Critical Analysis of Peer Engagement in HIV Testing and Prevention within Black, African, and Caribbean Communities in Manitoba, Canada

By

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Abstract

African, Caribbean, and Black (ACB) populations are overrepresented among new Human Immunodeficiency Virus (HIV) and Sexually Transmitted and Blood-Borne Infection (STBBI) cases in Canada. Manitoba has the second-highest rate of new HIV diagnoses in Canada. Peers have become increasingly important in the context of the HIV care cascade, serving to connect individuals and communities to HIV prevention, treatment, and related services. They play a crucial role in addressing disparities in HIV testing, prevention, and treatment access for communities. This is achieved by supporting individuals in navigating the healthcare system and overcoming bureaucratic obstacles and access barriers. Many studies have explored the impact of peer navigation in engaging communities in HIV prevention and treatment. However, no research has examined the acceptability of peer navigation among ACB communities in Canada and the power dynamics in the relationship between peer navigators and community members seeking HIV services.

This Master of Social Work thesis focuses on peer navigation within the context of HIV among ACB communities in Manitoba. The study explored the discourses surrounding peer navigation and the power dynamics between peer navigators and ACB community members in Manitoba. The study utilized a qualitative community-based participatory research approach and harnessed the insights of ACB community members through the Community Guiding Circle (CGC), consisting of ten ACB community members. The research included a secondary analysis of data from the Ubuntu-Pamoja study, with participants being recruited through agencies serving ACB communities, social media, and word-of-mouth. Thirty-three interviews (n=33) were analyzed to identify key themes and fulfill the established research objectives. Data analysis employed thematic analysis using critical, intersectional-feminist, and Afrocentric theories. The

methodology included two member checks to ensure the research process remained relevant to the needs of ACB communities in Manitoba.

The ACB community's perspectives on peer support in HIV services uncovered a complex interplay of trust, knowledge, professionalism, cultural and gender dynamics, as well as lived experiences. These elements influence the community's preferences for peer navigators in HIV testing and related services. The findings underscored the importance of integrating well-trained, culturally aligned peer navigators within the community. The study also revealed that power dynamics between peer navigators and community members seeking HIV services are nuanced and complex, involving trust, expertise, shared identity, and lived experiences.

Attention must be given to the perspectives and experiences of ACB community members concerning peer navigation and the power dynamics between peer navigators and those seeking HIV services. This consideration is crucial for policy reforms and future research within Black communities in Manitoba.

This study enhances our understanding of sexual health service delivery for Manitoba's African, Caribbean, and Black (ACB) communities. It supports developing a more inclusive HIV response plan/policy and health promotion efforts. Additionally, it establishes a solid platform for health agencies to promote and enhance strategies for HIV prevention and testing within ACB communities.

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Introduction

Overview

Sexual, racial, and ethnic minorities are disproportionately affected by the HIV epidemic in Canada. Notably, African, Caribbean, and Black (ACB) populations are overrepresented among new cases of Human Immunodeficiency Virus (HIV) and sexually transmitted and blood-borne infections (STBBI) in Canada (Mbuagbaw et al., 2022; Antabe et al., 2021). According to Etowa et al. (2022), ACB population represents approximately 3.5% of Canada's total population yet accounts for over 20% of HIV/STBBI cases in Canada.

Manitoba has the second-highest rate of new HIV diagnoses, and approximately 25% of those infected are unaware of their HIV status (Government of Canada, 2023). Epidemiological evidence revealed that specific populations, including ACB communities, are disproportionately affected by HIV (Etowa et al., 2022; Mbuagbaw et al., 2022; Zhabokritsky et al., 2019). Socio-demographic determinants, such as marginalization, lack of cultural sensitivity, and racial and sexuality-related discrimination, are documented barriers to equitable and affirming HIV care for ACB communities (Cahill et al., 2017; Maulsby et al., 2013).

Existing research revealed that the adverse effects of HIV stigma, racism, and structural bureaucracy serve as barriers to accessing sexual health services and the uptake of HIV services for ACB communities in Canada (Lo et al., 2021). To address the disproportionate burden of HIV/STBBI among ACB communities, a combination of strategies encompassing biomedical, behavioural, and structural approaches that are culturally sensitive and tailored to the unique needs of the affected communities are needed (Oliveira et al., 2023).

Peer navigation has emerged as one strategy to help communities overcome access challenges. While many studies have explored the impact of peer navigation in engaging communities in HIV prevention and suggest that it is effective in reaching hard-to-reach populations and increasing HIV testing and treatment uptake (Shah et al., 2019; Rhodes et al., 2020; Oliveira et al., 2023), fewer studies have examined the acceptability of this strategy particularly among ACB communities in Canada. Additionally, most research focused on how peer navigation approaches can increase service uptake, and no study has critically examined the power dynamics of peer navigators and community members seeking HIV services. This study addressed these knowledge gaps.

Terminology and Language

This paper will use the term *ACB community members* to refer to participants of African and Caribbean descent within the research. In the context of HIV, peer navigation encompasses a range of interventions and system navigation where non-healthcare-trained individuals support target community to access HIV-related services including linkage to care, patient-provider communication, and education, in addition to offering interpersonal support in HIV services. Below are other terms utilized throughout the paper. A definition of each has been included here for ease of reference and to establish the meaning that helped shape the research and findings.

HIV – Human Immunodeficiency Virus

ACB community – African, Caribbean, and Black community

STBBI – Sexually Transmitted and Blood-Borne Infections

Location of Self in this Research

In this study, I explore my social location as an insider researcher, drawing on my work experiences in the field of HIV and my identity as a member of the ACB community. Hulko (2009) defines social location as the degree of privilege and oppression that people face based on numerous identity constructs such as race, ethnicity, socioeconomic gender, sexual orientation, age, disability, class, and beliefs.

Examining my position in the research process is necessary to enhance research participants' representation and knowledge creation. Knowing how my social location might influence participants and community engagement is important as a social worker. Recognizing that social location allows for a better understanding of the subjectivity I bring with me based on my personal experience and how this experience may differ depending on intersectionality.

I consider myself an insider researcher while acknowledging that I do not possess knowledge of all the identities represented in the ACB population. I am mindful of how my status as an insider researcher may have shaped this research. Being an insider researcher presented an opportunity to build trust and confidence with research participants. While doing this study, I was conscious of how my ethnicity, gender, and immigration status might influence participants' experiences.

I undertook the study as an immigrant Nigerian (African) woman living in Manitoba, Canada, with over fifteen years of work experience in HIV programs. My journey in this field began with my early work in Nigeria, particularly with young women and mothers living with HIV. I have served as an educator, facilitator, peer navigator, community mobilization, and treatment adherence counselor.

I approached this inquiry as someone with knowledge of HIV from my work with different communities and diverse groups (youth, men, women, and people with disabilities). Furthermore, my experiences working with immigrant and ACB populations in Manitoba played a significant role in this study. While I had appreciated the benefits of addressing the unique needs of each group, I had not directly considered the issue of power dynamics among and within groups. Interpreting empirical data and representing ACB communities' experiences in research like this demonstrated how knowledge is power.

Black communities have operated within an anti-black Canadian society for decades, experiencing inequities and disparities in all societal systems, including healthcare, linking directly and indirectly to anti-black racism and social exclusion for black communities. I bring my insider knowledge to unmask and challenge the structure of systematic anti-black racism. My intention for engaging in this research is to engage in research that identifies and develops interventions specific to my community and to bring meaningful change to the problem identified by ACB communities. Most HIV-related services are offered using a universal approach, and according to Heard et al. (2020), dominant approaches in health interventions perpetuate disparities by focusing on interventions that serve dominant and privileged demographic groups.

I am part of the Ubuntu-Pamoja study, a larger research project that explored the health and well-being of ACB communities in Manitoba, a study that addressed the specific needs of my community. My experience with this study and other intersecting experiences and identities led me to engage in this research.

I believe in empowerment and collaboration, and conducting participatory community-based research empowers ACB communities. As a social worker, I am interested and motivated to explore the resilience and strengths of ACB populations throughout the research process, particularly during the data collection and analysis stages of the larger Ubuntu-Pamoja project. I knew my social location and how it may have influenced the interview process and data interpretation.

Research Purpose, Objectives and Questions

The Research Purpose

This research aims to critically examine discourses surrounding peers and peer navigation in the context of HIV testing and prevention within ACB communities in Manitoba.

Research Objectives

The research objectives are:

- To advance the understanding of the concept of peer navigators/navigation from ACB community's perspectives and address the knowledge gaps surrounding power dynamics in peer engagement in HIV testing and prevention among ACB Communities in Manitoba
- To advance recommendations on peer engagement with ACB communities with regard to HIV and sexual health services in Manitoba.
- To generate recommendations for effective and culturally safe initiatives and community action for ACB communities in Manitoba.

- To scrutinize existing power structures and societal norms that may perpetuate inequalities in HIV testing and prevention services for ACB communities and make recommendations for addressing structural inequalities.
- To contribute to more effective and culturally sensitive interventions in HIV prevention for ACB communities in Manitoba
- To theorize the connection between discourses on peers, how communities internalize those discourses, and their impact on HIV service uptake and delivery.
- To understand the power dynamics within peer navigation in HIV testing and prevention services for ACB communities and its impact on service delivery

Research Question

The following research questions were used to address the study goal and objectives.

- What are the perspectives and experiences of ACB community members regarding peer navigation?
- What power dynamics exist between peer navigators and community members seeking HIV services/testing?
- How do discourses of ACB community members frame the social identities of HIV peer navigators?

Literature Review

Peer navigation is an umbrella term that encompasses a range of interventions in which non-healthcare professionals who share similar characteristics with the target population (such as cultural backgrounds, a history of risk behaviours, or the same medical condition) provide

various activities, including linkage to care, patient-provider communication, and education, in addition to offering interpersonal support in the service of healthcare initiatives (Simoni et al., 2011; Oliveira et al., 2023).

Studies have highlighted the effectiveness of peer navigation programs in combating HIV and improving the quality of life among diverse populations. According to Quinn et al. (2020), racialized and minority groups harbour mistrust towards institutionalized health systems due to historical and ongoing structural racism perpetuated by discriminatory policies and the unequal distribution of resources, resulting in health outcome disparities. Through peer navigation, communities can connect to the healthcare system and access HIV-related services.

Many studies have demonstrated the effectiveness of peer-led interventions in HIV prevention, treatment, and retention in care. However, examinations of this strategy's impact among ACB communities are rare. According to Mullings et al. (2021), practitioners must consider what is essential for the target audience while acknowledging the diversity within groups when designing health interventions. Documented evidence suggests that peers are more likely than professionals to influence behavioural change among peers and access underserved communities with limited involvement in traditional healthcare programs (Shangani et al., 2017). Nevertheless, the influence of the peer navigation program and qualities, such as the nature of peer navigator activities and personal characteristics, skills, training, employment, and support structures, are less well-understood.

Various discourses on peers have contributed to the formation of peer subjectivities and social identities. For instance, Rhodes et al. (2020) frame peer navigators as individuals connected to the community and known by other group members, positioning peer navigators as

notable insiders to the community. These “insider” characteristics highlighted by Rhodes et al. (2020) include similarities in race, ethnicity, sexuality, and gender identity. Notably, the study also linked peer navigators to leadership roles, given their position within their communities and networks.

The participation of community leaders as peer navigators could encourage community acceptance and participation, as community members traditionally respond positively to initiatives backed by their leaders or that involve community leaders (Rhodes et al., 2020). Community leaders are respected and regarded as trusted individuals who can tailor interventions to the community's needs. However, less is known about the impacts of the power dynamics on this relationship, and scholars have not examined if the work of peer navigators can be seen as another form of social control over marginalized populations.

Community leaders’ involvement could be an act of persuasion or motivation to act in a certain way. According to Shangani et al. (2017), peer navigators are usually members of the same community. They thus can influence and support behaviour modification, such as engaging in a healthier lifestyle, changing risky sexual behaviours, and maintaining healthy sexual behaviours in a way that is conducive to the community. While peer involvement in HIV prevention is commendable, there is a need to explore the power dynamics inherent in these relationships (peer-to-peer) and the discourses that shape these practices to better understand their role in social control, particularly for ACB populations. The discourse of leadership as a characteristic of the peer identity promotes the idea that peer navigators wield influence within the community.

Dominant narratives on peers speak to the visibility of peers in the community. According to Quinn et al. (2020), the most popular member in a social network can impact the behaviour of community members. Popularity in the community may offer more accessible access to the community and gain support for programs due to existing relationships. Shah et al. (2019) framed peers as individuals who share a social identity with the population and can conduct community outreach. This suggests that peers should have similar life experiences to those they support, including some commonalities in demography, like race, gender, and lived experience. Knowledge and skill were also crucial in peer navigators' identity subjectivity (social identity) formation. Jaramillo et al. (2022) also suggest that peer navigators should have the requisite training, depending on the roles of peers in the intervention. They could be trained to provide HIV-related information, educate the population, develop communication skills, and build relationships, among other skills.

Peers consider information from their peers to be reliable. Similarly, community members regard community leaders as reliable sources of information (Rhodes et al., 2020). Given their shared experiences and familiarity with the community, peer navigators usually approach the community with cultural sensitivity, which is often absent in healthcare settings. For example, they can appropriately match age, gender, beliefs, and other community characteristics. In a recent study, peer navigators used condom distribution to initiate sexual health conversations and tailored their helping activities to the needs and priorities of their social network (Rhodes et al., 2020). Rhodes et al. (2020) also suggest that peer navigators provide more culturally and linguistically appropriate services to their communities.

Karver et al. (2022) conceptualized peer navigation using Freire's theory of critical consciousness, which speaks to the idea that inaction results from a lack of awareness of

structural inequality. People do not oppose repressive structures that uphold inequality because they do not know these inequities exist. In their study, peer navigators were viewed as responsible for the community's conscience and held accountable for awakening awareness and curiosity to challenge structural barriers within the healthcare system through awareness creation, community empowerment, active participation, engagement, and mobilization.

This discourse positions peer navigation as a strategy that can address the deficiencies and oppressions of the healthcare system. Critical awareness of the factors influencing knowledge creation is essential for being culturally sensitive and working with ACB communities. While studies on peer navigators have focused on some groups, such as gay men, women, transgender people, and youth (Rhodes et al., 2020; Shah et al., 2019; Quinn et al., 2020), the literature reviewed was silent regarding gender identity. From an intersectional, Afrocentric, and feminist perspective, gender discourse is crucial, given historical gender roles, community norms, and power dynamics implicit in the work of peer navigators. It is, therefore, crucial to examine the role of gender in the context of peer navigators within ACB communities in Manitoba.

The ACB population in Manitoba is diverse, with multiple and overlapping identities, such as age, gender, sexual orientation, immigration status, country of origin, socioeconomic status, ability, religion, and racialized identity shaping their experiences. For example, a queer or trans-Black individual may not only have to deal with racism but also homophobia, transphobia, and hetero-cis-normativity. These identities intersect uniquely and may have significant implications for health and well-being (Madison, 2020; Heard et al., 2020).

