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Exploring Young ACB Women's Experiences of Navigating Sexual Health in the Greater Toronto Area.

by
Natasha Afua Darko

THESIS

Submitted to the Department of Psychology

in partial fulfillment of the requirements for

Master of Arts in Psychology

Wilfrid Laurier University

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Abstract

This thesis explores the experiences of young African, Caribbean, and Black (ACB) women in the Greater Toronto Area (GTA) regarding how they navigate sexual health. Young ACB women face challenges that put them at increased risk for HIV and other sexually transmitted infections. Despite this, few studies have focused on the social contexts that affect sexual health for ACB women in Canada. This Community Based Participatory Research (CBPR) study (N = 24) utilized focus groups to examine young ACB women's experiences navigating sexual health. In the following thesis document, I present two manuscripts where I share a) a reflection on the process of engaging in a community-based sexual health project for young Black women and b) a results article that examines social factors that impact how young Black women navigate sexual health. A consideration of this research is to highlight how the intersectional nature of race and gender, creates challenges for young ACB women. This thesis follows the theoretical frameworks of Critical Race Theory(CRT), Intersectionality, and Reproductive Justice (RJ) to explore how ACB women are positioned within structures of power. This paper intends to add to scholarly discourse. It will also include strategies for use by researchers and community practitioners in sexual health care in the ACB community, specifically with young women.

Keywords: African, Caribbean, and Black, Black Women, Sexual Health, Community- Based Participatory Research.

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This thesis is dedicated to the young Black women I have encountered throughout my journey. Thank you for sharing your stories with me. I hope I made you proud.

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Chapter 1 — Introduction

The African, Caribbean, and Black (ACB) community in Canada consists of 1.2 million people. This number accounted for 3.5% of the total Canadian population in 2016 (Statistics Canada, 2016). Despite being a small proportion of the Canadian population, ACB communities experience disenfranchisement in many aspects. This stems from Canada's systemic history of anti-Black racism. Anti-Black racism is continually perpetuated through the legacy of the current social, economic, and political marginalization of African Canadians in society, such as the lack of opportunities, lower socioeconomic status, higher unemployment, significant poverty rates, and overrepresentation in the criminal justice system (Mullings, Morgan & Quelleng, 2016). The trend of economic, political, and social marginalization continues within the healthcare system, where ACB communities are overrepresented in poorer health outcomes, such as diabetes, heart disease, stroke, and HIV/AIDS (Veenstra & Patterson, 2015; Kaul et al., 2011).

ACB communities are overrepresented in HIV diagnoses in Canada. In Ontario alone, ACB people represent less than 12% of Ontario's population, yet account for 30% of HIV prevalence (African and Caribbean Council on HIV/AIDS in Ontario, 2018). Furthermore, there is a trend of HIV occurring in ACB women at higher rates. In 2002, ACB women accounted for half of the HIV infections in the ACB community (Public Health Agency of Canada, 2015). Additionally, 36% of new HIV diagnoses in women are among Black women (Challacombe, 2018). Research also shows that Indigenous youth and Black youth are diagnosed with HIV and

AIDS at increasingly younger ages than the young people of other racial groups (Public Health Agency of Canada, 2012).

There is a clear need for research and prevention initiatives that recognize and respond to the intersections between gender, race, and class reflected in the overrepresentation of young Black women in HIV statistics. ACB communities are among the most socially, politically, and economically marginalized in Canada, yet there are few evidence-based HIV prevention supports for young ACB women (Robertson, 2007). Despite being one of the most at risk groups for HIV transmission in Canada, young Black women seem to be falling through gaps in a system that is not tailored to their unique needs.

This thesis is nested within the larger *Sista2Sista* project. The *Sista2Sista* project is an adaptation of the Health Improvement for Teens (HIP Teens) intervention from its use and development from the American context to the Canadian context with ACB young women in the Greater Toronto Area (GTA) (Appendix A) . The HIP Teens project is an evidence-based sexual health risk reduction intervention for adolescent girls. The goal of the intervention is to enhance knowledge, increase motivation, and teach the behavior and skills needed to reduce pregnancy, HIV, and STI risk (Morrison-Beedy et al., 2013). In the *Sista2Sista* project, the HIP Teens intervention was further tailored to the specific needs of ACB young women in Canada. My thesis focuses specifically on the pre-pilot focus groups, which detailed the unique sexual health access and education needs of young ACB women in the GTA. The data from the focus groups were used to detail the sociocultural realities of ACB young women and to tailor the HIP Teens intervention to the Canadian context.

In this thesis, I will explore the process which I undertook, as a Black woman researcher, to conduct community-based research within the larger *Sista2Sista* project, an HIV prevention

intervention. I will also discuss the results of the pre-pilot focus groups with young ACB women in the GTA, in a separate article. This thesis consists of two research articles: the first is a process paper that discusses my narrative and how I became involved in HIV prevention research. I also reflect on my positionality as a Black woman conducting collaborative research, which focused on sexual health education and HIV prevention for Black women. This paper will outline the methodological challenges that occurred throughout the research process and highlight the reflective notes I took throughout the process.

The second article discusses the results of the pre-pilot focus groups, which outline the social contexts in which ACB women in the GTA live to provide insight and depth into the experiences of ACB young women when navigating sexual health. This paper will explore the themes representing their narratives navigating sexual health. The themes are perceptions and hypersexuality of Black Women's bodies, navigating sexual double standards and gender roles as Black Women, diverse blackness and experiences of migration concerning sexual health, and surveillance of Black women's bodies

Term Definitions

In Canada, the racial category 'Black' consists of three major ethnic groups. They are African, Caribbean, and Black Canadian, also known as ACB. Each of these distinct groups has a historical background. **African-Canadians** are individuals who immigrated to Canada from the continent of Africa, from countries such as Ghana and Rwanda (Mensah, 2015) . This term also includes first and second-generation immigrants who still call countries in Africa home. African-Canadian immigration primarily began after the 1960s due to economic hardships and negative consequences of colonization; many Black Africans left their native countries in search of greener pastures and a better life (Rotimi et al., 2017). The second ethnic group is the **Caribbean-Canadians**. This group calls the countries in the Caribbean their home, countries such as Jamaica and Barbados. However, many can trace their lineage back to the continent of Africa in which their ancestors came to North America through the Trans-Atlantic slave trade (Flynn,2013). The history of Caribbean-Canadians is an interesting one as broader migration did not begin until after the 1950s (Gooden, 2007). Despite this, there are some families from the Caribbean that have been in Canada since the early 1900s (Flynn, 2013). **Black-Canadian** refers to people of African descent whose families have been in Canada for several generations. It is important to note that the ancestors of this group tie their forced migration to Canada by way of the Atlantic slave trade (Winks, 2008). Many came to Canada from the United States through the underground railroad.

Though ACB consists of the three distinct ethnic categories that are identified predominantly in literature, it is essential to note that there are other ethnic categories that one can belong to and still be considered a part of the Black diaspora. For example, there are the Afro-Latinx people who, like the Caribbean and Black Canadians, tie their ancestry to the slave

trade, but their ancestors ended up in South America. The term 'Black' in North America is widely referred to in academic and non-academic literature as anyone of diasporic African heritage, either through forced migration or chosen migration (Wilson, Flicker, & Restoule, 2015). I speak about the history of the Black diaspora in Canada because of the diverse experiences of Blackness and to acknowledge that the Black community is not a monolith. Though there are many different experiences, there are some commonalities that ACB face.

Theoretical Frameworks

To provide a critical perspective to this research, I utilized two theoretical frameworks to inform my thesis: Critical Race Theory (CRT) and Intersectionality. A Reproductive Justice framework is also used in the analysis and framing of this paper. These theories influenced how the results of this research study were interpreted.

Critical Race Theory

Critical Race Theory (CRT) is a social-justice focused transdisciplinary, race-equity methodology with origins in legal studies (Ford & Airhihenbuwa, 2010). CRT is used to explain the position of marginalized groups from the viewpoint of participants and is most applicable in population health investigations where racial identity is associated with health outcomes (Mcgee, 2011). CRT aims to dismantle racial hierarchies by giving race attention while conducting research. CRT was developed by students at a law school in the United States, who sought to draw attention to the impacts of institutional racism and coined CRT to refer to the methodologies that address racial inequity and combat the root causes of structural racism (Ford & Airhihenbuwa, 2010). This framework is grounded in the view that race has no biological underpinnings but is socially constructed. Delgado and Stefancic (2017) note the guiding principles of CRT as the following: a critique of liberalism, the use of storytelling, structural determinism, Intersectionality (intersections of race, gender, and class), anti-essentialism and essentialism, cultural nationalism and separation and, lastly, critical pedagogy. To illustrate the practicality and utility of CRT in population health research, the principles of CRT will be utilized throughout this paper.

