].

The finding shows that systemic and embedded discriminatory policy and practice, anti-*Black racism,* trauma, and legacies *of colonialism* persist in the healthcare system as an obstacle to access health and HIV care for heterosexual ACB men and youth. Anti-Black racism is a system of inequities that discriminates against people of ACB descent [31]. Racism has well-documented consequences on health care access and quality that can influence the health and well-being of populations [32]. Evidence shows that this has the potential to lead, and continues to lead, to profound harm for people who use and work within these settings [33]. When racialized groups face racism and discrimination, they are more vulnerable and less likely to seek help until they are in desperate need [34-36]. Hence, in Ottawa and Ontario, addressing systemic and embedded discriminatory policies and practices,including dismantling racism in the health care system, is crucial using appropriate strategies [33,37].

The availability of culturally appropriate health services withing the health system was identified as important resource to access health and HIV care among ACB people in general and heterosexual men and youth in Ottawa and Ontario. Our analysis reveals that some ACB people who are newcomers to Canada have limited access to relevant supports at the community level. Some ACB people with low-income status are not aware of the available resources because there is a general assumption by the public actors that everyone knows where to go. The risk factors and disproportionate health outcomes are also associated with health system barriers like a linguistic and cultural mismatch between the patient and service providers, which continues to exist in the healthcare system [34,38,39]. People in Ontario who do not speak English or French fluently face challenges when trying to access health care [40]. There are also service provider-related barriers that include the language and ethnocultural mismatch between patient and health care provider [34,41,42]. Public health actors need to place emphasis on culturally appropriate health services to address health inequalities and address the rights of racialized populations who are disproportionately impacted including ACB people.

Multilevel intervention is required to address the complex ways in which barriers intersect and reinforcebarriers to access to health and HIV care among heterosexual ACB men and youth.This indicates that while planning and implementing ACB focused health interventions public health actors should employ an intersectional lens and SEM to better understand the causes of inequities and the complex ways in which access to healthcare relates, intersects, and mutually reinforces one another among heterosexual ACB men and youth in Ottawa and Ontario.

Our study suggests that 'one size does not fit all' in terms of responding to complex public health issues such as access to health

and HIV care of historically marginalized populations such as ACB people. Thus, to address barriers integrating culturally competent health and HIV care across the health care system and including community health workers' **o**utreach and community settings; deployment of and training professional ACB staff to provide linguistic and cultural matching health services at the point of service deployment and outreach community are crucial.Engagement of heterosexual ACB men's perspective and employing inclusive policies is a key strategy to ensure individuals, communities, and system level barriers are ameliorated and to enhance access to health and health care.

Strength and Limitations of the Study

As strength, this study used qualitative methods that add a greater depth of understanding to an under-researched area, heterosexual ACB people's health. Additionally, the study was organized and lead by experienced ACB community academicians, researchers, and community leaders. However, a limitation is that findings were confined to heterosexual ACB people, which means the findings are not inclusive of homosexual ACB men and women or heterosexual women in Ottawa. We believe that barriers in accessing health care by homosexual ACB men and women and heterosexual women in Ottawa would differ from the ACB people in our sample.

Conclusion

Our findings have examined how the critical intersections of multiple level factors impact the health and healthcare access of heterosexual ACB men in the Ottawa and Ontario.The use of a SEM helped to expose the layered factors to consider when addressing HIV in ACB communities, and of intersectionality theory that recognizes that being an ACB person is comprised of intersecting social identities that contribute to HIV risk and access to health services. Efforts to address ACB health and HIV outcome inequality in Ottawa and Ontario should be guided by SEM and an intersectionality lens while creating program planning and service provisions. While providing services to heterosexual ACB men, inclusive policies and programs are important to address individual, community, societal, and systemic barriers to access health care. This includes creating ACB-focused economic opportunities, culturally responsive community health and neighbourhood resources, newcomers credential/experience integration, dismantling anti-Black racism in the health care system, ACB community organization capacity building and engagement and acknowledging structural anti-Black racism.

Author Contributions

Conceptualisation: Josephine Etowa (JE) and Akalewold Gebremeskel (AG); Funding acquisition: JE**;** Investigation: AG, Doris Kakuru (DK), JE**;** Methodology: AG, DK & JE**;** Formal analysis: AG, DK & JE**;** Writing – original draft: literature review and original draft: AG; Writing – review & editing: AG, DK & JE; Supervision: JE; Software: AG, DK & JE; Project administration: AG & JE.

Data Availability

Datasets generated and analyzed during the current study are not publicly available due to participant private polices and research regulation agreement related to Ottawa University but are available from the corresponding author on reasonable request.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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