Rhodes et al. (2020) study showed that sexual orientation and age impacted the experiences of participants in the study, where older bisexual male participants were more concerned about confidentiality and thus preferred male peers of similar sexual identities. An aspect of peer navigation that is often unspoken is the dual responsibility of peers in most peer intervention programs. This dual responsibility encompasses their social interests (service to their communities) and their responsibility to the healthcare program that recruited them for the intervention. In exploring the peer relationship, it is essential to understand if peer affiliation and responsibility sway the relationships and power dynamics. McKechnie et al. (2023) conceptualize peer navigators as community members, part of the study population, who are paid and trained to support community members (peers) in navigating the healthcare system. This raises questions about how peers being paid and trained affect peer-to-peer relationships.

Personal information exchange may occur in the process of peer navigation. It could be a source whereby community information is shared with external bodies. Michaud, Meulen, and Guta (2023) describe it as using their social context and shared experiences with the community to fulfill institutional objectives. This practice could potentially abuse the community's sense of trust and solidarity and affect the power relationship between peers and their community.

As most literature suggests, the peer navigator's role includes providing social, health, and emotional support to peers, creating awareness, and raising awareness through education. Barriers to healthcare access may include non-health-related issues, and supporting clients to address these needs may facilitate accessing healthcare services (Karver et al., 2022; Khalpey et al., 2022). The role of peer navigators in promoting health is based on the affinity, connection, and experiences peers share with their communities, allowing for successful communication, education, advocacy, and social support. Peer navigators serve as a link between clinical,

community, and social resources while guiding and supporting patients through complex health systems. The uniqueness of the peer navigation model is the shared experience, background, and similarities with the target population.

Peer navigators facilitate access to resources and engagement with health services. This approach has effectively reached hard-to-reach populations and increased HIV testing and treatment uptake (Rhodes et al., 2020; Oliveira et al., 2023) among key populations and other marginalized groups. According to Pitpitan, Mittal, and Smith (2020), key populations are less likely to access healthcare services because of structural marginalization. Peer navigation addresses these socio-structural barriers and provides social support to help participants remain in care and promote treatment adherence. Thus, peer navigators are framed as helpers who can influence and promote community service utilization. Peer navigators attain this position through trusting relationships and connections with community members.

Koester et al. (2014) described the role of peer navigators as a "bridge to the healthcare system," given their social connection with the community, training, and resource hub. Finally, according to Khalpey et al. (2022), the emergence of peer navigation addressed the psychosocial needs of people living with HIV. Peers shared lived experiences with participants and were regarded as 'trustworthy' and 'reliable' sources of emotional support and resources. This is unsurprising, as many people are more likely to connect with peers.

Oliveira et al. (2023) described peers as non-prescription care providers who assist communities in overcoming care barriers by identifying unmet needs, facilitating access to resources, and encouraging participation in healthcare services. Peer navigation has been widely used to reach hard-to-reach, vulnerable, and marginalized populations, especially among those

facing inequalities and injustices in accessing healthcare and HIV prevention services (Oliveira et al., 2023). Peer navigators are perceived as facilitators of resource access and engagement with health services. Rhodes et al. (2020) suggested that peer navigation effectively reaches hard-to-reach populations and increases HIV testing and treatment uptake (Rhodes et al., 2020; Oliveira et al., 2023). ACB populations in Canada have historically faced disparities limiting their access to public health services (Oliveira et al., 2023). Typically, peer navigators can offer culturally and linguistically appropriate assistance to the target population while challenging structural barriers within the healthcare system. In HIV prevention and treatment strategies, peers are viewed as sources of social support, gaining the trust of their peers and using a communication style that offers respect, validation, and empathy.

In summary, the literature review showed that peer navigation, encompassing various interventions, deploys individuals with shared characteristics with the target population to offer essential support in healthcare initiatives. These peer navigators have proven highly effective in combating HIV and enhancing the quality of life among diverse populations, particularly within the context of HIV prevention and treatment. However, the dynamics of power, community influence, and the role of peer navigators in social control are critical areas that warrant further examination. As they serve as connectors between clinical, community, and social resources, peer navigators bridge gaps in healthcare access, making them a vital tool in reaching hard-to-reach populations and increasing testing and treatment uptake. Additionally, understanding the intersections of gender, cultural identity, and overlapping identities in the work of peer navigators is crucial for ensuring equitable healthcare outcomes within marginalized communities.

Theoretical Approaches

My Standpoint

In framing the epistemological foundation for my study, first, an anti-colonial epistemology is employed to challenge and deconstruct the historical legacies of colonialism and anti-Black racism that have shaped healthcare systems in Canada. This perspective recognizes the need to decolonize approaches and interventions, ensuring that my research respects diverse cultural contexts and empowers communities rather than perpetuating oppressive colonial structures.

Additionally, a feminist epistemology guides the study by emphasizing gender dynamics, intersectionality, and the experiences of Black women within this larger ACB community. This approach acknowledges the unique vulnerabilities and strengths of Black people based on their gender identities and addresses gendered power imbalances within the context of HIV testing and prevention. By adopting a feminist perspective, the study aims to contribute to more inclusive and equitable interventions that account for the nuanced ways gender intersects with health outcomes and within HIV testing.

Moreover, since much of my research is about investigating power dynamics within the context of peer navigation, the study incorporates a critical epistemology to scrutinize existing power structures and societal norms that may perpetuate inequalities in HIV testing and prevention for this community. This critical lens encourages questioning assumptions, uncovering hidden power dynamics, and fostering a deeper understanding of how social, cultural, economic, and political factors influence health disparities within Black, African, and Caribbean communities.

By intertwining anti-colonial, feminist, and critical perspectives, the study seeks to offer a holistic and nuanced analysis that goes beyond traditional approaches, ultimately contributing to more effective and culturally sensitive interventions in HIV prevention.

Epistemological and Theoretical Frameworks

The study examined power dynamics in peer relations in the context of HIV testing and prevention among ACB community in Manitoba using critical (post-structural), Afrocentric, and intersectional-feminist perspectives. The basis of my epistemology is 'critical (with a focus on critical theory) in that it questions dominant knowledge claims and the power dynamics that shape them. This epistemological standpoint examined how history, marginalization, and oppression are important factors in understanding our current modern discourses on peers. It is also post-structural (and to some degree constructivist) because of its focus on discourse, language, and ideology. Through critical and post-structural epistemological standpoints, I recognize that knowledge is not simply discovered (and has the potential to become oppressive) but is also actively constructed through social and political processes.

My epistemological framework aims to uncover the hidden assumptions and biases that shape knowledge claims and reproduce discourses on peers. It asserts that knowledge is not objective or neutral but rather constructed through the interaction between the knower and the known and influenced by social, cultural, and historical contexts. This approach emphasizes the importance of multiple perspectives, voices, and experiences in knowledge construction on peer navigators. Furthermore, my framework highlights multiple theoretical perspectives to

understand the power dynamics within peer navigation in HIV testing and prevention programs for ACB communities.

First, I introduce the concept of power to explore power dynamics within peer-to-peer relationships and assess their impact, examining whether these dynamics are oppressive and create divisions or hierarchies within the community. I then explore the theories of power and knowledge from the Foucauldian perspective, emphasizing that power is present in all social interactions and is discursively intertwined with access to social resources. I also discuss the critical and post-structural concept of governmentality (Gagnon & Guta, 2012) and its implications in the context of peer navigation, highlighting how discourses impact communities' psychology and how societies produce citizens who conduct their lifestyles according to various forms of knowledge.

I then highlight the utility of the Afrocentric social work perspective for my work. The Afrocentric perspective in the context of power dynamics within peer navigation for HIV testing and prevention among ACB communities is based on a paradigm that seeks to empower Black people by centring their cultural identity in social work practice. This framework draws from African philosophy, history, and culture to interpret social and psychological phenomena. It offers an approach relevant to personal, family, and community healing and societal changes (Mullings et al., 2021).

Lastly, I introduce intersectionality theory and feminist standpoint, emphasizing the importance of considering the intersection of various factors like gender, race, ethnicity, and other identity markers like age, nationality, and sexuality in understanding power dynamics within ACB communities. This framework recognizes the heterogeneity of experiences within

the Black community and the need to create feminist-intersectional spaces for expressing the diverse experiences of Black people. In summary, my work adopts a multifaceted approach to exploring power dynamics within peer navigation, drawing on various theoretical perspectives to understand the complexities involved in HIV testing and prevention among ACB communities.

Afrocentric Social Work's Perspective

As a paradigm, Afrocentric social work enables people of African descent to refocus their cultural identity in social work practice. This framework utilizes African philosophy, history, and culture to interpret social and psychological phenomena, creating an approach relevant to personal, family, and community healing and societal changes (Mullings et al., 2021). Using an Afrocentric social work framework enhances resistance to oppressive systems, strengthens communal protective factors, and supports the mobilization, education, and self-determination of ACB populations. The study employs an Afrocentric paradigm to deconstruct colonial power relationships inherent in the peer navigation realm.

Historically, Black communities have operated within an anti-black Canadian society, experiencing inequities and disparities in all societal systems, including the healthcare system, directly and indirectly, linked to anti-black racism and social exclusion for black individuals, families, and communities (Mullings et al., 2021). Peers foster participation in social movements and advance the positions and lived experiences of Black people in Canadian society, using their insider knowledge to unmask and challenge the structure of systematic anti-black racism.

HIV-related services are offered using a universal approach; however, working with ACB communities requires identifying and developing interventions specific to ACB populations.

Heard et al. (2020) suggested that dominant approaches in health interventions perpetuate disparities by focusing on interventions that serve dominant and privileged demographic groups. Systemic barriers, social exclusion, stigma, and isolation caused by anti-black racism contribute to the rise of inequities affecting the ACB population in Canada (Mullings et al., 2021). Peer navigation is one strategy that could support the community in overcoming healthcare barriers and addressing stigma and racism in healthcare systems. Oliveira et al. (2023) suggest that a structural approach that is culturally sensitive and contextualized to the target community is needed to address the peculiar needs of key populations.

Peer navigation can be viewed in many ways, one being a commitment to care for their communities. Usually, peers are members of the communities they serve. Oliveira et al. (2023) suggest that emotional dynamics and shared personal characteristics influence linkage through the peer navigator and peer relationship. The concept of care permeates peers' involvement in care strategy for HIV prevention and treatment. Caring implies tending to the needs of others, creating a feeling of healing, and supporting the health and wellness processes. Peer navigation involves reaching out of compassion to peers with similar experiences. As service users, peers understand the community's experience with the healthcare system. As service providers, they understand how the health system works and can use their personal experience to increase linkage to care while being sensitive to participants' specific needs.

The sense of community and caring for others aligns with the African philosophy of Ubuntu, which emphasizes communal values, human dignity, sharing, collaboration, social cohesiveness, social justice, human rights, and respect. Ubuntu is a way of life for many Africans and Caribbeans. It is a philosophy that emphasizes 'being self through others' (Chigangaidze, 2021, p. 4).

The Ubuntu philosophy (upon which the larger Ubuntu-Pamoja project was based) guided the data analysis for this project. Ubuntu philosophy is rooted in collectiveness and responsibility for oneself and others. In HIV prevention, individual actions within the community reflect on the community. It calls for consciousness - being aware of oneself in the context of others. Embracing this concept creates acceptance and reawakens the consciousness of the community (caring for self and through others) that is inherent in Black communities. Common communal issues, such as health disparities and HIV, can be addressed by applying Ubuntu's values. According to Mullings et al. (2021), "If knowledge is power, then decolonizing research is a process of challenging the dominant power"(p. 76). The Afrocentric framework utilizes African philosophy, history, and culture to interpret data on HIV testing and community health.

Intersectional – Feminist Theory

Intersectionality theory and feminist perspective emphasize the importance of considering the intersection of various factors like gender, race, ethnicity, and other identity markers like age, nationality, and sexuality in understanding power dynamics within ACB communities. This framework recognizes the heterogeneity of experiences within the Black community and the need to create feminist-intersectional spaces for expressing the diverse experiences of Black people.

According to Madison (2020), feminist theory is generally concerned with the power disparities between men and women and how these disparities impact their public and private lives. Gender inequities are a significant concern in feminist theory, and the focus is on power relations and how these distinctions are manifested, categorized hierarchically, and materially structured in the social environment.

Intersectionality theory, developed by anti-racist and feminist scholars like Kimberlé Crenshaw, explores how different forms of oppression and discrimination intersect and interact (Crenshaw, 1989). This framework is helpful to analyze and understand the complexity of the world and people's experiences. Typically, our experiences are shaped by multiple factors in diverse and mutually influencing ways; for instance, when analyzing peers' involvement in HIV intervention (testing and prevention) for ACB communities, intersectionality theory can help us identify how multiple intersecting factors, such as ethnicity, gender, sexuality, socioeconomic status, and immigration status, may influence peers' experiences and perspectives on HIV intervention. It may reveal how issues such as racism, sexism, misogyny, as well as stigma, discrimination, and cultural norms intersect to shape community members' attitudes and behaviours toward HIV/STBBI testing.

Early feminist theorists focused on empowerment. However, little consideration was given to the mechanism that disempowers the individual (Madison, 2020, p. 95). Empowerment has diverse connotations for people of different genders, ages, races, sexualities, ethnicities, nationalities, and classes. As Madison (2020) points out, lived realities are shaped by different factors and social dynamics (p. 90). Multi-level analyses of discourses on peers that link individual experiences of ACB people to broader structures and systems are critical for understanding how power relations are shaped and experienced. For example, research on peer navigation found that pairing genders and age helps foster linkage to care (Jaramillo et al., 2022). This study examined the gender power dynamic in peer engagement with ACB communities in Manitoba and its implications for peers and communities.

Intersectional feminism examines the impact of interacting variables such as race, gender, and sexuality on an individual's experiences and behaviours rather than focusing on a single

factor, such as gender (DeFelice & Diller, 2019, p. 6). In another way, Carastathis (2014) referred to intersectional feminism as a way of thinking about the relationship between oppressive systems that shape numerous identities and social positions in power and privilege hierarchies (p. 3).

This study uses feminist standpoint and intersectionality theory to understand better the health disparities within ACB communities, explore opportunities and challenges of peer engagement with communities in the context of HIV testing to understand better how multiple identities and social systems intersect to create compounded and unique experiences of oppression and discrimination for ACB communities (Heard et al., 2020).

The theory of intersectionality examines how race, gender, as well as age, nationality, or sexuality interact in contemporary practice to tackle the complexities of identity, belonging, and language. This study will examine the intersectionality of identities and how interlocking power systems affect peer-to-peer relationships. From an intersectional lens with a feminist standpoint, class, sexuality, age, disability, race, and ethnicity must be understood as intertwined with theoretical conceptualizations of gender to inform the data analysis (Madison, 2020).

As I recently learned, Blackness is intersectional; nationality, education, socioeconomic status, immigration status and even political affiliation intersect to define blackness and the power dynamics in interactions. For example, a lived/living experience of a Black woman who is born in Canada, compared to a Black immigrant woman, will be subjected to different power dynamics. Then, adding other factors like education and employment further differentiates the individual and their relationships in Canadian society, highlighting the heterogeneity of the experiences of Black people on these lands.