CRT used in health research utilizes the narratives of racialized people concerning health and health outcomes. Research is scarce regarding the extent to which racialized individuals have difficulty entering and navigating health services and acquiring health-related information or goods (Graham et al., 2011). CRT will be utilized in this research as a guiding framework to frame and understand how ACB young women are positioned within society and how they position themselves within society

Intersectionality

Although CRT acknowledges the impact of race and racism on sexual health outcomes, it is quite limited in scope because it does not account for the unique lived experiences of young Black women. Lorde (1984) states that racism, sexism, and homophobia are inseparable and create multiple levels of social (in)justice. The term Intersectionality was coined by Critical Race theorist, Kimberle Crenshaw, in 1989. It is a sociological framework rooted in Black feminist theory that discusses how various forms of oppression intersect, creating unique experiences of oppression and discrimination (Crenshaw, 1989). The theory of Intersectionality states that the experiences of a Black woman are not equivalent to the experiences of a Black man or a White woman. According to Bowleg (2012), the central tenets of Intersectionality are that social identities cannot be reduced to one entity, and they are multiple and intersecting. People from marginalized and oppressed groups are at the center of Intersectionality. Multiple social identities at the micro-level intersect with community, society and structural factors to produce health inequities.

Intersectionality is crucial to health research because it embraces the complexities that are essential to understanding health inequities (Hankivsky & Christoffersen, 2008). An

intersectional framework will be used in this study to acknowledge that young Black women have unique lived experiences because of the intersections of racism, sexism, classism, homophobia, and transphobia.

Reproductive Justice

Reproductive Justice (RJ) is a framework for activism and thinking about varying experiences of reproduction (Ross & Solinger, 2017). The framework was derived from women of color who did not identify with the pro-choice movement. The RJ framework was developed by individuals, groups, and organizations to address how gender, race, class, sexuality, and ability all intersect. Intersectionality heavily influences the reproductive justice movement. RJ looks to combine sexual rights and gender identity issues along with reproductive problems and social inequities. The definition of "reproductive justice goes beyond the pro-choice/pro-life debate and has three primary principles: (1) the right not to have a child; (2) the right to have a child; and (3) the right to parent children in safe and healthy environments" (Ross & Solinger , 2017, pg.9). RJ also demands that there is sexual autonomy and gender freedom for all. This framework was created because marginalized women did not feel that they were able to exercise their reproductive rights as much as their privileged counterparts. They felt it was their duty to provide birth control to their community because it was the key to upward social mobility (Price, 2010). Reproductive Justice fits well with the thesis focus because of its strong focus on structural and systemic factors, that impact women, particularly Black women's ability to access quality sexual and reproductive health care. The term 'Reproductive Justice' was coined by Loretta Ross in 2004 and continues to encompass social justice issues such as birth control,

access to abortion, sex education, LGBTQ+ access to reproductive health services, and environmental justice.

Connecting Theories and Frameworks

These multiple theories provided the blueprint for how the research project would be framed, and through which lenses the study would be understood. Critical race theory and Intersectionality provided theoretical underpinnings to explore the experiences of young ACB women who are navigating sexual health. CRT lays the groundwork to understand how race impacts sexual health and its outcomes. The objective of CRT is to go beyond documenting disparities in health but to also include policy and practice implications in published findings and to share essential findings with community members, stakeholders, and frontline service providers (Ford & Airhihenbuwa, 2010). Similarly, Intersectionality adds to this project by highlighting the complexities that ACB women face due to experiences of racism, sexism, and classism (Hankivsky & Christoffersen, 2008). These theoretical frameworks informed the study's research questions and provided insight into developing the analysis and discussion section of the thesis.

Reproductive Justice (RJ) provided the conceptual framework of the thesis that addresses how gender, race, class, sexuality, and ability all intersect and their implications for people's reproductive lives. RJ was utilized in this thesis to provide the perspective that ACB women are often not provided the autonomy to make decisions regarding their bodies and sexuality. This framework explores multiple systems of oppression and how these systems affect the lives of ACB people. Intersectionality and RJ are closely related and build upon one another. All the theories mentioned determined how the data in this thesis was organized.

Social Constructivist Paradigm

This thesis is also informed by a social constructivist paradigm. The social constructivist paradigm is interpretive, relational, holistic, and humanistic (Nelson & Prilleltensky, 2010). This paradigm proposes that people's everyday experiences are shaped by historical, social, economic, and political forces (Wong, 2006). The emphasis of this paradigm is on communication, subjective human experience, and the meaning people make of their experiences. My thesis will add to the limited literature on sexual health promotion of ACB young women in the Greater Toronto Area (GTA). A core assumption of this paradigm is that there are many mental constructions of reality, which are based on people's experiences in context. In the process paper, my narratives as a Black woman are utilized, where I examine the processes I undertook to conduct meaningful and relevant research within the ACB community. The qualitative method of focus groups was also employed to understand young women's personal experiences further. During the focus groups, open-ended questions were asked (Appendix B). Open-ended interview questions allowed participants to talk freely and form discussions about particular topics, and in this case, about sexual health education, programming, and services.

This paradigm was selected because it places importance on how knowledge is constructed through social interaction, and how knowledge is a shared rather than an individual experience. There is no single reality within this paradigm. This is important for this particular research because it speaks to the nuanced experiences that Black women face. I also provide my own nuanced experiences conducting research. The data collected focuses on the words of the participants, and participatory processes are used to arrive at a consensus on the findings and their meanings. The goal of this thesis is to understand the experiences of young ACB women in

the GTA regarding sexual health, whether it be as a participant, Youth Advisory Committee member, Stakeholder Advisory Committee member or a researcher. This thesis contributes to the existing literature by providing insight into the lives of ACB youth, specifically by speaking about sexual health.

Personal Reflexivity

The first thing that people realize about me is the fact that I am Black. However, beyond that, I am a ciswoman of Ghanaian descent, a daughter, a sister, and a friend, among many other things. I preface my identity with being Black and not as a woman, not because I value this aspect of my identity more. This is because often when there are discussions of womanhood, my Black body is not included. Often times in White feminist movement, Black women are excluded from the conversation. My experience as a Black woman is intersectional but my experience as a woman is defined by my race. I embarked on this academic journey to conduct health research focused on how Black women access sexual health services. This stemmed from my previous employment, where I saw that there was a severe gap in programming for African, Caribbean, and Black (ACB) people in Canada. The existing programming was not culturally competent, and communities of people were falling through the cracks. However, this journey has exposed me to much more. Through the data collection process, I spoke to young Black women who wanted their narratives heard beyond the confines of HIV and service access. They wanted their stories about living as Black women in Canada to be heard.

As a young Black woman myself, I felt it was essential to showcase the results of the focus groups that addressed access and HIV vulnerability, while also telling the stories of these young women. Alongside this, I wanted to share my story and reflect on my journey through this research process. This thesis focuses on my journey through academia and my journey as a Black woman. This thesis also showcases that, in the reality of community-based work, a researcher can plan everything, but if that is not what the broader community wants, the work is not relevant.

It is essential to note that I am just one storyteller for the many who were involved in this research project and the larger *Sista2Sista* project. I never envisioned that my academic journey would take me on a personal journey, which made me examine my self-discovery as a Black woman and, now, a researcher. After years of working in the HIV sector, I came into academia thinking that I would continue to conduct research about HIV prevention for ACB youth. However, this thesis process steered me in a different direction, where my focus shifted from solely focusing on HIV to centering my own voice and the voices of the young ACB women. This is reflected in the choice to write two separate articles: one that outlines the research process that I undertook, and the other that outlines the results of the focus groups. This thesis is a reflection of the importance of highlighting the voices of Black women in research, myself included. It was a challenging process, where I constantly questioned the importance of my own voice within white academia. My experience living as a Black Canadian woman underlies this thesis and is why I have chosen this field of study.