The intersectionality of identities and social locations in the context of peer navigation is under-theorized. Creating spaces for expressing diverse experiences and opinions is critical from an intersectionality-informed perspective that recognizes interactions between people's identities and social systems to create distinctive lived experiences (Heard et al., 2020). Power is central to intersectional feminist theory. Regarding social inequality, numerous elements influence each other to shape people's lives and power structures in a given society. (Carastathis, 2014).

Critical Theory

Critical Perspectives on Power

Critical poststructuralism represents a critical and socio-constructivist epistemology, emphasizing the social, cultural, and historical factors influencing knowledge construction. This theory contends that knowledge is not objective or neutral but is constructed through the interaction between the knower and the known, influenced by social, cultural, and historical contexts.

Mullings et al. (2021) assert that power is not inherently oppressive; it can also be a force for social good. Their definition of power comprises the ability to act (power to do things) and the capacity to compel others to act against their will (power over other people). These facets of power can be instruments of change. The power to do things can catalyze change, empowering individuals by enhancing their capabilities. Peer engagement could be regarded as enabling collective action. This study aims to delve into the power dynamics within peer-to-peer relationships, examining whether the power dynamics are oppressive and whether they create divisions or hierarchies within the community.

Peer navigation embodies a form of power, with individuals labelled “peer navigators” typically possessing more information than other community members. This power is fueled by the amount of knowledge they have as they are trained and well-versed in HIV prevention, testing, and treatment, thus strengthening their capacity to act. Mullings et al. (2021) demonstrate that the ‘power to act’ and the ‘power over’ others are not mutually exclusive and can exist concurrently with an individual or group. ‘Power over’ can enhance the power to act. Also, power over others is not necessarily harmful, especially if wielded in the interest of social good.

Mullings et al. (2021) proposed two concepts of power: the mainstream (power as domination) and the second-stream power (power as persuasion). Mainstream power aims to make people act contrary to their preferences, often securing compliance through control and dominance. The second-stream power, a persuasive view, considers power a collective property shared by collaborating partners and rooted in facilitation, communal cooperation, and societal consent. This perspective aligns more closely with the relationship between peers and target communities. As per Mullings et al. (2021), power is intricately linked to access to social resources. Peer navigators typically possess connections to agencies and social resources. Typically, they connect communities and healthcare systems and facilitate access to social resources, thus altering the relational dynamics between peers and communities.

Power/Knowledge

The power dynamics within peer-to-peer relationships can be analyzed through the lens of Foucault's power theory, which encompasses discursive power structures and power-knowledge relationships. According to Foucault (1980), individuals serve as conduits for power, and power is a fundamentally non-subjective phenomenon exercised by both structures and

actors (p. 101). Power relations pertain to situations where one person holds socially formative influence over another, as observed in peer-to-peer relationships (peer navigation), where peers guide community members to adhere to established protocols, whether through coercion or a more subtle means.

Foucault's theory of power suggests that power is omnipresent and inherent in all social interactions (Taylor, 2014). Power manifests in everyday social practices, shaping subjectivities and forms of knowledge. In the context of HIV testing and prevention among ACB communities in Manitoba, peers, in their relationships with one another, can facilitate specific outcomes, such as increased testing service utilization by peers. Knowledge and power are intricately linked; thus, power cannot be exercised without knowledge, and "knowledge inherently engenders power" (Avelino, 2021, p. 16).

Avelino (2021) proposes that power is wielded through the development and dissemination of knowledge, while Barnes' concept of power pertains to the distribution of knowledge. Barnes contends that to possess power, an agent must be recognized as having it (Barnes, 2002, p. 126). In HIV intervention programs, peers are often entrusted with educating and sharing information about HIV treatment, prevention, and testing with target populations. Typically, these peers are well-known community members (Rhodes et al., 2020; Karver et al., 2022; Shahmanesh et al., 2021) with access to the community.

Though peers share similarities with the community, their knowledge (about the issue) and connection to institutions (health facilities and social resources) alters the relational dynamics – creating an imbalanced relationship. Peer navigators navigate the realms of the healthcare system and target communities, serving as a point of reference in their communities

due to their knowledge of both worlds. In this context, peers exercise power that fosters interdependence among community members, rendering them only partially self-sufficient when accessing healthcare resources. This exercise of power does not necessarily entail overt control but instead exerts social influence. Peers are likely to leverage their relationships and positions within the community to influence the choices willingly made by their peers.

This study aims to examine power dynamics within peer navigators and communities and assess their impact, particularly in understanding the power relationship between peers and their communities in the context of HIV testing and prevention among ACB communities in Manitoba. Foucault's theory suggests that power is omnipresent and prevalent in all social interactions (Taylor, 2014); thus, it prominently influences peer-to-peer and peer-to-community relationships. This study delves into the power dynamics in these relationships and the implications for the community's utilization of HIV-related services. Peer navigators assume various roles and ethical stances, ranging from voluntary accompaniment and advocacy to highly directive demands involving inciting, promoting, or persuading behavioural compliance in their community (Cunningham et al., 2018).

Discourses and Ideology on Peer Navigators

The concept of discourse plays a central role in Foucault's theory of power and knowledge. Discourses act as filters through which individuals perceive the world and define what constitutes knowledge. Thus, discourses generate statements of knowledge and shape people's realities and how language is ideologically used in social groups (Statham, 2022). Within discourses concerning peers, common themes highlight how peers share similar backgrounds and demographic characteristics with the target community, making them akin to the target group. This presumed similarity fosters bonding and access to the community. For

instance, according to Pagkas-Bather et al. (2020), matching based on peer navigator characteristics (sexual orientation, race, age, and culture) may be effective in programs that utilize peer navigation to increase HIV PrEP acceptance and adherence among specific communities.

Discourses about peers influence the design of interventions involving peers. Some studies depict peers as advocates, educators, and interventionists who link communities to services and bring resources to them (Blackstock et al., 2021; Karver et al., 2022; Khalpey et al., 2022; Rhodes et al., 2010). Peers internalize their subjectivities and structure their practices as 'peers' through various mechanisms, including their participation in training, the professional discourses they internalize, their observations, and their continuous interaction with communities and health systems. Peers provide expert knowledge to both communities and service providers. Existing discourses also position peers as individuals who accumulate more knowledge about specific issues (e.g., HIV treatment) through their training, experience, and observations. This knowledge and their insight into power dynamics, power relations, and cultural practices within the community supports mobilizing communities and educates providers on the best approach to offering culturally appropriate services that promote community acceptance.

The discourse surrounding peer navigation frames peers as insiders to the community. An insider is someone connected to the group. The "insider" characteristics may include race, ethnicity, sexual and gender identity, and other identity markers contributing to the formation of the 'peer' subjectivity. Connection to communities, institutions, and resources is part of the discourse on peer navigators; as Statham (2022) suggests, power is about having access to social resources; thus, the peer-to-peer or peer-community relationship involves a form of power relation.

Statham's (2022) perspectives on power include power as domination and power as persuasion. Power as domination depicts power relations as unequal and hierarchical, where compliance is secured through control and domination. The persuasive view of power considers power as collective and collaborative with others. In the context of HIV intervention, power relations between peers and communities can be seen as either dominant or persuasive. Thus, several factors influence the power dynamics, such as the roles of peers (e.g., navigation or direct service provision), the social identity of peers (community leader or community member), and other socio-demographic characteristics (race, gender, age).

Post-Structural Theorizing: Governmentality and Peer Navigation

The post-structural perspective acknowledges that discourses on peers can potentially contribute to the formation of peer identities. A post-structural approach is particularly pertinent for understanding how communities internalize discourses on peers. For example, Foucault's governmentality framework can be applied to analyze how discourses around peer navigation impact community psychology by internalizing these discourses into practices and identities. According to Gagnon and Guta (2012), Foucault coined the concept of governmentality to explain how capillary forms of power infiltrate actions, attitudes, and discourses to generate a specific kind of person and population that is docile and easily governed. In this context, governmentality is seen as a form of social control. This study aims to apply the idea of governmentality in HIV testing and prevention among ACB communities and explore its implications.

Governmentality represents various forces, strategies, techniques, and procedures. Numerous connections are made between "the aspirations of authorities and the actions of

individuals and groups" (Gagnon & Guta, 2012, p. 3). Foucault's governmentality framework was used to analyze how discourses around peer navigation impact communities' psychology through their internalization of discourses into practices and identities. Thus, governmentality problematizes how societies produce citizens who conduct their lifestyle according to various forms of knowledge (O'Malley et al., 1997). Foucault sees power and knowledge as interconnected, which is a core component of governmentality, considering the ensemble of institutions, associated knowledge bases, techniques, and practices. According to Guta et al. (2016), community engagement has long been a strategy in the governance of people living with HIV. However, its affective dimensions have been under-theorized. Community governance uses allegiances and specific ties between individuals and communities to regulate, reform, and mobilize. One strength and success of the peer navigator strategy relies on allegiance and connection to the community (Guta et al., 2016, p. 10). This framework is therefore needed to theorize the connection between discourses on peers and how communities internalize those discourses. This approach is instrumental in examining discourses on peers and power dynamics within peer-to-peer relationships, assessing whether peer navigation is inherently oppressive and how it contributes to hierarchy formation or class divisions within communities.

Research Methodology

The study is part of a larger research project (the Ubuntu-Pamoja study) and thus utilizes the research methodology of the Ubuntu-Pamoja study. The study utilized a community-based participatory research (CBPR) approach to ensure the study was culturally appropriate, addressing the needs of ACB communities and ensuring their involvement in all aspects of the research from start to finish. The study included an active Community Guiding Circle (CGC) comprised of ten ACB community members. The CGC met bi-monthly in person and virtually during this research.

The involvement of ACB community members as a community guiding circle (CGC) provided more insight into complex community health problems. It ensured that the research focused on themes relevant to the ACB community. CGC members brought diverse views and experiences to the study as part of the project. This approach incorporates community philosophies, theories, engagement, and practices in the research, a vital aspect of the decolonizing CBPR. Integrating knowledge, experiences, and action for social change to enhance community health and eliminate health disparities (Rhodes et al., 2010; Coughlin, 2016).

The CGC members were involved in all stages of the research process within the Ubuntu-Pamoja Study. They guided the implementation of the study, reviewed and rectified the research approach, ensured it was culturally appropriate, guided the recruitment process, reviewed and validated the interview questions (designed the data collection tool), recruited participants for the study, and disseminated research results. Preliminary findings were shared with CGC members, who participated in member checking for feedback and validation. The study used qualitative research design and methods (interviews) to collect and later analyze textual data to understand the perceptions, experiences, and discourses on peers in the context of HIV testing and prevention among ACB communities in Manitoba.

Research Methods

Recruitment

A sample of thirty-three (n=33) interviews was selected from the Ubuntu-Pamoja study for the analysis in this thesis. The sample was sufficient to generate themes for this research. Semi-structured interviews captured participants' experiences and perspectives on peers' involvement in HIV testing and prevention strategies in Manitoba. Questions also focused on

preferences for different types of HIV testing (whether peers should be involved or not) and preferred qualities of peer navigators. Written consent was obtained from all participants.

Eligibility

Eligibility included identifying as a migrant (including newcomers, immigrants, and refugees) from African or Caribbean countries; participants had to be 18 or older and currently living in Manitoba. All participants engaged in informed consent before participating in the study. All data were kept confidential. Exclusion criteria included: 1) being a non-ACB person, 2) people younger than 18 years, and 3) people living outside Manitoba.

Sample Characteristics

Ethnoracial Identity	
Caribbean	10
African	18
Black	5

Gender	
Women	20
Men	13

Age Group	
8 – 25	5
26 – 33	8
34 – 41	7
42 & above	13

# Years Lived in Manitoba/Canada	
Less than 10 years	16
10 to 20 years	10
21 and Above	7

Sexual Orientation	
Heterosexual	25

Employment Status	
Employed	26
Unemployed	7

Bisexual	3
Gay	1
Lesbian	3
Asexual	1

Data Collection Procedure

Data was collected through semi-structured interviews using an interview guide. Semi-structured interviews were conducted in person and virtually. The interviews were conducted in English through a mix of face-to-face (in-person) and phone or via Zoom—interviews were scheduled at a convenient time for the participants. The interview questions included the acceptability of peer involvement in HIV testing, including the qualities of a peer navigator. The semi-structured interviews allowed for follow-up questions and probes for additional information, which helped better understand the perceptions about the topic, thus enriching the findings. Interviews were recorded, transcribed, and coded using the MAXQDA software (Gill et al., 2022; Razzaq et al., 2021).

Data Analysis

Thematic analysis, guided by the procedures defined by Braun and Clarke (2006), was utilized to develop an understanding of ACB community members' experiences and perspectives of peer navigation. Thematic analysis of the 33 interventions from the Ubuntu-Pamoja study followed a deductive process (using predetermined questions to test the ideology) and an

inductive analysis approach (data review process). This approach helped me to discover patterns, discourses, findings, and interrelationships and highlight the frequent and dominant discourses inherent in raw data that was elevated to distinct themes (Braun & Clarke, 2006)

The first three transcripts were reviewed and used to develop the initial codes. The codes and themes developed were discussed with members of the CGC to reach an agreement on the themes and codes. Once the research team (CGC members and myself) agree on the codes, I proceed with coding and interpreting the transcripts. The developed codes were applied to all the data (transcripts). Transcripts were imported into MAXQDA software for coding and analysis. This helped to organize the data, identify patterns, and understand the themes present in the data.

Preliminary findings were presented to CGC members for feedback. The next level of coding was used to identify more prominent themes across and within data sources. Relevant categories were retrieved to identify common thematic areas and to produce findings that answer the research question. To enhance the trustworthiness of the study's findings, member-checking forum was held with members of the ACB community.

As part of the Ubuntu-Pamoja research team, I was largely involved in the data collection. I conducted 60% of the interviews and the initial transcripts coding using the MAXQDA software. I also did the first-level coding with the agreed-upon codes identified by the research team and the CGC members.

I conducted a secondary qualitative data analysis using previously collected data sets. The data were sourced from qualitative interviews and focus groups that explored the experiences and needs of the ACB community in relation to HIV prevention and testing.

For this process, first, I pulled the peer navigation code from the overall data/ transcript of interviews with participants on MAXQDA. I then reviewed the transcript (data) to familiarize myself with the data. Then, I highlighted words, ideas, or statements that stood out to me or came up repeatedly; then, I selected quotes most representative of viewpoints and patterns relevant to my research questions. I coded them and then categorized the codes to form themes.

Quotes/statement	Code	Theme	Interpretation / Analysis Notes	Question addressed
"Maybe if someone was more informed and could help talk through what steps to take next, if you got certain results, or informed about HIV testing. "If it's their job, I will be comfortable"	Informed /knowledgeable	Professionalism and Knowledge	Peers' identities are framed around their experience and training. They are viewed as professionals who support the community. Expertise is expected and respected.	Q2
"I guess just being charismatic and supportive, or patient and non-judgmental. I	Trained, charismatic and	Desired Qualities in Peer Navigators	Participants expected peers to be charismatic, supportive, and non-judgmental.	Q 2

think that would be really good characteristics for supporting someone through that time"	Supportive		The charismatic attribute could mean someone who should have the persuasive words/power to make community members take certain actions. And someone who commands respect in the community.	
"Would I feel comfortable; I feel like I'd be more inclined to someone I know personally."	Peer as a known community member	Trust, Familiarity, and Relational Dynamics	The perception is that peers should be known to their communities or individuals they support. Power relation in familiarity/ collaborative power. If the peer is known, community members could likely trust the information (teachings) because they know the community and would provide relevant information. Community members will likely be more confident in sharing personal information with them. Known to the community could also imply someone they can relate with and	Q1

			someone with a connection to the community, e.g., similarity in race, ethnicity, religious or communal activity.	
"if I had the preference, I would prefer if they were female, I'd be more, you know, be willing to be open and honest with, if I had any questions, I wouldn't necessarily hesitate to ask"	Prefer female peers	Gender Considerations and Dynamics in Working with Peers	Participants alluded to the gender identity of peer navigators in the HIV/STBBI context to be female. The perception is that females are more approachable and are more inclined to discuss sexual health with females than other genders.	Q3
"I think I would prefer somebody that, I guess, maybe …(someone)… I can relate to in a certain way"	Relatable	Trust, Familiarity, and Relational Dynamics	The discourses around peers include familiarity to the community and more importantly, someone relatable. In terms of relatability (someone I can relate to), what does this mean in the context of HIV/STBBI Peer Navigation?	Q1

			Relatability could mean similarities in Lived experience, same community, immigration status, and cultural and gender affiliations.	
"I think I would prefer somebody that, I guess, maybe …(someone)… I can relate to in a certain way".	Relatable /Approachable	Desire for Peers with Similar Ethnoracial Identity and Socio-Economic Location	The power dynamics in having someone relatable could be shared experience and collaboration compared to someone unrateable, which is likely unreachable and creates a hierarchy. Compliance and peer involvement at the level could be cohesive, which might impact service delivery/update. Even though sharing similarities could foster collaboration, Knowledge may place one peer above the other. Peers could bring resources or link communities to services, thus becoming a point of reference for community members.	Q2
"A person that is well adjusted in the society that may be of our same type of ethnicity,	Black people helping	Similar Ethnoracial Identities /	Participants expected that peers should share similar characteristics with the community regarding Race dynamics and economic status.	Q1 & Q2

I guess, same type of skin colour, Black, like Black people helping Black people. And it would be better if they were like maybe similarly situated, maybe people that are adjusted in the community"	Black people. Similar identity	community connections	Peers are perceived as advocates, able to seek justice for the people. There is also the notion that peers should be well-adjusted in the society. This speaks to Power Dynamics. What does it mean to be well-adjusted? (immigration status/ privileges/ power economic)? The term "well adjusted" could mean that the peer should be in a more economical place, of a higher social or economic status, and more knowledgeable in society. It could also imply immigration status, i.e., an Afro-Canadian citizen versus a new immigrant could have more power or affluence than the newcomer. PN should know more and be more influential. It also speaks to privilege, which shows the power dynamic in the peer-to-peer relationship. The subjectivity of peers is about black people helping black people.	

The following research questions are represented with numbers in the above table.

Q1: What are the perspectives and experiences of ACB community members regarding peer navigation?

Q2: What power dynamics exist between peer navigators and community members seeking HIV services/testing?

Q3: How do discourses of ACB community members frame the social identities of HIV peer navigators?

Ethical Considerations

The University of Manitoba Research Ethics Board approved the larger Ubuntu-Pamoja research and this study. Informed consent was obtained from all participants, in writing and verbally (recorded audio consent), before they participated in the study. Information about the study and consent forms were sent to the participants via email or provided in person. Participants who could not consent by themselves did not participate in the study.

The interview discussions lasted between sixty and ninety minutes, and participants were compensated for their time. Participation was voluntary, and participants were informed of their right to withdraw from the study during the recruitment, consent, and interview stages. All participants were given a copy of the consent form as a reminder of their right to withdraw from the study at any point.

Data Management

Participants' interviews were audio-recorded, and indirectly identifying data (voice data) was collected. The audio data was transcribed, coded, and anonymized. The audio recorder was stored in a secured cabinet with restricted access, and transcribed data was stored on a secure computerized program for coding. This anonymized data will be retained for at least ten years for future research. Documents containing identifying data were securely stored in a locked cabinet with limited access. After data collection and utilization, these documents were securely destroyed using a shredder.

Privacy and Confidentiality

Data collected from participants was kept confidential and indirectly identifiable. The data was stored in a secured cabinet with restricted access, with only the research team having access to it. Participants were assigned numbers (codes) used on transcripts, and all identifiable information was removed from the data. All digital files were deleted, and paper documents were destroyed through confidential shredding.

Compensation for Participation

Participants from the Ubuntu-Pamoja study received a forty-dollar ($40) honorarium for participating in the interviews. This compensation was provided for their time, and the amount was determined not to exert undue influence on participants to take part in the study.

Findings

Overview

The insights gathered from these interviews provide a nuanced understanding of ACB community's expectations and preferences regarding peer navigators. Participants expressed varied opinions about the concept of peer navigators in HIV testing, with a focus on trust, knowledge, and community connection. Overall, the findings suggest a complex interplay of trust, knowledge, professionalism, cultural and gender dynamics, and lived experiences in shaping community preferences for peer navigators in HIV testing in their community. Participants emphasized the importance of having peer navigators who are trained, well-adjusted, share similar ethnic backgrounds, and are effectively integrated into the community. The emphasis on trust, knowledge, cultural sensitivity, gender considerations, lived experience, advocacy, and versatility highlights the complex role that peer navigators are expected to play in supporting individuals in the ACB community with HIV testing and related services. The power dynamics between peer navigators and community members seeking HIV services/testing in the ACB community are also nuanced and complex, involving elements of trust, the influence of peers' expertise, shared identity, and lived experiences. These factors interplay to create a unique dynamic of influence, support, and mutual understanding.

In my analysis of the ACB community's perspective on peer support in HIV services, several key themes emerged, reflecting the community's needs and preferences. These themes, encompassing trust, familiarity, and relational dynamics; professionalism and knowledge as power; desired qualities in peer navigators; desire for peers with similar ethnoracial identity and socio-economic location; gender considerations and dynamics; the importance of lived experience; and diverse and flexible roles, illustrate a multifaceted view of the ideal peer navigator.

Theme One: Participants Highlighted the Importance of Trust, Familiarity, and Relational Dynamics in Peer Navigation

ACB community members expressed a preference for peer navigators who are well-known and trusted within their community. This trust is rooted in the belief that a familiar peer would safeguard personal information and provide relevant and relatable support, considering shared racial, ethnic, religious, or communal backgrounds. This preference underscores the importance of personal connection and familiarity in the context of sensitive health issues. Trust forms the core of the power relationship, with community members preferring familiar and trusted peer navigators. This preference highlights the power of personal connection in sensitive health matters. A quote illustrates this: "I guess because the test is very personal, or I guess I would want someone there, I trust the most." (18-year-old Caribbean woman, ID#29). These dynamics place peer navigators in a position of trust and influence, where their guidance and confidentiality are highly valued.

The discourses of ACB community members frame the social identities of HIV peer navigators predominantly around the themes of trust, familiarity, and relational dynamics. The community's preference for well-known and trusted peer navigators who share similar racial, ethnic, religious, or communal backgrounds emphasizes the social identity of navigators as integral members of the community. This preference is rooted in the belief that such peer navigators can offer more relevant and relatable support while safeguarding personal information. The importance placed on personal connection and familiarity in the context of sensitive health issues like HIV testing situates peer navigators in a unique position of trust and influence within their community. Another participant, emphasizing the importance of community connection, commented, “I think

… it is a community consultation if the community themselves nominate them, it would be ... that's a good one at the beginning because that means there is trust. Being nominated or chosen by the community themselves, that's what gives part of our ownership and involvement in the project" (African man, ID#011).

Community members expect their peers to be nominated through a thorough consultation process. The connection and relationship of these peers with their community are essential for navigating peer involvement in ACB communities. This involvement is linked to trustworthiness and safety, as being nominated by the community itself is a significant factor. The community's active participation in engaging peers fosters a sense of ownership over collective actions aimed at combating the spread of HIV/STBBIs within the community. It empowers the community, allowing them to control their processes and address the power imbalances that lead to health and social inequalities in ACB communities. The dynamics of this power relationship can range from participation to collaboration. Moreover, this approach promotes trust-building relationships and structures that empower the community in decision-making processes. One participant emphasized that while it is crucial for the community to nominate peers, selecting individuals who have a strong relationship within the community is of utmost importance. A way to gauge this is by considering their previous involvement and relationship with the community: "I think one of the qualities should be prior involvement with the community" (33-year-old African woman, ID#007).

In discussing preferences for peer involvement in African, Caribbean, and Black (ACB) communities, one participant proposed that peers remain anonymous to the community. This perspective on anonymity was linked to issues of power and privilege. The argument was that peers involved in HIV services might gain privileged access to health information, which could affect the dynamics within the community. Furthermore, concerns about privacy and

confidentiality are particularly significant in ACB communities, where healthcare access is often impacted by HIV-related stigma and discrimination. The suggestion for anonymity may stem from the potential risk of indirect disclosure, which could occur through shared lived or living experiences. When queried about the preferred characteristics of a person who would approach and support them in taking an HIV test, one participant responded: "An anonymous person and a person that's maybe specifically who's trained as a psychologist or a social worker" (50-years-old African Man, ID#023).

A breach of confidentiality can disempower community members and increase their vulnerability by stripping away their autonomy. This is particularly relevant in the peer-to-peer relationship within communities, where there's potential for one party to access the other's personal information. During the process of peer navigation, the exchange of personal information is common. There's a risk that information pertaining to the community could be shared with external entities, such as the healthcare system. Such practices could undermine the community's trust and sense of solidarity. Furthermore, they could negatively impact the power dynamics between peers and the community, altering the balance of trust and authority that is crucial for effective and respectful interactions.

Theme Two: Respondents Discussed How Professionalism and Knowledge Shape Power Dynamics in Peer Relationships

The need for peer navigators to be knowledgeable about HIV and able to provide guidance was a recurring theme. Participants valued the professionalism and expertise of peer navigators. Many participants highlighted wanting "someone who is knowledgeable" (Caribbean woman, ID#013).

The power dynamic is further influenced by the professionalism and knowledge of peer navigators. This professionalism is crucial for community members to feel comfortable engaging with peer navigators, especially regarding sensitive health topics like HIV testing and support. For example: “Need for peer navigators who are professionally trained as psychologists or social workers” (50-years-old African Man, ID#023). The discourses of ACB community members distinctly frame the social identities of HIV peer navigators as knowledgeable professionals. This framing underscores the importance of expertise and professionalism in their role. Community members value navigators who are not only well-informed about HIV but also capable of providing crucial guidance, positioning them as authoritative figures in the community. This professional identity is seen as essential for ensuring comfortable engagement with community members, especially in the context of sensitive health topics like HIV testing and support. The emphasis on professional training and comprehensive understanding of health-related issues further solidifies their identity as experts beyond just being community members.

Participants perceived peer navigators not just as community members but also as experts in their field, particularly in HIV/STBBI knowledge. Community members value navigators who are well-informed and able to guide them, especially on complex issues like HIV. This expertise positions peer navigators as authoritative figures in the community whose advice and support are crucial: “Maybe if someone was more informed and could help talk through what steps to take next..." (18-year-old Caribbean woman, ID#29). A comprehensive understanding of health-related issues and resourcefulness was seen as vital. Participants expected peer navigators to be well-informed and able to provide or direct to necessary resources: "Well, someone who is super friendly but also knows a lot about other resources in the community. Somebody who is, well, knowledgeable" (Caribbean woman, ID#013).

Education and training are also crucial elements in peer navigation, as highlighted by community members. The necessity for education and training arises from the desire to interact with someone who is well-informed about HIV/STBBIs and possesses comprehensive information on the subject. This aligns with the African, Caribbean, and Black (ACB) community's interest in being educated about these health issues. The lack of awareness about HIV within the ACB community in Manitoba has been identified as a significant barrier to accessing HIV-related services. There is a frequent call for peer navigators to be knowledgeable individuals. One community member, a 26-year-old Caribbean man, underscored the importance of this aspect, especially for immigrants adapting to a new environment: “We are mostly immigrants, so this is a new city, new country, new everything for us, and we don't necessarily know how to navigate the system and to get information. We don't know who we can necessarily trust. So, having somebody out there who is knowledgeable and looks like us, because representation matters, then it would give a level of confidence and comfort in sharing information and asking questions.” (ID#009).

Members of the ACB community recognize the significance of representation within the Health System. Having ACB members serve as peers enhances confidence in the system and fosters trust. It becomes easier for community members to communicate with someone they view as an equal. There is a strong call for such representation, particularly due to the unfamiliarity many new immigrants have with the health system and the complex structural bureaucracy they encounter. This perspective stems from the understanding that many ACB immigrants are newcomers to the country and lack experience in navigating various systems. In this context, the relationship with peer navigators might be somewhat hierarchical, with the peer taking a leading role and community members following their guidance. Decision-making in these scenarios can be both cohesive in terms of working together and influential in terms of the peer's impact on the

community member's choices. However, the dynamic may differ for Canadian-born ACB members. In these cases, the power dynamics in peer relationships are likely to be more collaborative and motivational. This distinction highlights the varying needs and experiences within the ACB community, emphasizing the importance of adaptable and culturally sensitive approaches in peer navigation and healthcare provision.

Theme three: Participants Identified Desired Qualities in Peer Navigators

Key attributes expected from peer navigators include charisma, supportiveness, patience, and non-judgmental attitudes. Furthermore, participants emphasized the importance of peer navigators being knowledgeable about HIV, able to provide guidance, and possessing qualities like compassion and effective communication skills. Desired qualities also included being charismatic, supportive, patient, non-judgmental, and possessing effective communication skills: "I guess just being charismatic and supportive, or patient and non-judgmental. I think that would be really good characteristics for supporting someone through that time." (18-year-old Caribbean woman, ID#29).

The power dynamics between peer navigators and community members seeking HIV services/testing are significantly shaped by the characteristics and capabilities of the peer navigators. The key attributes that community members expect from peer navigators—charisma, supportiveness, patience, non-judgmental attitudes, knowledge about HIV, guidance abilities, compassion, and effective communication skills—place peer navigators in a position of empathetic authority. These qualities enable them to offer support in a manner that is both authoritative and compassionate, creating a dynamic where they are seen as both guides and allies. This combination of expert knowledge and empathetic communication fosters a balanced power dynamic, where

peer navigators are respected for their expertise while being approachable and relatable. One participant said, “I think if someone has an approachable face…. and has the right education for it; I think that is the only two things that’s important” (42-year-old, African man, ID#005).

In the context of HIV, community members emphasize the importance of approachability and relatability in peer navigators. This suggests that members of the ACB communities prefer working with someone with whom they can relate. This relatability might involve shared aspects such as lived experiences, ethnicity, social class, gender, or sexual orientation. Consequently, matching peer navigators with community members based on characteristics like sexual orientation, race, age, and culture could be an effective strategy in HIV peer navigation for the ACB population.