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Chapter 2 — 'You're One of Us' : Reflecting on the Process of Engaging in a Community-Based Sexual Health Project for Young Black Women in the Greater Toronto Area

Introduction

This paper outlines the research processes involved in my thesis, nested within the larger *Sista2Sista* project. The *Sista2Sista* project is an HIV prevention intervention for young Black women in the Greater Toronto Area (GTA). This paper presents my narratives and how I became involved in HIV prevention research. I also reflect on my positionality as a Black woman conducting collaborative research, which focuses on sexual health education and HIV prevention for Black youth. In this paper, I reflect on the history of chronic disease within Black communities and unethical research conducted on Black bodies. It is with this history in mind that the *Sista2Sista* project is entirely community-based, involving Black youth and relevant stakeholders throughout the entire process. This paper also outlines the process of situating the community within my master's thesis research and the methodological challenges faced throughout this research process.

Positionality – Who Am I?

I want to start this paper by introducing myself and sharing my journey that led to conducting research regarding HIV prevention programming and sexual health for African, Caribbean and Black (ACB) women in the GTA. I was born in Canada; however, this is not my home. My home is a small village in the Ashanti Region in Ghana called Abuakwa. Like many other children of the diaspora, the cultural ties to our home countries are robust. I am the child of Ghanaian immigrants who migrated to this side of the world in search of greener pastures. Due to the aftereffects of British colonial rule, Ghana faced economic hardships that caused many to

come abroad to build a better life for themselves and their future generations. Starting from the 1980s, many Black Africans left their homelands fleeing from broken and breakable states, wars, hopeless poverty, or political persecution (Rotimi et al., 2017). In 1970s Ghana, the economy collapsed, and the political landscape in Ghana became unstable. The economic uncertainty caused many Ghanaians, including my parents, to immigrate to Western countries.

My life experience is nuanced because I also had the fortune of living in Accra, Ghana, in my younger years, and this shaped who I am. When I returned to Canada as a young teenager, I had better knowledge of where I came from concerning my ancestors. I recall my grandmother telling stories of a Ghanaian Queen Mother who led the Ashanti tribe to victory in a war against British colonialism (McCaskie, 2007). Her name was Yaa Asantewaa. In Ghanaian culture, it was not unheard of for women to take on traditionally Western masculine roles, such as being the political leaders or military heads of an empire (McCaskie, 2007). When I was younger, this was my vision of women in society: as leaders, and as essential to society as men were.

Years later, I studied Psychology and Social Sciences of Health at the University of Ottawa, and it was through formal education that I began to understand how social factors, such as race, gender, and culture, affect health and health outcomes. Wanting to pursue a health profession, I began to volunteer at health-related organizations in my local community. Through volunteering at my university's Women's Health Centre, I noticed that many of the women who were affected by HIV/AIDS looked like me: young and Black. After this experience, I became motivated to understand why Black women were at a higher risk for this disease. Upon graduating, I became involved in a volunteer capacity in the *Cocoa and Condoms* initiative, and became a youth outreach coordinator in the Durham Region. I became involved through a friend who knew that I had an interest in sexual health education. Furthermore, the goal of this initiative

was to introduce conversations about sexual health, sexuality, and relationships to young Black women in the Durham Region through a series of educational town halls. Through informal discussions with young Black women, I discovered that there was a lack of consistent sexual health programming and HIV prevention interventions for us.

As someone who later became employed in the HIV sector, I sought to find evidence-based sexual health programming that I could implement for the Black youth in my region. When I realized that there was a gap in research on Black youth sexual health programming in Canada, I decided that I wanted to embark on a research journey that would allow me to continue to be involved in the HIV sector and be a part of creating a tangible solution to the lack of conversation around Black women's sexual health needs. Due to my work and life experience, I could see the result of not having relevant programming and interventions for Black women in many capacities. Very early on, I realized the importance of involving the community in programming and research. If it was not for those informal conversations with Black women about their sexual health experiences, I would not be where I am today. This project comes from someone who has lived as a Black woman her whole life, someone who is a service provider in the HIV sector, and someone who is now an emerging researcher.

HIV in Ontario

In Canada, an estimated 63,110 Canadians are living with HIV (Public Health Agency of Canada, 2017). This statistic roughly translates to a prevalence rate of 173 per 100,000 people in Canada (Public Health Agency of Canada, 2017). ACB people make up a disproportionate number of HIV positive tests in Canada. In 2011, ACB communities accounted for 2.2% of the Canadian population but comprised 16.9% of new HIV infections (Public Health Agency of Canada, 2012). Provincially, we see the same trend of ACB communities being at higher 'risk'

for HIV acquisition. ACB people make up less than 5% of Ontario's population but make up 25% of all new HIV diagnoses (Public Health Agency of Canada,2012). HIV, like many other chronic diseases, is exacerbated by social factors such as discrimination, anti-Black racism, poverty, gender, and class. Communities that face overlaps of social identities, such as Black women, often are at particular risk for acquiring HIV.

The intersection of race and gender creates a complex trend as ACB young women are disproportionately affected by HIV. In 2014 and 2015, ACB women accounted for 51% of HIV diagnoses in women in Ontario (Public Health Agency of Canada, 2016). Results from a national study suggest that ACB women remain at a higher risk for contracting sexually transmitted infections (STIs) and HIV, even though they engage in the same level of sexual activity as their non-racialized counterparts (Hallfors et al., 2007). Few studies have examined the correlation between community characteristics and STI transmission. However, the studies conclude that communities plagued by systemic violence and institutional racism have higher STI and HIV rates (Krieger et al., 2003; Shahmanesh et al., 2000). There is a salient connection between STI transmission and socioeconomic status, poverty, race, gender, and employment. Social and environmental factors ought to be examined when discussing ACB young women and HIV transmission.

History of HIV and Research in Black communities

To examine why HIV/AIDS disproportionately affects Black bodies, we must consider the link between chronic disease and colonization. ACB communities in North America and throughout the diaspora have been impacted by the effects of colonialism. Historically, the first Black people were brought to what we now know as North America through the Trans-Atlantic slave trade (Noonan, Velasco–Mondragon & Wagner, 2016). Due to the poor conditions on the

slave boats, many did not survive the passage to North America. This lays the ground for how Black health and Black bodies are viewed through to contemporary times. Once enslaved in North America, Black people lived in deplorable conditions, in which they endured physical and social trauma (Noonan, Velasco – Mondragon & Wagner, 2016). The end of slavery did not signify a significant change in the health of Black people as we still see the health of Black bodies primarily ignored. In modern times, we see systemic violence and oppression that is entrenched in our society and cause ACB communities to face poorer health outcomes, including HIV/AIDS (Wilson, 2016). There is a misconception that colonization has ended. However, colonialism is perpetuated through systemic violence and institutional racism. Health equity is one of the outcomes of the ongoing colonialism that is ever so present in Canadian society. Poor health outcomes manifest in a higher prevalence of HIV in ACB communities. Furthermore, Black bodies are also treated unethically when it comes to research.

Historically, sexual health and reproductive research concerning Black bodies has often been unethical due to systemic racism and discriminatory practices dating from before the Trans-Atlantic slave trade (Prather et al., 2016). A notable example is Sarah Baartman, known as Hottentot Venus, who was taken from the Cape Colony in South Africa and exhibited at the Picadilly Circus in London because of the "abnormality" of her sexual organs. She was said to suffer from both steatopygia (an enlargement of the buttocks) and the elongation of the labia. Baartman suffered the indignity of public exhibition and became the subject of popular lore and political lampooning before her premature death (Magubane, 2001). It is important to note that the exotification of Baartman's body was based on the perception of Black bodies by white Europeans, and it was not based on facts or scientific evidence. Due to the sexualization of Sarah Baartman's body, she was put in a cage and inspected by white people in England. The discourse

surrounding the exploitation of Black bodies continued in medical literature. In 1932, the United States Public Health Service (USPHS) initiated an experiment in Macon County, Alabama, to determine the natural course of untreated, latent syphilis in black males. The test was comprised of 400 syphilitic men, as well as 200 uninfected men who served as controls. When penicillin became widely available by the early 1950s as the preferred treatment for syphilis, the men did not receive therapy. In fact, on several occasions, the USPHS sought to prevent treatment. Only in 1972, when accounts of the study first appeared in the national press, did the Department of Health, Education, and Welfare halt the experiment. At that time, 74 of the test subjects were still alive; at least 28, but perhaps more than 100, had died directly from advanced syphilitic lesions (Brandt, 1978). This research project is widely known as the Tuskegee Syphilis Experiments. It is relevant to discuss this history because Black people still experience the effects of the past with sexual health and reproductive research.