What can be seen is that the discourses of ACB community members frame the social identities of HIV peer navigators in a multifaceted way, highlighting a blend of personal attributes and professional skills. The desired qualities in peer navigators, such as charisma, supportiveness, patience, non-judgmental attitudes, knowledge about HIV, guidance abilities, compassion, and effective communication skills, construct an identity that transcends conventional professional roles. These expectations reflect a perception of peer navigators as not just service providers but as empathetic, approachable, and capable individuals. This multifaceted identity suggests that peer navigators are considered integral to the community's health and well-being, combining personal qualities with professional expertise to support those seeking HIV services and testing: “I would like them to be compassionate and patient and composed” (38-year-old, Black woman, ID#026).

In addition, the expectations for peers include the ability to provide emotional and mental health support while being empathetic, confidential, and responsive to community needs. “I think somebody with a great deal of empathy, somebody that shows genuine concern, somebody that

I'm sure will keep things confidential, will not discuss your health issue with any other person" (23-year-old African woman, ID#003).

Person-centeredness was another quality when talking about preference for peer navigators: "I would say they would have to have the value of person-centeredness—recognizing that they are supporting an individual to make a choice. So, recognizing that person-centeredness is about recognizing where persons are and allowing them to make their own choices at their own pace" (Caribbean woman, ID#012).

Theme Four: Respondents Expressed Preference for Peers Sharing Similar Ethnoracial Identities and Socio-Economic Backgrounds

Participants favoured peer navigators who share similar racial and economic backgrounds. These shared characteristics were seen as empowering and enabling a more effective and empathetic peer support system. The following quote exemplifies how some participants expressed a preference for peer navigators who share similar cultural and ethnic backgrounds, reflecting the importance of relatable experiences and understanding in healthcare navigation: "A person that is well adjusted in the society that may be of our same type of ethnicity, I guess, same type of skin colour, Black, like Black people helping Black people" (49-year-old, Black Man, ID#030).

The desire for peer navigators with similar ethnoracial identity and socio-economic backgrounds reveals a power dynamic that values shared experiences and cultural understanding. "As a Black woman myself, there are a lot of common shared experiences, and they can have a perspective that maybe you won't get from somebody who doesn't share the same cultural background as you" (38-year-old Black woman, ID#026).

The discourses of ACB community members frame the social identity of peer navigators as not just service providers but as individuals who embody the shared experiences and cultural understanding of their community. Such a framing suggests that community members see peer navigators as relatable and empathetic figures, capable of providing more effective and meaningful support due to their common backgrounds and experiences. This viewpoint underlines the significance of cultural and socio-economic alignment in establishing trust and effectiveness in peer navigation for HIV services.

The emphasis on having peer navigators who share ethnicity with community members is a crucial aspect of HIV services for the ACB community. Peers with similar ethnic backgrounds have the unique ability to translate information into the community's language and adapt it to meet their specific needs in a culturally sensitive manner. This approach goes beyond mere linguistic translation; it involves a deep understanding of cultural nuances, beliefs, and practices that are integral to effective communication and support. Such tailored support is not limited to language and ethnicity alone. It also includes aligning peers with community members based on other characteristics such as age, gender, and beliefs. This matching process ensures that the support provided is relevant, respectful, and responsive to the diverse needs within the community. By incorporating these elements, peer navigators can establish a stronger connection, foster greater trust, and provide more effective assistance, as they are seen not only as service providers but as individuals who genuinely understand and respect the community's cultural context and lived experiences.

The ACB community values the concept of peer support in HIV services. Their perspective on peers includes the importance of having a knowledgeable individual from within the ACB community, someone with whom they share an identity. This shared identity, or similarity, is seen

as crucial. A 46-year-old Black woman (ID#024) expressed this need: “Somebody who is just knowledgeable, who knows what my next steps are, things that I need to do, how to navigate the healthcare system because it is notoriously difficult here, and really just somebody who will be able to answer questions about how they are navigating this new development.”

Age is also considered a significant factor in being a peer. The community perceives that younger people, particularly those aged 20-30, require more support. This is based on observing a growing number of young people within the ACB community. An African male (ID#011) noted, “the number of people within that age range 20 to 30, is high. The numbers are high between this age. So, that means more connections, more communications, using the same language, and I mean, to that age, and more people to be reached out.” Similarly, a Caribbean woman (ID#013) added, “I can see peer support coming in to help someone with this issue, answer many questions, and be there to do the test, and before you know it, they’ve already supported them in other ways, too. But it would especially be for people who maybe are young.” These insights highlight the community's desire for peer navigators who not only understand the healthcare system but also resonate with the specific age group's needs and experiences.

Theme Five: Participants Highlighted Gender Considerations and Dynamics in Working with Peers

Gender considerations also affect power dynamics, with a preference for female peer navigators in certain contexts: "I would prefer somebody that, I guess, maybe I can relate to in a certain way. Like, if I had the preference, I would prefer if they were female " (27-year-old, Caribbean woman, ID#028). Indeed, gender identity emerged as a significant factor in the community's preference for peer navigators. Female peer navigators, in particular, were seen as

more approachable for discussions on sexual health, reflecting societal stereotypes and gender roles.

Many participants explained that they preferred female peer navigators due to perceived differences in approach and understanding of sexual health issues: "I just feel like the experiences might be different when males are, you know, concerned about their sexual health, rather than females." (27-year-old, Caribbean woman, ID#028). This indicates a nuanced power interplay were gender and cultural identity influence comfort and openness in discussions. Another participant stated, “Personally, I just feel all right; when it comes to health, I prefer an opposite sex talking to me” (30-year-old African man, ID#002). Another participant also indicated a preference for a woman of colour. “I would prefer a female. I would prefer someone of colour, someone very knowledgeable about what they’re doing” (45-year-old Caribbean woman, ID#014).

The preference for female peer navigators in certain contexts, particularly for discussions on sexual health, frames their social identity in a way that recognizes and responds to societal stereotypes and gender roles. This preference indicates a nuanced understanding within the community that gender identity can impact the comfort and openness in sensitive health discussions. Female peer navigators are perceived as more approachable and possibly having a different, perhaps more empathetic, approach to sexual health issues, reflecting a broader social context were gender discourse and gender norms shape health communication and support dynamics.

Theme Six: Respondents Suggested Lived/Living Experience as a Crucial Factor in Peer Interactions

The value of lived experience, particularly relating to HIV, was highlighted: “Emphasis on the value of navigators who have personal experience with HIV for emotional processing” (41-year-old Black woman, ID#025). Participants believed that peer navigators with personal experience in dealing with HIV could offer empathetic and emotionally supportive counseling. Lived experience with HIV/STBBI was viewed as vital for peer navigators, fostering empathy and understanding.

Lived experience, particularly relating to HIV, alters the power dynamics by fostering empathy and mutual understanding. Peer navigators with personal experience are perceived as more empathetic, creating a less hierarchical and more supportive relationship: "It doesn’t matter what member of the community. I would think that if it was a member, somebody who had HIV, that’s helpful so you can process emotions." (41-year-old, Black woman, ID#025).

This perspective positions peer navigators not just as service providers but as empathetic allies who can relate deeply to the emotional and psychological aspects of living with HIV. Their lived experience is viewed as a vital asset that enriches their ability to provide emotionally supportive counselling, thereby reshaping the traditional patient-provider dynamic into a more relatable and supportive relationship: “When I see the term peer, I'm thinking, okay, somebody with a lived experience “(Caribbean woman, ID#012).

Theme Seven: Participants described Diverse and Flexible Roles for Peer Navigators

The role of peer navigators as advocates and their involvement in the community was emphasized. Participants saw peer navigators as essential in navigating the healthcare system and

different contexts systems, research, and emotional support: “supporting people to navigate systems..." (29-year-old African Male, ID#015). Another participant commented: " I think peer navigators … it’s kind of a vessel between the research team and the community, and it’s also their role to support." (33-year-old African woman, ID#007).

Participants also valued community engagement and leadership experience in peer navigators, seeing these as indicators of reliability and effectiveness in providing support and navigation within the health system: “Importance of peer navigators having prior involvement with the community, especially in health-related issues” (33-year-old African woman, ID#007).

The participants also recognized the diverse roles that peer navigators can play: "I see myself in the counselling part and the interpretation, but with the flexibility of being assigned whatever just because I see in myself, I can do any of the roles" (33-year-old African woman, ID#007). Similarly, others spoke of roles ranging from counselling to interpretation, indicating a preference for peer navigators who are versatile and can adapt to different needs: "I see myself in the counselling part and the interpretation, but with the flexibility of being assigned whatever just because I see in myself I can do any of the roles." (33-year-old African woman, ID#007).

The power dynamics between peer navigators and community members seeking HIV services/testing are influenced by the diverse roles and flexibility of peer navigators. As community members, advocates, researchers, and support workers, peer navigators hold a multifaceted position of influence and support. Their involvement in various aspects of healthcare and research, combined with their ability to adapt to different needs and contexts, creates a dynamic where they are seen as both relatable peers and authoritative figures. This duality enhances their ability to effectively support and guide community members through the

complexities of HIV testing and services while also maintaining a sense of shared understanding and community engagement.

The discourses of ACB community members frame the social identities of HIV peer navigators as multifaceted and dynamic, emphasizing their roles as community members, advocates, researchers, and support workers. This diverse role allocation portrays peer navigators as essential in various aspects of healthcare navigation and community involvement. They are seen as crucial links between the research team and the community, highlighting their role in supporting both knowledge dissemination and emotional support. The emphasis on community engagement and leadership experience in peer navigators underscores their perceived reliability and effectiveness. Moreover, the flexibility in roles, ranging from counselling to interpretation, showcases the adaptive nature of peer navigators, catering to the diverse needs within the community.

Discussion

Summary of Research Findings

ACB community's perspective on peer support in HIV services reveals a complex interplay of trust, knowledge, professionalism, cultural and gender dynamics, and lived experiences. These factors shape the community's preferences for peer navigators in HIV testing and related services. The findings highlight the importance of having well-trained, culturally aligned peer navigators who are integrated into the community, emphasizing personal connection, familiarity, and trust.

Firstly, the themes of trust, familiarity, and relational dynamics were significant. ACB community members preferred peer navigators who are well-known and trusted, emphasizing the

importance of personal connections and shared backgrounds in sensitive health matters. This trust positioned peer navigators in a role of influence, where their guidance and confidentiality are highly valued. The community's active involvement in nominating peers underscored a sense of ownership and empowerment, crucial for addressing health and social inequalities.

Professionalism and knowledge were also paramount. Participants valued peer navigators who were not only well-informed about HIV but also possessed the professional skills necessary for providing guidance and support. This professionalism helped community members feel comfortable and supported the establishment of authoritative yet approachable relationships. The role of peer navigators as knowledgeable professionals highlighted the importance of expertise in their identity within the community.

The desired qualities in peer navigators were multifaceted, ranging from charisma and patience to compassion and effective communication skills. These attributes construct an identity that transcends conventional professional roles, portraying peer navigators as empathetic, approachable, and capable individual's integral to the community's well-being. This blend of personal attributes and professional skills emphasized the role of peer navigators as more than just service providers but as crucial supporters in the community's health journey.

Furthermore, the desire for peers with similar ethnic-racial identities and socioeconomic locations underlined the power dynamics that value shared experiences and cultural understanding. This preference for culturally and ethnically aligned peer navigators reflected the community's need for relatable, empathetic figures who can provide effective and meaningful support.

Lastly, peer navigators' diverse and flexible roles, ranging from community members to advocates and researchers, highlighted their multifaceted position of influence and support. Their ability to adapt to different needs and contexts, combined with their involvement in various aspects

of healthcare and research, enhanced their effectiveness in supporting and guiding community members.

Reflexivity

According to Guillemin and Gillam (2004), reflexivity is a professional approach wherein researchers reflect on their research practices and the generation of knowledge. Reflexivity in research often entails critically reflecting on one's role in constructing and producing social knowledge. Guillemin and Gillam (2004) further argue that incorporating reflexivity is crucial in conducting ethical research with marginalized communities.

I view myself as an insider researcher while recognizing that my knowledge does not encompass all identities within the ACB population. I am aware of how my insider status may have shaped—and continues to shape—this research. This position has allowed me to build trust and confidence with participants, although I remain conscious of how ethnicity, gender, and immigration status may have influenced their experiences.

My background as an immigrant African woman from Nigeria, living in Manitoba, Canada, for the past six years, and my over fifteen years of experience in the HIV field inform my approach to this study. Starting my journey in Nigeria, working particularly with young women and mothers living with HIV, I have served in various capacities including educator, facilitator, peer navigator, community mobilization/outreach worker, and adherence counselor.

In Manitoba, my role as a settlement worker with ACB communities, in both community and healthcare settings, and my ongoing support for HIV and health research at the University of

Manitoba and Nine Circles Community Health Center, have shaped my understanding of this thesis research.

Approaching this inquiry from a position of lived experience, my work across Nigeria's diverse regions and with varied groups, as well as my interactions with immigrant and ACB populations in Manitoba, have been instrumental. While I recognized the benefits of addressing each group's unique needs, the issue of power dynamics among and within groups was not my initial focus. However, interpreting empirical data and representing the experiences of ACB communities in research underscored for me how knowledge can become a source of power.

I advocate for empowerment and collaboration, believing that participatory community-based research empowers ACB communities. As a member of the ACB community, engaging in decision-making processes and advocating for health (including HIV) issues within Black communities is paramount. My role as a social worker motivated me to explore the resilience and strengths of ACB populations, especially during the data collection and analysis phases of the larger Ubuntu-Pamoja project. I have been mindful of my social location and its potential influence on the interview process and data interpretation.

Given my extensive experience in the HIV field, researching topics that reflect my community has been a priority. The overrepresentation of the ACB population in Canada's epidemiological data necessitated an exploration of what this means for my community. A significant barrier identified was the lack of awareness about HIV within the ACB community in Manitoba. Another focus was on strategies for engaging communities in discussions around HIV, with peer navigation being a key strategy.

Peer navigation has become a prominent strategy in HIV services, often adopted by agencies and programs to reach those living with or affected by HIV. My observation is that agencies usually select peer navigators without community consultation. This study highlights ACB community members' preference for peer navigators chosen by their community, emphasizing ownership and collaboration. This approach shifts the relational dynamics in peer engagement, challenging structural barriers and encouraging community participation.

Connecting Findings to Literature

While there are limited studies that have specifically explored the concept of peer navigation in the context of HIV/STBBI with ACB communities in Manitoba / Canada, the findings from my thesis can be compared to existing literature.

The discourses of members of the ACB community evoke the social identities of HIV peer navigators primarily through themes of trust, familiarity, and relational dynamics. This community's preference for peer navigators who are well-known, trusted, and share similar racial, ethnic, religious, or communal backgrounds underscores the navigators' role as integral members of the community. These findings align with research by Rhodes et al. (2020), which characterizes peer navigators as individuals deeply connected to the community and recognized by its members, thereby positioning them as significant insiders. This emphasizes the importance of personal connections in addressing sensitive health matters.

Community members advocate for peer navigator nominations through a comprehensive consultation process, underlining the importance of the nominees' connection and relationship with the community in facilitating their involvement. This process is pivotal for ensuring trustworthiness and safety, with community nominations playing a crucial role. Although Rhodes

et al. (2020) stress the significance of including community leaders as peer navigators, ACB community members prioritize a more inclusive consultation process over mere leadership involvement. Despite the traditional respect for leadership within African communities, there is a call for leaders to engage with various community structures to gain broader support. Rhodes et al. (2020) suggest that the involvement of community leaders as peer navigators could enhance community acceptance and participation, given the positive traditional response to leader-endorsed initiatives or those involving leaders directly. This reflects the complex interplay of power and cultural dynamics in defining peer roles and engagement within ACB communities. The active participation of the community in nominating peers fosters a sense of ownership and empowerment, which is essential for addressing health and social inequalities.

Participants expressed a preference for peer navigators sharing similar racial and economic backgrounds, viewing these commonalities as empowering and enabling a more effective and empathetic peer support system. This preference is supported by Shah et al. (2019), who emphasize the significance of shared social identity among peers and community members. Shangani et al. (2017) further affirm that peer navigators, being community members themselves, can significantly influence behavior modification and service uptake.

The study revealed a preference for versatile peer navigators capable of adapting to various needs, from interpretation and counseling to direct service provision, such as testing. The diverse roles and flexibility of peer navigators, who serve as community members, advocates, researchers, and support workers, establish a multifaceted position of influence and support. Their involvement in various healthcare and research aspects, coupled with their adaptability, positions them as both relatable peers and authoritative figures, enhancing their support and guidance through the

complexities of HIV testing and services while maintaining community engagement, as echoed by Cunningham et al. (2018).

Education and training emerged as critical elements in peer navigation, with community members valuing interactions with knowledgeable individuals about HIV/STBBIs. This aligns with Jaramillo et al. (2022), who recommend comprehensive training for peer navigators. Such expertise grants peer navigators authority within the community.

The importance of lived experience, particularly regarding HIV, was emphasized, with participants valuing peer navigators who could offer empathetic and emotionally supportive counseling based on personal experiences. This perspective, supported by Khalpey et al. (2022), highlights peer navigators as trustworthy and reliable sources of emotional support, reshaping the traditional patient-provider dynamic into a more relatable and supportive relationship.

Furthermore, the study identified desired qualities in peer navigators, such as charisma, supportiveness, patience, non-judgmental attitudes, knowledge about HIV, guidance abilities, compassion, and effective communication skills. These qualities underscore a perception of peer navigators as empathetic, approachable, and competent individuals, fostering a balanced dynamic where they are respected for their expertise while remaining relatable.

Gender identity also played a significant role in the community's preference for peer navigators, particularly favouring females for discussions on sexual health. This preference acknowledges societal stereotypes and gender roles, influencing health communication and support dynamics. Research by Jaramillo et al. (2022) on peer navigation supports the effectiveness of pairing genders and ages to improve care linkage.

ACB community members preferred peer navigators nominated through a consultative process with their community. The connection and relationship of peers with their community were

essential for navigating peer involvement in ACB communities. The ideal or community connection and nomination align with Mullings et al. (2021) concepts of power as persuasion. The view considers power a collective property shared by collaborating partners and rooted in facilitation, communal cooperation, and societal consent. This perspective aligns more closely with the relationship ACB community member expects from peer Navigators.

The emotional dynamics and shared personal characteristics that peer navigators share with their community influence service uptake (Oliveira et al., 2023). The concept of care permeates peers' involvement in care strategy for HIV prevention and treatment. The sense of community and caring for others aligns with the African philosophy of Ubuntu, which emphasizes communal values, human dignity, sharing, collaboration, and respect (Chigangaidze, 2021).

Connection to communities, institutions, and resources is part of the discourse on peer navigators. This discourse aligns with Statham's (2022) perception of power as having access to social resources, which could be considered persuasive or domination. Power as domination depicts power relations as unequal and hierarchical, where compliance is secured through control and domination. The persuasive view of power considers power as collective and collaborative with others. The peers' relationship with ACB community involves a form of power relation. The relational dynamic is influenced by several factors, such as prior involvement with the community (connection), shared characteristics. This preference for peer navigators with personal connection in sensitive health matters. place peer navigators in a position of socially formative influence over community members seeking HIV services. According to Mullings et al. (2021), power over others is not necessarily harmful, especially if wielded in the interest of social good.

Addressing the Study's Research Question

My research questions have been addressed through participants' responses in semi-structured interviews, focusing on the perspectives and experiences of ACB community members regarding peer navigation, the existing power dynamics between peer navigators and community members seeking HIV services/testing, and how ACB community members' discourses frame the social identities of HIV peer navigators.

Regarding the perspectives and experiences of ACB community members on peer navigation, participants indicated a preference for peer navigators who share similar racial, ethnic, religious, or communal backgrounds. They expect peer navigators to be well-known and trusted and to have a personal connection with their community, advocating for their selection through a comprehensive consultation process. This emphasizes the importance of the connection and relationship between peers and their community for effective participation and engagement, as Rhodes et al. (2020) suggested.

Participants view peer navigators as experts, preferring those who are knowledgeable and professionally trained, particularly as psychologists or social workers. According to Khalpey et al. (2022), the emergence of peer navigation addressed the psychosocial needs of people living with HIV. Koester et al. (2014) described the role of peer navigators as a "bridge to the healthcare system," given their social connection with the community, training, and resource hub. This stems from a desire to engage with someone who offers comprehensive information, crucial guidance, and resource linkage. Expectations include providing emotional and mental health support while being empathetic, confidential, and responsive to community needs. Desired traits in peer navigators include charisma, supportiveness, patience, non-judgmental, compassion,

person-centeredness, and effective communication skills, underscoring the need for approachability and relatability.

Lived experience with HIV/STBBI is considered crucial for peer navigators, fostering empathy and understanding (Shah et al., 2019). This perspective views peers with lived experience as more empathetic, less hierarchical, and more supportive. However, some participants believe peer navigators should remain anonymous to mitigate stigma around HIV and address issues of power and privilege. Personal information exchange may occur during peer navigation, potentially damaging the community's sense of trust and solidarity and affecting the power relationship between peers and their community. (Michaud, Meulen, and Guta, 2023).

In exploring the power dynamics between peer navigators and community members seeking HIV services/testing, the analysis reveals nuanced and complex dynamics involving trust, peer expertise, shared identity, and lived experiences. The characteristics and capabilities of peer navigators significantly shape these dynamics, with a preference for peers sharing similar ethnic identities and socio-economic backgrounds indicating a power dynamic that values shared experiences and cultural understanding.

Professionalism and knowledge of peer navigators also influence this dynamic, where expert knowledge and empathetic communication foster a balanced power relationship, making peers respected for their expertise while remaining approachable and relatable. The relationship between community members and peer navigators can be somewhat hierarchical but also cohesive and influential, varying among Canadian-born ACB members towards a more collaborative and motivational dynamic. This aligns with Mullings et al. (2021) view of power as a collective property shared by collaborating parties.

Gender considerations play a role in these dynamics, with a study showing a preference for female peer navigators in specific contexts due to perceived differences in approach and understanding of sexual health issues. This indicates a nuanced interplay were gender and cultural identity influence comfort and openness in discussions. Rhodes et al., 2020 suggest appropriately matching age, gender, beliefs, and other community characteristics to address relational dynamics. The ACB population in Manitoba is diverse, with multiple and overlapping identities shaping their experiences. These identities intersect uniquely and may have significant implications for health and well-being (Madison, 2020; Heard et al., 2020).

Furthermore, lived experience, particularly relating to HIV, alters power dynamics, with peers' lived experiences fostering empathy and mutual understanding, thus creating less hierarchical and more supportive relationships. Peer navigators' diverse roles and flexibility as community members, advocates, researchers, and support workers influence the power dynamics, positioning them as relatable peers and authoritative figures.

Lastly, the discourses of ACB community members frame the social identities of HIV peer navigators around themes of trust, familiarity, and relational dynamics, emphasizing the importance of a familiar peer who can safeguard personal information and provide relevant support. This framing constructs an identity for peer navigators that blends personal attributes and professional skills, highlighting the significance of cultural and socio-economic alignment in establishing trust and effectiveness in peer navigation for HIV services (Rhodes et al., 2020; Khalpey et al., 2022).

Connecting Findings to Theories

Afrocentric Social Work Theory

I have chosen to investigate the experiences of ACB communities with peer navigators from their own perspectives. Being African myself, it was crucial to conduct research that reflects the cultural background, unique identity, and experiences of the community. The Afrocentric framework offers deeper insights and clarity, enhancing understanding of participants' perspectives or responses. It facilitated comprehension of the participants' language and the multifaceted and intersecting factors influencing their experiences. For instance, discussions on age matching revealed a preference for younger individuals to receive peer support, in contrast to older adults who are traditionally associated with wisdom. Peer support, reflective of the age-grade system, is an integral part of Black and African traditional practices, particularly in advisory, participatory, and community mobilization roles. It serves as a mechanism for information sharing and education promotion, with participants highlighting the significance of age in peer navigation.

The study applies an Afrocentric paradigm to deconstruct colonial power relationships in the peer navigation domain by integrating ACB cultural identity and perspectives into the research and aligning the research's objectives with the discourses emerging from the study. Adopting an Afrocentric perspective, the research is centered on the ACB community's experiences and interprets data from their viewpoint. This perspective leverages African philosophical concepts—such as collaboration, collectivity, and a deep connection to community and culture—to interpret social and psychological phenomena, crafting an approach relevant to both personal and community healing and societal shifts (Mullings et al., 2021).

The aim of employing this paradigm is to introduce an Afrocentric viewpoint in creating knowledge about peer engagement within communities and to incorporate the cultural identities of the ACB population into social work practice. Utilizing this paradigm actively involves ACB communities in the generation of knowledge that mirrors their cultural and social contexts. I opted for the Afrocentric perspective in my research because it resonates with and recognizes the ACB population, facilitating an understanding of the concept of peer navigation from their standpoint. The Afrocentric view posits that a culturally sensitive and contextually appropriate structural approach is necessary to meet the unique needs of ACB populations. As the study's participants demonstrated, a sense of community is consistent with the African philosophy of Ubuntu, which underscores communal values, sharing, collaboration, social cohesion, and representation.

Dominant health intervention strategies often exacerbate disparities by concentrating on services for privileged demographic groups, as noted by Heard et al. (2020). Systemic barriers, social exclusion, stigma, and isolation resulting from anti-black racism exacerbate inequities within the ACB population in Canada (Mullings et al., 2021). Peer navigation has proven effective in overcoming healthcare obstacles and addressing stigma and racism within healthcare systems. Oliveira et al. (2023) advocate for a culturally sensitive and context-specific structural approach. An Afrocentric framework embodies such an approach, being culturally attuned and tailored to the community's specific needs.

Intersectional-Feminist Theory

In my research, I integrate intersectional feminist theory (as outlined by Crenshaw in 1989 and further developed by Ciurria in 2019) into the study of peer navigation within ACB communities, specifically focusing on HIV testing in Manitoba. This theoretical framework is employed to dissect the gender power dynamics inherent in peer engagement in HIV programs

targeting ACB communities. It aids in uncovering how a confluence of intersecting factors — such as ethnicity, gender, sexuality, socioeconomic status, and immigration status — can significantly affect participants' experiences and their perceptions of peer navigators in the realm of HIV services. Utilizing this theory has illuminated the complex interplay between patriarchy, sexism, cultural norms, societal stereotypes, and HIV-related stigma, all of which converge to influence community members' views on peer navigators.

Intersectional feminist theory offers a lens through which to understand the interrelations between various systems of oppression that simultaneously construct our multiple identities and determine our positions within hierarchies of power and privilege. It elucidates how power relations are established, categorized, and materially entrenched in our societal fabric. For example, the theory assists in recognizing how the intersections of gender, age, education, immigration status, lived experiences, historical contexts, and HIV stigma shape the experiences and viewpoints of ACB community members regarding peer navigators.

This analysis of discourses surrounding peer roles links individual experiences of community members to larger structural and systemic frameworks, such as gender norms and societal expectations. It is instrumental in unpacking how power dynamics are both formed and felt. The application of Intersectional feminist theory proved invaluable in exploring the nuanced interplay of identities and the interconnected systems of power impacting peer relationships within Manitoba’s ACB communities.

The study underscores the multifaceted roles and experiences of peer navigators within the community, alongside the implications of these roles. Drawing on Madison (2020), it is highlighted that feminist theory primarily concerns itself with the disparities in power between genders and how these imbalances affect individuals' lives, both publicly and privately.

Many study participants expressed a preference for female peer navigators, attributing this choice to perceived differences in approach and a deeper understanding of sexual health issues. This preference signifies a subtle yet profound dynamic where gender and cultural identities play crucial roles in fostering a sense of comfort and openness in discussions. Gender inequities, a focal point of feminist theory, spotlight the importance of scrutinizing power relations and how these differences are systematically established, categorized, and materially instantiated within our social milieu.

Critical Post-Structural Theory

In this study, I utilize a critical epistemology to examine dominant knowledge claims, the power dynamics that shape them, and the significance of history, marginalization, and oppression in our current discussions on peer interactions. This research adopts critical and post-structural epistemological approaches, as detailed by Foucault (1991), focusing on the discourse, language, and ideology surrounding peer navigators within HIV-related services for the ACB population in Manitoba. It recognizes that knowledge is formed through the interaction between the observer and the observed, influenced by social, cultural, and historical contexts.

The framework investigates the assumptions and biases that underlie knowledge claims and the reproduction of discourses on peers. It highlights the necessity of including a variety of perspectives, voices, and experiences in constructing knowledge about peer navigators. Moreover, the framework employs multiple theoretical perspectives to explore the power dynamics within peer navigation in HIV testing and prevention programs targeting ACB communities.

The study probes into the intricate power dynamics in peer engagement within ACB communities, particularly regarding HIV/STBBI testing in Manitoba. The findings reveal that

these dynamics, characterized by trust, peer expertise influence, shared identity, and lived experiences, are complex. Discourses in ACB communities about HIV intervention depict a relationship viewed as collective and collaborative, stressing the community's active participation and control over their processes to tackle power imbalances and health and social inequalities.

Additionally, the critical and post-structural notion of governmentality, as discussed by Gagnon and Guta (2012), assists in understanding how peer navigators' discourses affect the psychology of ACB communities. This includes community self-care and lifestyle choices in response to various knowledge forms, such as societal stereotypes and gender roles, thereby illustrating how sexism, cultural norms, societal stereotypes, and HIV-related stigma converge to shape community members' views on peer navigators.

Adopting critical perspectives on power, this research seeks to understand the discourses of the ACB community on peer navigators. According to Mullings et al. (2021), power can act as a force for social good, with community discourse on peers emphasizing supportiveness and compassion. Education and training emerge as crucial elements in peer navigation, aligning with the community's interest in being knowledgeable about HIV/STBBIs.

The dynamics between peer navigators and community members seeking HIV services are influenced by the diverse roles and adaptability of peer navigators. As community members, advocates, researchers, and support workers, they hold a significant position of influence and support. This aligns with findings by Shangani et al. (2017), indicating that peer navigators are pivotal in influencing and supporting behavioral changes in their communities.