In modern times, as an effect of the medical research that has been published about Black women's bodies, Black women report discrimination when seeking family planning services. They are more likely than white women to be advised to get an intrauterine device and to restrict childbearing (Prather et al., 2016). The historical underpinnings and contemporary research on, and treatment of, Black bodies showcase that there need to be strategies that focus on contextually and culturally competent research and prevention.

Using Community-Based Participatory Research Methods to Centre Black Voices

The question that guides my research process is: How can we centre young Black women's voices in the research process? Through conversations with my supervisor and community partners, the conclusion was to not only engage Black folks in varying capacities throughout this process but to conduct this research with them. Through further engagement with

experienced researchers, background research, and personal reflection, we came to utilize a Community-Based Participatory Research (CBPR) methodology to guide the *Sista2Sista* project. CBPR is a scientific inquiry approach that equitably involves community members, organizational representatives, and researchers in all aspects of the research, including the expertise of all partners (Israel et al., 2005). Researchers have used CBPR in marginalized communities to successfully address a variety of health issues including tobacco use, cancer prevention and control, elder abuse, youth wellness, genetic problems, environmental exposures, and HIV/AIDS (Daley Maksosky et al., 2010; Baffour & Chonody, 2009). Due to the historical and contemporary unethical treatment of Black bodies in research, a CBPR methodology was selected through various conversations with my supervisor and relevant stakeholders.

There have been research projects completed in Toronto that have focused on Black youth's sexual health needs. For example, The Let's Talk About Sex (LTAS) photovoice project is a community-based research project that consulted with multiple community members, stakeholders, and a community advisory committee. This project was completed to understand the sexual health programming needs of young Black women in the Jane and Finch area. This project employed a nine-week workshop for 14 young Black women and examined their sexual agency (Wilson, 2011). Another example of a research study focused on addressing the sexual health of ACB youth is Bringing Sexy Back (BSB). This is an art-based sexual health education intervention developed by Rose-Ann Bailey and Arlene Jardine for racialized and marginalized youth aged 15–21. Youth were engaged in a compact education process focusing on issues around the social determinants of health associated with sexual health using Urban Arts Therapy (Taibu Community Health Centre, 2009). This intervention increased youth capacity to use arts-based community-level intervention to disseminate sexual health education, addressed the lack of

condom usage, and increased safer sex. These examples showcase reasonable efforts in utilizing CBPR in research because they are community-based and focus on the needs of the community served.

In stark comparison, the Black Experience Project (BEP) is a research project based in the GTA that examines the lived experiences of ACB people. The study examined the factors leading to the successes and challenges faced by ACB people in the GTA (James, 2017). This project was problematic because it was run by a marketing company and not by the community. Despite this fact, there were multiple group discussions held across the GTA with community leaders and individuals with a vested interest. The community members that were consulted did not have any research background. To date, none of the data collected has been utilized to better the Black community in the GTA. This study showcases why it is vital to nest research in the community and why it is essential to understand local realities, conduct relevant research, and create impact within the community. It also highlights why it is necessary to have Black community-based researchers involved in all processes of research.

For a project to be considered CBPR, it must abide by two principles. The first is that the project must be regarded as ethical. This is a direct response to a history of exploitation of minority and low-income communities (Daley Maksosky et al., 2010). The project must protect the rights and dignity of the participants. Engaging community members and relevant stakeholders in the project should prevent unethical projects. The second facet is community empowerment. This simply means the project must have aspects that lead to community empowerment (Daley Maksosky et al., 2010). The project must focus on the strengths of the community and not the weaknesses. To follow the facets of CBPR for *Sista2Sista*, two advisory committees were created by the research team that would assist in designing and developing the

research project. As a Black researcher, I knew that my voice is not the only important one and wanted to conduct this research using a collaborative process. Thus, it was essential to add the nuanced experiences of Black youth in this project.

The first developed committee was the Youth Advisory Committee (YAC). Through conversations with my supervisor and community partners, a collaborative decision was made to have a YAC. Incorporating the voices of the youth throughout the research process allows for research findings and outcomes that are relevant to the youth themselves (Arunkumar et al., 2019). Youth engagement was utilized in the Toronto Teen Survey where a Youth Advisory Committee was struck to assist in the research objectives and goals, the survey, and protocols. The YAC assisted in the development of the study used to assess the existing sexual health services and to determine the ideal sexual health services for youth in Toronto (Flicker et al., 2009). Youth were integral to all stages of the Toronto Teen Survey, as is the case with the *Sista2Sista* project.

For the *Sista2Sista* project, the YAC consists of seven youth from across the GTA. The youth involved in the committee are all Black-identifying. The YAC is open to members who are Black women, as well as male and non-binary-identifying members, because the perspectives of all Black youth are essential in this project, and the project focuses on the sexual health of Black youth. Furthermore, I led recruitment for the YAC and was assisted by my supervisor. I accessed Black youth in my networks, some of whom I knew personally and others I knew through working in the community. It is important to note that there were members of the YAC from locations outside the GTA who were not in my immediate network. The YAC meets quarterly via teleconference and receives an honorarium of $30 for each meeting they attend. The YAC also assists in the development of the research goals and objectives. Its role is to assist in the

development of the research questions and to provide advice on how to create a youth-friendly and accessible protocol for the intervention. Members also help with the extensive community-based promotion of the focus and knowledge transfer plan. Switzer and colleagues (2016) noted that young people know how to structure programming and spaces to meet their particular needs. The primary source of sexual health information for youth is from peers (Senteio et al., 2018; Vibert, 2010; Layzer, Rosapepe & Barr, 2017). Hence, involving youth in the planning, development, and implementation of sexual health research and programming has been proven to be highly effective. To conclude, I value the input of the YAC because they provide feedback on the research that is meaningful because it is relevant to their lived experiences.

Though having Black youth voices is essential, it is also important to include stakeholders such as front-line service providers, community health workers, Executive Directors of AIDS Service Organizations, and community members with an interest involved in the process. Stakeholders are vital because they provide insight into what can be done at an organizational level. Based on the results found in the research project, stakeholders are able to discuss how the findings can be implemented into community programming. Furthermore, to facilitate meaningful engagement, the Stakeholder Advisory Committee is developed with stakeholders who work specifically with ACB youth in health care and social services. The Stakeholder Advisory Committee was intentionally separated from the YAC because of the power dynamics that exist between youth and adults that put the involved youth at risk of tokenism or having their voices silenced (Arunkumar et al., 2019). The purpose of the Stakeholder Advisory Committee is to understand what gaps exist in sexual health services and programming for ACB youth from an organizational perspective. The Stakeholder Advisory Committee also provides information about what would be needed to improve HIV prevention

programming and sexual health services for ACB youth. Their perspective provides insight into the organizational readiness for local community health organizations to implement the *Sista2Sista* intervention for ACB youth.

My Project and Methods

The *Sista2Sista* project is a research project that is an adaptation of the Health Improvement for Teens (HIP Teens) Intervention from the American to the Canadian context. HIP Teens is an evidence-based sexual health risk reduction intervention for adolescent girls that enhances knowledge, increases motivation, and teaches the behavior and skills needed to reduce pregnancy, HIV, and STI risk (Morrison- Beedy et al., 2013). In the *Sista2Sista* project, the HIP Teens intervention was further tailored to the specific needs of ACB young women in Canada. This is the first evidence-based intervention catered to the sexual health needs of young Black women in Canada, and that makes the *Sista2Sista* project a novel one. Thus, this master's thesis is nested within the larger *Sista2Sista* project.

My research focuses explicitly on the pre-pilot focus groups, which detailed the unique sexual health access and education needs of young ACB women in the GTA. The data from the focus groups was used to provide the sociocultural realities of ACB young women and to tailor the intervention to the Canadian context. These focus groups were crucial, making the intervention relevant for youth in the region. ACB women participated in two focus groups led by myself and my supervisor. Each focus group was two hours long. There were 24 participants in total for the *Sista2Sista* project. Both focus groups took place in the summer of 2019. The data collected from the focus groups was used to assess the sexual health needs of Black women in the GTA and also provided vital information for the adaptation of the *Sista2Sista* project. The research project addresses the following objectives: a) to evaluate whether ACB youth are aware

of and/or accessing sexual health services in the GTA b) to identify where ACB youth are currently receiving sexual health services and HIV prevention programming, and c) to understand where, how, and from whom ACB youth would like to receive sexual health services and programming. As a result, this research project centres local Black voices by involving youth and relevant stakeholders throughout the entire research process.