Mullings et al. (2021) perceive power as a collective asset, focusing on the importance of collaboration, facilitation, cooperation, and societal consent. In discussions about peer navigators,

the importance of community connection and participation in selecting peers was underscored as crucial for empowerment and addressing inequalities and power imbalances. The need for well-trained, culturally aligned peer navigators, integrated into the community, and emphasizing personal connections, familiarity, and trust, was highlighted.

The study also addressed the preference for peers involved in HIV services to remain anonymous, associating it with considerations of power and privilege. This anonymity is viewed as a method to manage the privileged access to health information that peers might have, potentially affecting community dynamics. Concerns about privacy and confidentiality are particularly relevant in ACB communities, where access to healthcare is often obstructed by HIV-related stigma and discrimination.

A comprehensive understanding of health-related issues and resourcefulness is deemed essential, as Statham (2022) defines power as having access to social resources. Thus, the peer-to-community relationship involves a power dynamic. Peer navigators are framed as insiders, with characteristics such as race, ethnicity, age, gender identity, knowledge, and connection to the community playing a role.

The professionalism and expertise of peer navigators are crucial in influencing the power dynamics in peer relationships within ACB communities. Participants stressed the importance of peer navigators being professionally trained, such as psychologists or social workers, to ensure community members feel at ease engaging with peers in the context of HIV testing and related services, thus positioning them as authoritative figures in the community.

Implications for Social Work Practice

This study acts as a crucial resource for engaging with ACB communities in Manitoba, particularly in the realm of HIV/STBBI testing and services. It fills knowledge gaps about the power dynamics involved in peer engagement in HIV testing and prevention among ACB communities in Manitoba. The insights gained will assist social workers who provide direct services to ACB communities, enhancing their understanding of power dynamics in peer-to-peer relationships and their impact on service provision and uptake. This understanding is vital in social work practices to ensure that efforts do not further marginalize the oppressed but rather address the concerns of both communities and peers by advocating for policy changes and reforms aimed at addressing social inequalities and protecting the rights of marginalized individuals and communities this aligns with social work values and Guiding Principles (CASW, 2024).

The study underscores the significance of community consultation in peer engagement processes within ACB communities. It highlights the necessity for social workers to promote and support relationships and structures that empower community decision-making and active participation in addressing community needs. This approach is critical for effective programming and community action aimed at combating HIV/STBBIs among ACB communities in Manitoba. Future policy reforms and research should pay close attention to the perspectives and experiences of ACB community members regarding peer navigation and the intricate power dynamics between peer navigators and community members seeking HIV services.

Further, the study sheds light on the roles of peer navigators from the perspectives of ACB communities, emphasizing the importance of understanding these roles, especially in

addressing sensitive sexual health topics like HIV. Social workers will gain valuable insights into the role of peers in HIV intervention and its implications for community engagement and service uptake.

Social workers engaging with ACB communities will benefit from strategies that address the socio-cultural and power dynamics in peer relationships. This study offers perspectives on these relationships and suggests strategies for working effectively with ACB communities in Manitoba. It proposes various approaches to HIV services and collaboration with communities to develop acceptable and empowering strategies.

The study paves the way for a broader exploration of peer relations and offers new insights for social workers involved in research on HIV and peer engagement. The knowledge acquired will deepen our understanding of peer engagement in ACB communities in the context of HIV services, shedding light on the unique social power dynamics at play among individuals and groups within ACB populations with intersecting identities.

Following Freire's theory of critical consciousness (Karver et al., 2022), social work should strive to create a space for culturally and linguistically appropriate exchanges that allow individuals to address structural barriers perpetuating inequality. As well as providing training and resources for peer navigation.

Ultimately, this study emphasizes the need for adaptable and culturally sensitive approaches in peer navigation and healthcare provision. It calls on social workers to be well-versed in these approaches to effectively meet the diverse needs and experiences within the ACB community. Through this work, it is hoped that social workers will better understand the role of

peers in HIV services, the nuances of peer-to-peer relationships, and their implications for community engagement and HIV service uptake.

Recommendations

The study emphasizes the importance of ongoing consultation and collaboration with ACB communities to effectively address sensitive health issues, such as HIV. It underscores the necessity of building prior connections and relationships within these communities to ensure the success of peer involvement initiatives.

To combat HIV in ACB communities effectively, it is crucial that strategies are culturally sensitive and tailored to meet their unique needs. The selection of peer navigators should prioritize individuals who possess firsthand experience and a profound understanding of the local context and culture of their communities. This lived experience is invaluable for peer engagement, as it significantly enhances the ability of peers to provide emotionally supportive counseling. Such an approach transforms the traditional patient-provider dynamic into a more relatable and supportive relationship.

The study calls for attention to the perspectives and experiences of ACB community members regarding peer navigation and the power dynamics between peer navigators and those seeking HIV services. This consideration is vital for policy reforms and future research within these communities in Manitoba. Peer navigators should receive appropriate training for their roles, along with ongoing support, and information about external programs and services relevant to ACB communities. This knowledge is crucial for making effective referrals to facility or community programs.

There is a need to develop new policies or modify existing ones to ensure cultural safety in peer engagements with ACB communities. Addressing the ethical concerns of power

imbalances in community peer engagement is essential, as such imbalances may arise within peer-to-peer relationships.

The study further highlights that the role of peer navigators extends beyond system navigation to include providing emotional, cultural, and social support to individuals and their communities, based on shared similarities and cultural backgrounds. It suggests aligning peers with community members by considering characteristics such as age, gender, and beliefs to ensure that the support offered is relevant, respectful, and attuned to the community's diverse needs. Given the geographical limitation of the study, a province-wide study is recommended to explore peer navigation within ACB communities further and gain more insights.

Policies should incorporate cultural and gender considerations and promote community involvement in healthcare and health promotion for ACB communities. Policy reforms and research must pay close attention to the perspectives and experiences of ACB community members concerning peer navigation and the intricate power dynamics involved.

Finally, the establishment of research guidelines for working with ACB communities is recommended. These guidelines should promote community involvement and foster participation and ownership of the research process, supporting culturally appropriate and gender-sensitive initiatives. This facilitates collaborations that advance HIV prevention knowledge and action within ACB communities in Manitoba.

Study Limitations

The participants' experiences might not fully represent the ACB population in Manitoba, given that most participants were based in Winnipeg. This indicates a necessity for a more detailed exploration of peer engagement within ACB communities. While most participants

hailed from West and East Africa, their insights were lucid, and the data analysis revealed a conceptual depth that instilled confidence in the themes discussed. This study serves as an important foundational piece for further research in this field, suggesting the need to include a broader array of ACB community experiences.

The study investigated how peer engagement facilitates HIV testing and prevention in ACB communities, primarily through the lens of ACB community members. However, a comprehensive understanding necessitates exploring these dynamics from the perspective of peer navigators as well. Although the analysis was guided by specific theoretical frameworks, it's important to acknowledge that scholars with diverse social backgrounds might interpret these frameworks differently. Additionally, the study did not incorporate alternative theories that could have offered valuable insights into the analysis. This limitation suggests potential areas for further research to enrich our understanding of peer engagement in HIV prevention and testing within ACB communities.

Concluding Remarks

The study indicates that the ACB community appreciates the role of peer navigators. Insights from this research enhance our comprehension of how peer navigators engage with ACB communities, specifically regarding HIV services. It offers a further understanding of what the ACB community expects and prefers regarding peer navigators. Participants shared diverse opinions on the role of peer navigators in HIV testing, highlighting a multifaceted interaction of trust, knowledge, professionalism, cultural and gender dynamics, and personal experiences in determining the community's preferences for peer navigators within the context of HIV testing.

This study enhances our understanding of sexual health service delivery for the African, Caribbean, and Black (ACB) communities in Manitoba. It supports the development of a more inclusive HIV response plan/policy and health promotion efforts. Additionally, it establishes a solid platform for health agencies to promote and enhance strategies for HIV prevention and testing within ACB communities.

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Appendices

Appendix C

CONSENT FORM FOR CONSULTATION WITH COMMUNITY MEMBERS

STUDY TITLE:	HIV/STTBI Testing & The Health of African and Caribbean Migrant Communities in Manitoba
STUDY ADDRESS:	Faculty of Social Work University of Manitoba 173 Dafoe Road West Tier Building, Room 500C Winnipeg, MB, R3T 2N2
FUNDING SOURCES:	Canadian Institutes of Health Research
PRINCIPAL INVESTIGATOR'S NAME:	Dr. Rusty Souleymanov, MSW, PhD Assistant Professor, Faculty of Social Work University of Manitoba
RESEARCH ASSISTANTS:	Dr. Bolaji Akinyele-Akanbi, MSW, PhD. Chinyere Njeze, MA, PhD Candidate Patricia Ukoli, BSW, Graduate Student
DAYTIME TELEPHONE NUMBER:	1-204-474-6743
EMAIL:	rusty.souleymanov@umanitoba.ca

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you a basic idea of what the research is about and what your participation will involve. If you would like more details about something mentioned here, or information not included here, you should feel free to ask. Please take your time to review this consent form and also discuss any questions you may have with the principal investigator before you make your decision. This consent form may contain words that you do not understand. Please feel free to ask for explanation of any words or information that you do not clearly understand.

A. Purpose of the Study

You are invited to participate in *HIV/STTBI Testing & The Health of African and Caribbean Migrant Communities in Manitoba Study* that aims to achieve the following:

1. Promote the creation of new knowledge that is relevant to African and Caribbean migrant communities in Manitoba through the implementation of a cross-sectional, province-wide survey (online, phone, and mail-in versions) with an opportunity to do DBS (Dried Blood Spot) self-sampling.

2. To increase HIV/STBBI DBS testing among African migrant communities in Manitoba through a community-based peer-led DBS testing program.

3. To build capacity among African and Caribbean migrant community members in Manitoba as peer researchers, community leaders/peer testers.

4. To shape the next generation of HIV/STBBI community-based researchers through the meaningful engagement of trainees from African and Caribbean communities in high-quality Community-based Research.

This community-based and team approach study is a three-year project, funded by the Canadian Institutes of Health Research. This study is being led by Dr. Rusty Souleymanov at the Faculty of Social Work at the University of Manitoba. (Contact: 204-474-6743 rusty.souleymanov@umanitoba.ca).

We are consulting with community members for your input and to get your feedback for the DBS testing project. Taking part in this study is voluntary. We want to make sure that you understand what this study is about and what your role will be in the study. We are interested in facilitating DBS (Dried Blood Sampling) testing among members of African newcomer communities to focus on increasing knowledge on HIV/STBBI testing, treatment, prevention, and reducing HIV-related stigma. We will evaluate the acceptability of DBS testing among the African and Caribbean communities within a culturally responsive framework and create recommendations on how to develop interventions for these communities.

By taking part in this study, you will be asked to answer questions about the following issues:

<u>Community Needs Priorities</u>

- What type of roles do you want to perform?
- What does community think is the value of this program for African and Caribbean migrant communities?
- What do you think is community readiness towards this project?
- What are the ways we can engage community in this project?
- What are your compensation expectations? (participant/session attendee, community leadership, facilitation, recruitment, preparation, peer testing & system navigation)?
- How do you want to use and access survey?

<u>Feedback on Testing Process</u>

- Do you feel community has enough information to make an informed choice about taking the DBS test?
- What are your perspectives and acceptability of multiplex testing (HIV, COVID, Hep C, syphilis)?
- Does testing for COVID-19 makes it easier to also test for HIV, Hep C, syphilis?
- What is participants' preference in relation to testing, nominal, non-nominal?

- What do you think about DBS self-collection at home, for participants who chose not to do the DBS collection at agencies or healthcare providers?
- Are there any concerns with self-sampling at home and delivery of tests kits at home residence?
- Do you prefer supervised or unsupervised testing?
- Would you be willing to receive DBS kits from a trained local person in your community (peer tester/navigator)?
- What are your preferences in relation to the kind of person/peer you would like to distribute DBS kits in the community?
- Would you be willing to go for confirmatory testing if necessary?
- Would you be receptive to phlebotomy if you are diagnosed through DBS testing?
- Would you be interested in linkage to care if you are diagnosed with HIV or other STBBIs? Would you prefer post-test counselling?
- Would you like more information on any of the following topics-the safety of the DBS test; how to access DBS test; support for people taking DBS test; how to self-sample for DBS test; and issues with DBS test?
- What kind of support would you need to perform DBS self-sampling?

Safety, Privacy, and Risks

- How do you want to be notified regarding your results?
- How important is it to you who has access to your results? What is acceptable?
- What do you think needs to be done to make sure that community members feel confident in our work and in the protocols?
- How can dissemination of knowledge be done in the right way?
- How do you assess risks from a variety of sources? E.g., institutions and systems (immigration, criminal justice, CFS, Public Health, Insurance)

We ask that you read this form and ask any questions you may have before agreeing to take part in the study. You can contact the principal investigator at rusty.souleymanov@umanitoba.ca or by calling 204-474-6743 and leave a message about the best way and time to reach you.

The study findings will be published and made available online, however, your personal information will never be shared with anyone. All personal information will be removed and de-identified. After you have signed both copies of this form, please keep one of the forms for your own records.

B. Inclusion and Exclusion Criteria
In order to be in this study, you need to:

1. Be 18 years of age or older
2. Identify as an African, Caribbean and Black member
3. Currently live in Manitoba.

C. Procedures (the process)
If you choose to take part, you will be asked to do the following:

1. You will be asked questions to ensure you are eligible to be in the study.
2. If you are eligible to be in the study, you will be asked to review and electronically sign this consent form.

3. You will also be asked to participate in the consultation interview which will last approximately 45 to 90 minutes. Interviews will be audio-recorded with a recorder and transcribed by a professional transcriptionist manually. Afterward if you consent, you will also be asked to take part in the survey, DBS testing, and post-survey/testing interview.
4. An honorarium of $40 (CAD) will be made available to you for taking part in the consultation interview.

D. Risks/Discomforts

1. You might be uncomfortable with some of the questions.
2. Only the core research team members (B. Akinyele-Akanbi, C. Njeze, and P.Ukoli)), and principal investigator (Dr. Rusty Souleymanov) will have access to the data collected during the consultation.
3. All your research records will be kept confidential.
4. You can stop participating in the consultation at any point in time.
5. Your e-mail address will never be included in the transcript or any subsequent publications using the research data.
6. There are no hidden tricks or deception involved in the study.

E. Costs

There will be no other costs to you, except the time it takes you to complete the consultation.

F. Benefits

You may find that you enjoyed being part of the study and helping to address issues important to the ACB communities. You may feel a sense of satisfaction of having participated in research that will help to inform services amidst the COVID-19 pandemic, as well as the health and well-being of the African and Caribbean communities. We hope that this study will help better the health and health care of the African and Caribbean community members in Manitoba. The results of this study will be available to the public and on our lab website, www.villagelab.ca. You can also contact the study's principal investigator to request a copy of any findings if you choose (contact: Dr. Rusty Souleymanov, rusty.souleymanov@umanitoba.ca, 1-204-474-6743).