Employing a qualitative research method is vital with this research topic because it allows for the participants to engage in meaningful discussions about their views and experiences. This is integral for tailoring a program such as the HIP Teens intervention to the locally specific needs of young people in Ontario. Focus groups encouraged discussions around sexual health services and programming for ACB young women. Focus group methodology has been used in the past to explore various issues surrounding adolescent sexual health (DiCenso et al., 2001). According to Krueger (2002), open-ended interview questions allow participants to talk freely and form discussions about particular topics, such as, in this case, sexual health education and services. Focus groups were intentionally selected to provide the opportunity for participants to engage in dialogue and to build a sense of community.

The focus groups that were conducted for the *Sista2Sista* project provide nuanced experiences of young ACB women accessing sexual health services and HIV prevention programming. Along with discussing access to sexual health services, these focus groups shed light on where and how Black women want to receive sexual health services and information. What makes the focus groups novel from existing research is that there is a broader discussion about the state of sexual health services and programming. The first focus group consisted of 13 ACB young women between the ages of 16–29 and was co-facilitated by myself and my supervisor. This focus group took place in the summer of 2019 at York University. Most of the

young women had experiences accessing sexual health services and provided their insight on the state of the healthcare system. To encourage dialogue, the facilitators created an open environment by offering examples and sharing in the lived experiences of being Black women in Canada. The second focus group was comprised of 11 ACB young women, also between the ages of 16–29. This focus group was facilitated by myself. It took place in late summer of 2019 at TAIBU Community Health Centre in Scarborough. These young women provided their thoughts and insights on experiences with sexual health services and information. Overall, themes that emerged from the focus groups included the perception of Black bodies, culture, stigma, and surveillance of Black bodies.

To make this research relevant to the *Sista2Sista* project, a short slide was showcased at the tail end of each focus group. The slide outlined the existing HIP Teens intervention and its components. Participants were then asked what topics they felt were missing from the intervention and how the elements could be changed to suit the sociopolitical context of Black women in the GTA. Participants provided insightful suggestions, such as speaking about colorism, queerness, and masturbation.

Each young woman was provided an honorarium of $30, $5 for transportation, and a catered meal. The ethics for this project were provided in February 2019, by Wilfrid Laurier University. The transcripts for the focus groups and the demographic surveys all became data for this thesis (Appendix C). To document the process of using CBPR with young ACB women on the topic of sexual health, I kept a reflective journal. My notes from my reflective journal are data that influence this paper.

Reflections on the Process

Utilizing Community-Based Participatory Research

CBPR was used to guide my research through the focus groups and advisory committees, not only to use the findings to tailor the HIP Teens intervention but also to give Black women a space to talk about their experiences with sexual health. The CBPR process allowed me to gain knowledge not only from participants but also from the Advisory Committees and other researchers. Through incorporating CBPR, the research team was able to conduct research that is relevant to the community. It was a personal goal of mine to decolonize my research by giving a platform to those most impacted by this research. Though the CBPR process was beneficial, it was not an easy one.

Utilizing the CBPR approach was integral to making this project a successful and relevant one. However, CBPR is a time-consuming process. The recruitment of the advisory committees and focus groups took approximately four months in total. This process was slow in many facets, between email correspondence, phone conversations, and even in-person meetings. It was challenging to manage all of the different aspects of the project while keeping in line with the principles of CBPR. An example of this is when my supervisor suggested that both of Advisory Committee meetings would occur quarterly as opposed to monthly in order to make the workload more manageable for the research team. Employing CBPR is also labor-intensive for the research team because of the same reasons mentioned above. From the onset of the project, it was a priority to identify the right stakeholders and advisory committee members. Having to be in constant communication with them about the project meant allowing extra time for all facets

of the project. It was essential to the research team to have the representation of the community and only include those with a committed interest in the health of young Black women.

Advisory Committees

There was careful consideration and thought about how the committees would function. For this research project, there were two advisory committees, and this was done intentionally because, many times, there is an unspoken power dynamic when there are members of the community and service providers on the same committee. This dynamic, unfortunately, silences the voices of those who truly matter. The intention behind having the two advisory committees was to have space where youth could give their opinions and thoughts on the project. Some barriers may prevent youth engagement in sexual health research. A barrier that may impede youth involvement is that the youth are often viewed by adults as lacking skills and knowledge to enable participation (Nelson, Prilleltensky, & MacGillivary, 2001). This results in the dismissal of young people's beliefs, even when asked to engage. Adults may also lack skills and knowledge of how to engage young people. The aim was to provide stakeholders an opportunity to give suggestions about how the research project and intervention can be utilized in practice.

When it comes to CBPR in research, advisory committees are often the preferred approach. These committees usually consist of people who are members of the community or share an experience with the research project. However, these committees may not be accessible for members of the community who experience complex health and social issues (Switzer et al., 2019). Community advisory committees represent one way of engaging community members in research processes (Switizer et al., 2019). However, even with the committees in place, I realized that there was more that could have been done to centre Black voices in this research. Methods of centring Black voices in research include hiring Black peer researchers to engage in paid

work. Another example might be having community consultations with individuals who are not involved in academia and/or the social services sectors to get the opinions and feedback of those outside of those sectors.

Having the Advisory Committees was essential to making this project community- based and relevant. Due to the delay in the ethics process, the recruitment for the advisory committees began much later than anticipated. Both of the committees meet quarterly, but due to the busy schedules of the members of the Advisory Committees, it was determined early on that the meetings would occur via teleconference or through video calling. I managed both committees and was involved heavily in the recruitment process of the advisory committees. Managing the two committees, along with the recruitment and execution of the focus groups, became an overwhelming and time-consuming experience. Due to the precarity of the non-profit sector, there was a high turnover rate of staff and structure. Within the first month of the project, one of the community agencies we partnered with had a change of management that affected many of the staff. Additionally, many of the team members would either leave the organization or assume different positions within the organization. This caused them to leave the Stakeholder Advisory Committee because it was no longer within the scope of their job. Further, the constant changing of staff and committee members caused a challenge in itself.

Black Sisterhood

In my field notes I noted that, throughout the focus groups and YAC meetings, it was important for Black women to have space solely for themselves. Black Sisterhood is defined as "an unexplainable bond that includes love and respect for one another" (Elite Daily, 2017). Though many of the women came from different backgrounds, there was a common thread that united us, and it was that we all shared the experience of being Black in Canada. The women felt

as though there were not enough opportunities for Black women to meet and share a space to discuss sexual health and wellness. One participant reflected on the fact that often when decisions about Black women's bodies are made, they are made by old White men.

As a Black woman, it was exciting to see that Black women, who did not know each other, bonded through everyday experiences that they shared, while often laughing and exchanging jokes. This camaraderie went beyond the walls of the focus groups. After the focus groups, some of the participants stood outside talking, and some exchanged social media handles and phone numbers to keep in touch. It was noted by a participant that the sense of sisterhood would not have come about if there were participants of other racial identities in the room. It was evident that the use of focus groups was vital to gather rich experiences by allowing participants to share and bond over mutual experiences.

Recruiting Queer ACB Youth

An essential difficulty in recruitment was recruiting queer-identifying ACB youth for the focus groups. The original goal was to have a focus group with only queer-identifying youth to discuss their nuanced experiences accessing sexual health programming and to tailor the *Sista2Sista* intervention for queer youth. Through the networks of the YAC and the Stakeholder Advisory Committee, it was still hard to access queer ACB youth. As a cisgender, heterosexual Black woman, I may not have been able to provide a space where queer Black women would have felt safe to express their identities. Some women who identified as queer in the screening forms declined to join the queer-specific focus group. Also, these women asked that their queer identity not be mentioned in the focus groups. Additionally, there were queer voices at the focus groups; however, they were silenced. This is due to the fact that there is always a fear that research and spaces could harm queer communities. Furthermore, the Black queer community in

the GTA is a tightknit one, especially when it comes to research studies. A peer researcher would be hired to recruit and facilitate to mitigate this challenge. This person would be queer, Black, and woman-identifying. Also, there would be a specific queer ACB youth focus group. During the focus groups, it was named by participants that marginalized communities want to be in focus groups with people who share their lived experiences. A participant expressed that if I was a white woman, she would not have been there. This showcases the importance of having peer researchers that can identify with particular backgrounds and experiences.