G. Compensation (What you will be paid):

Everyone who participates in and completes the consultation will be paid once participants consent to participate or at the end of the consultation process. You will be required to provide us with your email so that we can Interac e-transfer you your honorarium ($40).

H. Confidentiality Statement

Your research records will be kept confidential. To protect your privacy, and to minimize the possibility that any information you give us is traced back to you, we will not ask you for your date of birth or address (except for those who decide to do their testing at home).

We are very concerned about the confidentiality of the information you provide to us. Your answers during consultation are confidential. All the data will be stored in secured computers. Only the investigator and the research core team members will have access to the records.

Your personal information (i.e., your email) will never be linked to your answers in any way. We will not secretly record any other information about you. Any publications from the data collected in this study will never include any identifying information about you or anyone you talked about. Data collected during screening will be destroyed for those who are excluded or refuse to participate.

The research study you are participating in may be reviewed for quality assurance to make sure that the required laws and guidelines are followed. If chosen, (a) representative(s) of the Human Research Ethics

office at the University of Manitoba may access study-related data and/or consent materials as part of the review. All information accessed by the research ethics office will be upheld to the same level of confidentiality that has been stated by the research team.

I. Confidentiality will have to be broken if you disclose that:

- You are going to harm yourself or another person; and/or
- You know of a child who is being abused in any way; and/or
- You know of a person who is being sexually abused or harassed by a health professional
- You will be notified if confidentiality must be broken.

In case we need to break confidentiality, relevant professional bodies may need to be informed, for example CFS [Child and Families Services] in case of child abuse, neglect, or maltreatment, or police in case of potential harm to yourself or another person.

If required by law the following information may be disclosed about your case: the specific information giving rise to the concern, the source of the information (including your name) and all relevant known contact information.

J. Contacts and Questions

General questions about the interviews? Questions about the interview findings?
Please call 1-204-474-6743 or email Rusty at rusty.souleymanov@umanitoba.ca
Questions about your rights, or if you wish to report any harm or injury as a result of this interview?
Please contact the University of Manitoba Office of Research Ethics at humanethics@umanitoba.ca or 204-474-7122

K. Voluntary Nature of the Study
If you decide to participate, you are free to stop participating at any time before completion of the consultation, and you will not receive your compensation ($40). The honorarium will also be paid regardless of if specific responses are skipped or completed.

If you decide to withdraw from the study before the completion of the consultation, your responses will not be retained or used in the study. Participants may withdraw from the study during the interview by telling the interviewer and after the interview by sending an email to the principal investigator at rusty.souleymanov@umanitoba.ca. The deadline to withdraw is July 2024. Your data can be destroyed any time up until the data analysis has begun. After that time, your data will be aggregated with others, and your data cannot be withdrawn. If you choose to receive your interview transcripts for review, you will be asked to provide an email address to which the transcript can be sent. Interview manuscripts will be shared as soon as the interviews have been transcribed and received from the professional transcriptionist by July 2024. Participants will have up to two weeks to review manuscripts and revert with any feedback. If the research team does not get a response by the deadline, it will be assumed that participants do not have any input on the interview data and most likely agree with the transcripts' content. As such, the research team can proceed with the interview data analysis as required. All confidential data will be destroyed by December 2025, while the results of the study will be made available online through the Village Lab (www.villagelab.ca) approximately by December 2025.

L. Statement of Consent

By clicking YES to the statement "I give my consent to participate in this study" below indicates all of the following:

- I have read the above.
- I am eligible to participate in this study.
- I consent to participate in the study.
- I know I may stop participating in the study at any time after answering yes to the “I give my consent to participate" question.
- I am 18 years of age or older.
- I have asked any questions I have, and they have been answered to my satisfaction.
- I have been offered a copy of this form to keep.

I give my consent to participate in this study and to have the interview audio recorded.

- Yes
- No

Consent for Virtual Interviews:

Verbal consent has been captured in the recording

- Yes
- No

Would you like to receive your interview transcripts for review? ( ) Yes ( ) No. If yes, please share an E-mail address: _____

[Only print version has the following space for participant’s and investigator’s signature]

_____ _____
Signature of participant Date

_____ _____
Investigator’s Signature Date

Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a public health professional. In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence. Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation. The University of Manitoba may look at your research records to see that the research is being done in a safe and proper way. This research has been approved by the Research Ethics Board at the University of Manitoba, Fort Garry campus.

If you have any concerns or complaints about this project, you may contact any of the above-named persons or the Human Ethics Coordinator at 204-474-7122 or humanethics@umanitoba.ca. A copy of this consent form has been given to you to keep for your records and reference.

Interview screening and consent instructions

Please approach all potential participants with the utmost respect and thoughtfulness. At no point in time should anyone feel coerced into participating in this study or answering a question that they do not want to. Remind the participants of their rights to withdraw at any time. They can withdraw their participation during or after the interview.

State the name and purpose of the study:

- Thank you for taking the time to speak with me. Thank you for participating in our project called "Ubuntu-Pamoja".

- The Ubuntu-Pamoja Study (HIV/STTBI Testing & The Health of African and Caribbean Migrant Communities in Manitoba) is interested in learning more about your experiences and preferences for HIV and STBBI testing, as well as facilitating Dried Blood Spot testing among members of African and Caribbean migrant communities. Our research tries to explore what approaches to HIV testing (such as dried blood spot) work best for African and Caribbean communities. We also want to create recommendations on developing appropriate programs for these communities. As part of this project, we will ask you questions about HIV/STBBI testing, treatment, prevention, and reducing HIV-related stigma. It is a community-based project, which means members of the African and Caribbean communities are guiding the development and implementation of this project.

- The name *Ubuntu-Pamoja* was chosen in consultation with the members of community guiding circle which consists of Black, African, and Caribbean community members. We have chosen words that resonate with our African and Caribbean cultures: 'Ubuntu-Pamoja.' Ubuntu is an African concept that refers to acting in ways that benefit the community (Humanity to others/everyone). Its origin is south Africa. However, the idea commonly runs through African and Caribbean cultures. Pamoja means "Together" in Swahili. We were also inspired by the saying of one of the prominent African leaders Archbishop Desmond Tutu, "we are connected, and what each of us do affects the whole of humanity." That is why we ended up with this name.

- You have been invited to participate in this study because we are interested in learning more about you, and your experiences, perspectives, opinions, and views relating to the HIV testing process in Manitoba.

- I'd like to remind you that your responses will be confidential and used as data for this research study only. Also, please keep in mind that you do not have to answer any questions that make you feel uncomfortable. Just let me know if you feel uneasy, and we can move on to another question.

- Do you have any questions? [wait for verbal affirmation]

- The interview will last approximately 1.5 hours. Once you have participated in the interview, we will give you $40 compensation for your time. The discussion is confidential. We will not ask for your name or any information that will identify you, thus, no identifying information will be connected to the transcript of the interview discussion. The Interview will be audio-taped and then transcribed. Only the research assistant (give your name) and the research advisor (his name is Rusty [Dr. Rusty Souleymanov]) will have access to these tapes and associated transcripts. Your involvement is voluntary, and you can withdraw at any time.

- Would you be interested in participating in this interview?

If they are interested, please then explain that we have a few screening questions to make sure they are eligible to participate.

The screening questions are:

- Are you 18 years of age or older?
- Do you identify as African, Caribbean, or Black?
- Do you currently live in Manitoba?
- Would you feel comfortable answering personal questions about your health and wellbeing, access to health care, health status, experiences of oppression, and experiences with low-threshold services in Manitoba?

If they are eligible, please have them review verbally and in writing the consent form and mark the form (an actual signature is not required of participants, and an "X" mark is enough).

Demographic Questions for Community Members

- How old are you?
- How long have you lived in Manitoba?
- What gender do you identify as?
- How do you identify in terms of your ethnicity?
- What is the highest level of education you completed?
- Current employment or community role: Do you currently have paid employment? What is your occupation?

Questions on HIV/STBBI Testing (including DBS):

1. What do you know about HIV and STBBI testing in Manitoba? *(Provide interviewee with a definition of STBBI or HIV if needed)*
    a. Do you know how to access HIV or STBBI testing in Manitoba?
    b. What do you think are the gaps with regards to HIV or STBBI testing in Manitoba?
    c. What works well for you in terms of testing in Manitoba?

2. What do you know about Dried Blood Spot (DBS) testing? *(Provide interviewee with a definition of DBS if needed)*
    a. Do you think you need more information about DBS testing? (For example: evidence on the safety of the DBS test; support for people taking the DBS test)
    b. Do you know how to access the DBS test?
    c. Do you know how to self-sample for the DBS test?
        i. What kind of support would you need to perform DBS self-sampling?

3. *Provide information on how DBS testing allows individual to do self-sampling at home.* What does it mean to you to have access to testing in the place of your choice (for example home)?
    a. What do you think about DBS self-collection at home?
    b. Do you think there could be any issues with self-sampling at home, and delivery of tests to your home/residence?
    c. Would it be OK to pick up the DBS test kit at a clinic/agency and then bring it home to do your test at home?

4. Where (location-wise) would you find it safe to be tested for HIV or STBBI in Manitoba?
    a. What about specific locations for testing? (*Ask them to name clinics, agencies, and organizations that they think are safe for testing).*

5. *Explain how DBS test allows to be tested for multiple health issues (HIV, Hepatitis C, syphilis).* If you were able to use the same DBS sample to test for multiple health issues (HIV, Hepatitis C, syphilis), would you like to be tested using this combination approach?
    a. What does it change in terms of your willingness to take this test?
    b. *Is this approach more or less appealing?*

6. Where would you prefer to do the DBS test? *Give examples: at home, or in a clinic/hospital, community center/agency.*

7. Do you prefer supervised or unsupervised testing?
    a. Would you be willing to allow a trained local person in your community (we call them peer navigator) to collect your blood for a DBS sample?
    b. Which kind of person would you like to do this type of work in your community?
        i. What are the preferred qualities that persons/peer navigators would possess?

8. Would you be willing to go for confirmatory testing if necessary? (*Explain what confirmatory testing means).*
    a. What would make it easier to go for confirmatory testing?
    b. *Explain what phlebotomy means and how invasive it is.* Would you be receptive to phlebotomy if you are diagnosed through DBS testing?

9. Would you want to know the result of your test?
    a. Why? Why not?

10. How do you want to be notified regarding your results? Would you want someone to give you a call, or would you prefer going to the clinic?

11. . Would you be interested in linkage to care if you are diagnosed with HIV, or hepatitis C or syphilis?
   a. What would make it easier for you to reach out to service providers if you are diagnosed?
   b. If you need to be linked to care, do you know where to go?

12. *Explain what post-test counseling means.* Would you prefer post-test counseling?

Thank you for your answers.

I have a more questions for you. Are we OK to proceed?

Questions on Safety & Confidentiality:

13. What information (e.g., name) would you be comfortable sharing with the service provider if you go for testing at a health clinic/agency?
   a. Are you concerned about confidentiality? Why?

14. Are you concerned about the use of your samples and health information that is collected during testing?
   a. Are you concerned where it travels, what happens with it, who has information to your health-related answers or blood sample? Why?
   b. Do you have any concerns about who can have access to your results?
   c. Do you think community members may be concerned who has access to their results? (for example: Public Health, Social Workers, Immigration Canada, Police, Child and Family Services, Health Insurance, etc)?
      i. Do you think the Black, African, Caribbean community members have enough information about where their blood and health information travels after they do HIV or STBBI test in Manitoba?

15. What are your suggestions for supporting community members to feel confident about our research and the protocols?

Thank you for your answers.

I have a more questions for you. Are we OK to proceed?

Capacity Strengthening Questions for Those Interested in Joining the Peer Navigator Program (These Questions Only Asked of Participants who Express Interest in Joining This Training Program):

Explain what our Peer Navigator Program is about.

16. What do you think is the value of this peer navigator program for African and Caribbean migrant communities?
   a. How do you think this project is going to affect the community?

17. If you were to join this program, what type of roles do you want to perform?
   a. How do you want to be involved?
   b. How do you want to be called?

Thank you for your answers.

Ending Interview

- Is there anything else you would like to add that was not addressed?
- Thank you very much for your time.

** EXPLANATIONS OF EVERYTHING BOLDED IN GREEN **

1. STBBI: Sexually transmitted and blood-borne infections (STBBI) is an infection that can be transmitted from one person to another through the exchange of semen, vaginal fluid, blood, or other body fluids, during sexual contact including oral sex or contact with any of these body fluids.
2. HIV: HIV is a virus that weakens your immune system, which is your body's built-in defense against disease and illness. It can be transmitted through sexually or contact with infected blood and from mother to child.
3. DBS: Dried blood spot (DBS) testing is a method of blood collection that can be used for diagnosing hepatitis C, HIV, and other STBBI. The test involves pricking one of your fingers with a sterilized lancet to get some blood samples on a DBS card. A test kit will be mailed to you and after collection of the sample, you will mail it out to a designated collection center (lab).

4. Provide information on how DBS testing allows individuals to do self-sampling at home: Dried blood spot (DBS) self-sampling removes the need for medical personnel to collect the specimen directly from you. A test kit will be mailed to you, to perform the test, you will prick the finger with a lancet and then spot the blood onto a card made of filter paper, making sure the finger doesn't touch the card. After collection of the sample, you will mail it out to a designated collection center (lab).
5. Explain how the DBS test allows being tested for multiple health issues (HIV, Hepatitis C, syphilis: Dried blood spot (DBS) sample can be used to test for different health issues, like HIV, Hepatitis C, syphilis, COVID-19, and others. At the laboratory where the DBS sample is sent, standard hepatitis C, HIV, and other STBBI testing can be performed. For this study, we will be testing the sample for HIV, Hepatitis C, and syphilis if participants indicate they want these tests.
6. Explain what confirmatory testing means: Confirmatory tests are the tests required to confirm the analysis or test result from the DBS sample. If the DBS test result for any of the HIV/STBBI tests is positive, you will be contacted by a health practitioner to take a confirmatory test. The test will be done at a designated health facility. The confirmatory test is more comprehensive. Confirmatory tests are done in a lab and cannot be done at home. More blood samples will be taken for the test.
7. Explain what phlebotomy means and how invasive it is: phlebotomy means obtaining blood samples from an individual with the aid of a needle and syringe blood is drawn and the obtained sample is used for analysis or diagnosis.
8. Explain what 'linkage to care' means: Participants are referred or connected with facilities providing treatment for their diagnosis.
9. Explain what post-test counseling means: this is counseling that is done after the test has been done. It provides information about prevention, managing the diagnosis, and treatment including coping skills.
10. Explain what our Peer Navigator Program is about: Peer Navigators are members of the African, Caribbeans, and Black communities, who are trained to support participants who have indicated interest or consented to participate in the study. They will educate and/or provide information about the study to participants, as well as assist participants with DBS self-sampling when requested. Peer navigators will also guide interested participants through the process of collecting samples and provide information on self-sample collection (in-person and at community events), sending off samples, and other available options for sample collection. More so, peer navigators will also support participants who need to engage with other processes, assist with system navigation, referral, and linkage to services based on participants' needs, and also provide language interpretations.