Nested in A Larger Project

Nesting the *Sista2Sista* preliminary focus groups into the larger study also created a methodological challenge. This delayed the ethics process tremendously because the larger project was quite complex. For instance, the original intervention study required biological data (i.e. the collection of urine samples), a requirement the adaptation study in Ontario will no longer be collecting, in-part due to the points mentioned above, namely the problematic nature of collecting biological material from Black-identifying people for the purpose of research. Such practices, even from a CBPR frame, are still political issues that are hotly contested within Black communities in Canada today, and so the eventual decision was made that this component of the original study would be foregone in the adaptation study in Ontario. Additionally, with the focus of the project geared towards ACB young women ages 15–19, there were ethical concerns regarding the vulnerability of young participants who required parental guidance. This caused the ethics process to take much longer than anticipated. It took approximately five months for the project to gain ethics clearance. At that time, many aspects of the project were at a complete standstill. Also, nesting this project within the *Sista2Sista* project caused conflation between the two projects. Many times, it was challenging to differentiate this project from the larger project.

Due to the larger project requiring more time and resources, my research project was often overshadowed by the time demands of the larger project.

There is a complicated relationship between my project and the larger project with many benefits and challenges. An advantage of having a project nested in the *Sista2Sista* project was that I only had to undergo the rigorous ethics process once. Since my project was not a stand-alone project, I was able to experience ethics through the larger project. Another benefit is that my research was able to inform the larger project, which became a part of a tangible solution. As someone who came into research with a background of working in the HIV sector, it is a great feeling to know that I have a hand in contributing to the field I once worked in. Through my project being nested in the *Sista2Sista* project, I had access to resources to cover research-related expenses. I was also able to pay for transcription and data analysis software through the support from the larger project. In addition, I was able to increase the amount of the honoraria through the funds from the larger project.

There were also multiple challenges of having my project nested in the *Sista2Sista* project. As mentioned above, this process was time-consuming as the broader project in which my thesis project is nested dictated much of the parameters of what I was able to do and had to simultaneously coordinate, and both required significant time commitments—the *Sista2Sista* project dictated the timeline of the my project, which consisted of two focus groups. Further, due to the involvement of many stakeholders, I could not move along with the process when I was personally ready or needed to do so.

All-Black Spaces

When dealing with research surrounding racialized communities, the problems in the communities are often highlighted with few suggested solutions attached. What makes this

research project unique is that the findings will be used to inform the adaptation of an HIV prevention intervention for Black youth. This will be the first of its kind in Canada. The process of incorporating CBPR, the advisory committees, and focus groups on this project was comprehensive. I had to be extremely intentional about who I was involving and who we were bringing to the table. This process required a lot of time and vetting on the part of myself and the research team. We also learned the value of having a community at the table through the focus groups and committees. This was beneficial in two ways: having members of the population caused this research to be relevant, and it provided assurance that Black voices do matter. Participants were often excited when they found out that everyone involved in this project is Black-identifying. And for this very reason, this research project needed to reflect the voices of those impacted. A participant in the second focus group noted how important and necessary it was for this project to be followed through on because these are conversations that are not being had. The reaction to this project being a part of a solution that will address barriers in HIV prevention and sexual health services was positive.

Conclusion

My positionality and unique life experience greatly influence this master's thesis. As a Black woman who was employed in the HIV sector and later on as an emerging researcher, it is imperative that the voices of the ACB community are central in this research project. Utilizing a CBPR approach in this process allowed a collaborative process in which I was just a small piece of the overall project. A CBPR approach promoted relationships amongst the research team, the Youth Advisory Committee, the Stakeholder Committee, and the participants. This approach also supported the research process to be inclusive and engage the community in various capacities. Though CBPR is the ideal approach to this research, it does not come without its own challenges.

The research process was often tedious and time-consuming due to the many layers and people involved in the process. This research project was nested in the larger *Sista2Sista* project, which also came with its own benefits and challenges. Having a project nested in a larger project meant that there were two projects being worked on simultaneously, and often the larger project dictated the timeline of my project. However, due to the fact that the project was nested, I was able to access the financial resources associated with the larger project. Overall, this paper showcases that, despite the challenges that come with CBPR and a nested project, it is important to centralize the voices of the communities involved in the research.

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Chapter 3— 'We are Mothers, Sisters, and Lovers Too': Examining Young Black Women's Experiences Navigating Sexual Health in the Greater Toronto Area.

Introduction

In Canada, there is a lack of research that addresses the sexual health and wellbeing of African, Caribbean, and Black (ACB) young women. The experience of being both Black and a woman create a unique life experience that impacts ACB women's daily lives and how they navigate sexual health. This stems from social contexts that have historical underpinnings, such as the perception of Black women's bodies, Black identity, gender roles, and sexual double standards. There is a body of research that examines the social contexts of sexual health, often this research highlights the notion of sexual risk. The concept of what is considered risk is a social construction, the risk notion only takes the analysis of the individual and collective perceptions, representations and interactions of social actors (Bankof & Ferks,2004) . The assumption this intervention makes is that 'risk' is the same for is problematic because it does not account for larger systemic factors and social factors. Also, existing research does not speak particularly to the unique experiences of ACB women who face both sexism and racism while navigating sexual health. In addition, studies that speak to the experiences of Black women and sexual health often have a theoretical framework (Prather et al., 2016; Mincey, 2014; Fasula, Carry & Miller, 2014). Following suit, this study utilizes the theoretical frameworks of Critical Race Theory, Intersectionality and Reproductive Justice.

The intersections of being a young ACB woman facing multiple forms of oppression create interesting lived experiences, which include racism, ageism, misogyny but other can include other factors such as culture, religion, ability, sexual orientation, gender identity, etc. Most importantly, these intersections affect how young ACB women view themselves and this,

in turn, affects how they navigate sexual health. In this article, I will discuss various social factors that impact how young ACB women understand sexual health in the Greater Toronto Area (GTA). I specifically address how notions surrounding Black women's gender and race impact their sexual health. Edwards and Coleman (2004) define sexual health as "physical, mental, and social well-being in relation to sexuality." Sexual health goes beyond the absence of disease or health outcomes but also encompasses youth having the possibility of having pleasurable, comfortable, and safe sexual experiences. According to Flicker et al. (2009), the definition also encompasses sexual health as a basic human right, and youth should be equipped with all of the necessary skills and technologies to protect themselves. This study embraces the Edwards and Coleman (2004) definition of sexual health in order to explore the social contexts that impact young ACB women's ability to navigate sexual health. This definition provides a more holistic definition of sexual health, which also includes Sexually Transmitted Infections (STIs), HIV, and pregnancy prevention.

Utilizing the theoretical frameworks of CRT, Intersectionality, and Reproductive Justice, I intend to explore social contexts that impact young ACB women in their daily lives, and more specifically regarding sexual health. This study is relevant because it provides insight into the lives of young Black women in the GTA. This research is conducted by a Black woman researcher using qualitative methodology, open-ended questions and focus groups. In the sections that follow, I examine the historical underpinnings and previous literature that discusses perceptions of Black women's bodies, gender, and Black identity.

The purpose of this study is to address the gap in literature with regards to exploring young ACB women's narratives in which they navigate sexual health and related topics. A thematic analysis was used to identify themes and patterns in two focus groups with 24 young

ACB women (aged 16–29). Participants identified the social contexts of perceptions of Black women's bodies, gender roles, and diverse Blackness as impacting their ability to navigate sexual health. Participants identified four themes emerging from their narratives of navigating sexual health. The themes included the perceptions and hypersexuality of Black women's bodies, navigating sexual double standards and gender roles as Black women, diverse Blackness, and experiences of migration concerning sexual health and surveillance on Black women's bodies. Young Black women often have to navigate sexual health with these social factors and various notions about Black women in mind. This paper is intended to add to scholarly discourse and will include practical strategies for use by researchers and community practitioners in sexual health within the ACB community, specifically with young women.

Literature Review

In the sections that follow, I examine existing literature regarding the perceptions of Black women's bodies, gender, intersectionality and the concept of Black identity in Canada. Exploring these themes is critical because they each impact how Black women navigate sexual health. Intersectionality provides insight into how Black women's experiences move beyond the scope of just race or gender. Perceptions of Black women's bodies stem from the Trans-Atlantic slave trade and still have remnants in contemporary times.

It is crucial to examine the historical context that influences and continues to impact the lives of Black women in the Western world today. From the onset of colonialism, when European colonizers landed in the continent of Africa, they perceived Black African bodies as subsets of humanity (Story, 2010). This meant that Black bodies were not seen as fully human. Blackness was not seen as a race or culture but as a negative or opposite of whiteness (Bernard, 2016). Black people were also perceived as underdeveloped not only in their physical traits, but

also in their cultural and intellectual abilities (Strings, 2015). This view led to the mistreatment of Black Africans and, ultimately, the Trans-Atlantic slave trade. Many Black Africans were taken from their homelands and sold into slavery throughout North America (Noonan, Velasco-Mondragon & Wagner, 2016).

Under slavery, physically strong enslaved women were often sold for higher bids and were prized possessions to exploit their ability to do hard, manual labour (Nelson, Cardemil & Adeoye, 2016). Historical accounts of enslaved women often emphasize strength, but it is important to note that Black women at this time were considered and treated as property. This is showcased in the cruel treatment of Black women who were often forced to work in poor conditions, and whose fertility was often dependent on a slave owner's desire to improve their economic gain (Collins, 2000, p.4). Black women and girls were denied reproductive rights to control their sexuality which meant that they were usually unable to determine with whom they reproduced. During these times, Black women embraced their strength to protect themselves and their families from further trauma, which included physical abuse or separation from their kinfolks (Thompson, 2000).

The perception of the 'Strong Black Woman' has provided Black women a façade of resilience despite the multiple layers of discrimination and oppression within a society that often devalues them. Research shows that Black mothers often socialize their daughters to be strong, which includes higher expectations in general, and higher expectations of their daughters than of their sons (Elliot & Reid ,2016). Though this parenting style is often associated with positive outcomes, it is vital to mention that this perception of the Strong Black Woman can also be problematic. These stereotypes continue to affect perceptions of Black women, and Black

women tend to internalize these stereotypes, which can have deleterious impacts on their mental health.

In a study conducted by Donovan and West (2014), they found that the high acceptance of the Strong Black Woman stereotype by Black women college students often limits Black women's ability to cope positively with adverse health outcomes associated with mental health problems. This stereotyping of the Strong Black Woman also affects Black women when seeking sexual and reproductive health care. According to Prather and colleagues (2016), the historical narrative of racial inferiority and stereotyping, including the Strong Black Woman perception, exacerbated the sexual and reproductive health disparities faced by Black women. History continually provides insight to the present and, given the racist, sexist, and classist ideologies that exist within Western culture, stereotypical views of Black women that originated during the slave era are pervasive and continue to affect the lives of Black women in modern times.

Another stereotype about Black women that is pervasive in modern times stems from colonialism and is the stereotype of the hypersexualized Black woman or the 'Jezebel.' Hypersexualization is defined as making something or someone extraordinarily sexual or as accentuating the sexuality of something (Brooks, 2010). During slavery and colonial times, the sexualization of Black women not only made Black women accessible sexual targets as victims of sexual violence, but they were also painted as 'dangerous' because their so-called 'promiscuous behaviour' caused them to contract venereal diseases and spread them to the general public (Feder, 2007). The image of the hypersexual Black woman was essential to the creation of the pure, marriageable, white lady. Oftentimes, prostitutes and concubines within slavery and colonialization were Black, and this aided in making white women's virginity possible by comparison (Stoler, 1989). Black women's positionality in society did not allow

them to conform to white standards of womanhood and femininity. The narrative surrounding Black women's hypersexualization continued within the medical literature, with diseases such as tuberculosis and syphilis, which suggested that Black women engaged in risky behaviour that rendered them diseased and dangerous (Strings, 2015).

The historical contexts in which Black women's bodies were portrayed as overtly sexualized influence how Black women's bodies are viewed in recent times. The stereotype is exemplified by how Black women are described in the media. A study conducted by Johnson (2015) showcased that 90% of magazines with Black women on the covers showed images of Black women being hypersexualized. Additionally, Turner (2011) found that, in music videos, Black women were more likely to appear in provocative clothing than any other racial background. Contemporary images, often perpetuated by the media, showcase Black women as hypersexual and simple-minded; the images also often connect women's worth to their physical and emotional labour (Collins, 1990).

Existing research shows that there are consequences for sexualization that impact Black women negatively. Studies state that, due to sexualization, Black women are unable to effectively negotiate sexual encounters, resulting in their increased vulnerability to STIs and HIV/AIDS (Aral et al., 2008; Wingood & DiClemente, 1992). In a study conducted by Davis (2013), a qualitative approach was used to determine the effects of sexual stereotyping on the decision-making of young Black women. The results of the study found that Black women saw a salient connection between Black women's sexual stereotypes and their sexual decision-making and connect it to increased 'risky' sexual behaviour. In Patricia Hill Collin's *Black Sexual Politics (2006),* a connection between the two ' Jezebel' stereotype and the strong Black woman is made. The interconnected of the stereotypes results in a representation of Black women as

being too strong and less attractive to men because they are viewed as feminine(Collins, 2004) . In order to be more attractive to more appealing to men and mainstream society , ' strong' Black women has to appear hypersexual (Johnson, 2015). This image prevades popular culture.

Black feminists have been exploring what it means to be a Black woman for decades (Hill Collins & Bilge, 2016). During the 1960s and 1970s, African American women developed intersectional analyses within social movements. An example was Frances Beal's essay, "Double Jeopardy: To be Black and Female," published in 1969. The piece laid out the patriarchy within the Black Power Movement and the racism within the White Feminist Liberation Movement (Beal, 2008). The Combahee River Statement (CRC) is viewed as a catalyst for intersectionality in social movements. The CRC is a document curated by Black feminists in 1977 that laid out how systemic oppressions of racism, patriarchy, and capitalism interlock (Hill Collins and Bilge, 2016). The notion developed by the CRC of interlocking systems was further explored by Patricia Hill Collins (2000) in what she called the 'matrix of domination.' The concept of the matrix of domination served as the precursor to the theory of intersectionality.

Intersectionality is often used by scholars to question society's ambiguous relationship with Black women, who were not perceived as feminine like White women but were simultaneously expected to be subordinate to Black men. Prior to the aforementioned Black feminists, Sojourner Truth penned an essay called "Ain't I a Woman" in 1851. The essay demands equity for Black women within the anti-slavery movement (Brah & Phoenix, 2004). The essay encompasses the central tenets of intersectionality. African American women's work and voices laid the groundwork for what became known as intersectionality. Bell hooks' book entitled *Ain't I a Woman: Black Women and Feminism* (2005) explores the effect of racism and sexism on Black women and denounces the second-wave feminist movement for only catering to

the needs of middle-class White women and neglecting the needs of the women of colour and the poor. The book goes into depth to explore the stereotypes that surround Black femininity and how these stereotypes have origins in slavery. Also written around this time, Angela Davis's volume in *Women, Race, and Class* (1981) focuses on the ways in which race, gender, and class worked together to shape inequality. Davis argues that racism is inherent in the women's rights movement and that Black women are largely excluded from the movement. When discussing intersectionality, it is also important to examine Black identity.

Race is a category used to differentiate skin color, and classifying humans was introduced in the 1700s by a French physician. This categorization was Eurocentrically focused and degraded those classified as non-European (Ford & Harawa, 2010). These classifications later gained traction in the scientific field. It is essential that the foundations of racial categories are explored to understand why the disparities in health exist. Race is a social construct, but the notions about race shaped early scientific research and continue to place racialized individuals at a disadvantage today. Black communities face high rates of many social, economic, and political markers of disenfranchisement (Wilson, Flicker, & Restoule, 2015 ; Mullings, Morgan & Quelleng, 2016 ; Rodney & Copeland, 2009).

According to Cornell & Hartmann (2007), ethnicity refers to cultural practices and beliefs that connect to the role of people. In contrast, race refers to physical characteristics that distinguish a group of people. Both ethnicity and race contribute to Black identity. Black identity is said to imply a consciousness of self within the Black community (Spencer & Markstrom-Adams, 1990). It is also noted that Black identity is complicated in the sense that it provides a sense of belonging (Smith, 1989). In research, the terms Black and African-American have different socio-cultural and political contexts. However, they are often used interchangeably

(Johnston-Guerrero, 2016). The term 'Black' in North America is widely referred to in academic and non- academic literature as anyone of diasporic African heritage, either through forced migration or chosen migration.

In Canada, the Black community is often portrayed as a monolith or a homogenous group in academic and non-academic discourse (Mensah, 2005). This is despite vast differences in the Black community in ethnicity, immigration status, place of origin, generation, and many other factors (Mensah, 2014). Black immigrants in Canada come from diverse locations, such as Africa, the Caribbean, the United States, and other places. There are also some Black Canadians who trace their origin to Canada many generations before the way of the Trans-Atlantic Slave Trade. With this wealth of knowledge produced by Black people coming from diverse backgrounds, it is fascinating that public discourse tends to homogenize the Black community as part of the othering process.

Research Objectives

The results of this paper are drawn from the results of the focus groups of the more extensive *Sista2Sista* study. The *Sista2Sista* focus groups had the goals of: 1) evaluating whether ACB youth are aware of and accessing sexual health services in the GTA; 2) identifying where ACB youth are currently receiving sexual health services and HIV prevention programming, and 3) understanding where, how, and from whom ACB youth would like to receive sexual health services and programming. The *Sista2Sista* study was in collaboration with the AIDS Committee of York Region, AIDS Committee of Durham Region, and 360 Kids.

The goals of this article differ from the *Sista2Sista* focus group goals, in that it focuses specifically on the social contexts that impact ACB young women navigating sexual health. This

project examines the social context in which ACB women live in order to provide insight and depth into the experiences of ACB young women when navigating sexual health.

Research Context

The research project occurred in the Greater Toronto Area (GTA) (Appendix A). The GTA is the most populous metropolitan area in Canada. It consists of the city of Toronto and four regional municipalities: Durham, Halton, Peel, and York. As of 2018, the population of the GTA is approximately 6.4 million (Statistics Canada, 2016). According to the 2016 census, more Black Canadians resided in the GTA than in any other region in Canada (Statistics Canada, 2016). Black Canadians make up approximately 8.5% of the population in the GTA (Statistics Canada, 2016). Due to gentrification and rising housing costs, there are noticeable trends in the number of ACB people migrating to regions neighbouring the city of Toronto. In York Region, there are reportedly 61,965 ACB people residing there, 70,000 ACB live in Peel Region, and 52,000 in Durham Region (Statistics Canada, 2016) This research did not intentionally seek participants from the city of Toronto and Halton region. The city of Toronto was not prioritized in the study due to the large focus of research on the city of Toronto at the detriment of the areas surrounding it. Halton region is also excluded because there was a lack of community organizations with an HIV prevention focus in the region.

Method

Recruitment

This study focuses on a specific population: young ACB women; hence, convenience sampling was used between April and August 2019. Convenience sampling is a type of non-probability sampling where members of a population meet specific criteria, such as willingness

to participate in the study and geographic proximity (Etikan, Musa & Alkassim, 2016). This method is most accessible for researchers, hence why it was selected for this research project. Recruitment occurred in many forms, including posters in ACB-focused community organizations (i.e., Black Coalition for AIDS Prevention), community events (i.e., Afrofest), in-person at local health centers, community centers, high schools, and shopping malls. The collaborating community organizations were also approached to access young ACB women to participate in the research project. Online platforms such as promotion on social media and email, etc., were also employed for recruitment. Online flyers were distributed to Black community organizations through various email listservs throughout the (GTA).

Potential participants were screened via phone calls to ensure they met the eligibility requirements. Participants had to identify as African, Caribbean, and/or Black, be between the ages of 16–29, be woman-identifying, and reside in the GTA. Initially, 32 participants were interested and screened, but a number dropped out due to scheduling conflicts, geographic distance to locations, personal reasons, etc.

Participants

A final sample was obtained of 24 young Black women participants (N = 24). There were two focus groups held in the summer of 2019. The first focus group had 13 participants (n = 13) and the second focus group had 11 (n = 11). The sample consisted of young Black women who were between the ages of 16 and 29. All participants identified as African, Caribbean, and/or Black. 23 participants identified as heterosexual, and one participant identified as bisexual. All participants identified as cisgender. Participant demographic information can be found in Table 1.

Procedure

A Youth Advisory Committee (YAC) was recruited, including eight ACB youth aged 16–29 from across Ontario. The committee comprised of young women, young men, and non-binary folks. Additionally, a Stakeholder Advisory Committee was recruited, including front-line service providers, community health workers, Executive Directors of AIDS Service Organizations, and community members who work with diverse ACB communities. Both committees were heavily involved in the process; the YAC and Stakeholder committees met quarterly via teleconference and contributed their insights and perspectives throughout all stages of the project.

Two 90-minute focus groups were conducted and facilitated by my supervisor and myself, both Black women. My supervisor and myself facilitated the first focus group. I facilitated the second focus group by myself. Ground rules were discussed at the beginning of the focus group sessions. All participants were given an informed consent form at the beginning of the focus groups. This form was explained and signed before the audio device was powered on. Participants were also asked to fill out a demographic survey, which took approximately 10 minutes to fill out. The informed consent form also included a section on confidentiality, which was further explained to participants. Due to the sensitive nature of sexual health and HIV, participants were asked to not share any identifiable information (i.e., names and HIV status) with others in the community.

Participants were asked a series of questions regarding a) sexual health, b) access to sexual health services, c) sexual health education, and d) preferred sexual health resources. The research questions were tailored to align with the objectives of the project. Prior to the start of each focus group, there was time dedicated to networking and a catered meal. Participants received $35 as compensation for their participation in the focus group. All research procedures

conformed to institutional and Tri-Council research ethics requirements for Wilfrid Laurier University.

Data Collection Methods

Demographic survey. Anonymous demographic surveys were provided to participants at the beginning of each focus group. Participants were asked questions such as their age, where they lived, their sexual orientation, gender identity, and ethnicity. The surveys were accessible and jargon-free.

Characteristics	Total Sample N = 24 n(%)	FG 1 n = 13 n(%)	FG 2 n = 11 n(%)
Age Range	16-29	22-29	16-26
Age Mean and SD	M = 24.3 SD = 3.2	M = 25.7 SD = 2.1	M = 22.6 SD = 3.5
Ethnicity			
African	12(50.0)	7(53.4)	5(45.4)
Caribbean	8(33.3)	4(30.8)	4(36.4)
Black- Canadian	1(4.2)	0(0)	1(9.1)
Mixed	1(4.2)	0(0)	1(9.1)
Other	2(8.3)	2(15.4)	0(0)
Sexual Orientation			
Heterosexual	23(95.8)		
Bisexual	1(4.2)		
Region of Residence			
City of Toronto	11(45.8)	4(30.8)	7(63.6)
Durham Region	3(12.5)	0(0)	3(27.3)
Peel Region	4(16.7)	3(23.1)	1(9.1)
York Region	6(25.0)	6(45.2)	0(0)

Table 1. Participant Demographic Survey Information

Focus groups. A focus group guide (Appendix B) was used to initiate a discussion about the experiences of ACB young women accessing sexual health services and information in the GTA. Questions were co-created by my supervisor and me, with the goals of the *Sista2Sista* project in mind. The questions focused on access to sexual health and HIV prevention services, sources of sexual health information, and crucial sexual health issues facing young Black women in the GTA.

To facilitate discussion about sexual health for ACB women, participants were asked questions such as: What are the most important sexual health issues facing young Black women in the GTA? What are the pressing issues? What sexual health programming is available to you to discuss issues of sex, sexuality, STIs, etc.? How would you like to receive information on sexual health? What is the best way to engage ACB youth and get them involved in sexual health issues?

Data Analysis

Qualitative analysis. Data analysis took place after all focus groups had been completed. Focus groups were audio-recorded and transcribed verbatim with written consent from participants. An undergraduate student transcribed the audio recordings using NVivo 11. The transcripts from the focus groups were analyzed using a thematic analysis framework for common themes. This process was completed using Braun and Clark's (2006) six-step process. The first step is gaining familiarity with the data. This was achieved through reading over the transcripts multiple times and having meaningful discussions with my supervisor about the transcripts. The second step is creating coding categories or subcategories; due to the useful conversations with my supervisor, we were able to create codes that were reoccurring, and that fit the goals of the project. The third step involved combining various codes and generating

themes. Reviewing the themes is the fourth step and was achieved through understanding if the theme fits with the entire data set. The fifth step is labeling themes, which included deciphering what belongs under each of them and what does not. The sixth step is identifying exemplars, which requires selecting examples that convey the message of the theme.Following the six-step process, a codebook was co-created by my supervisor and me. A codebook was created to provide a guide for coding responses from participants. Potential codes and themes were selected after each focus group and were narrowed down until they were clearly defined. The initial coding of the transcripts was completed on NVivo. However, coding was finalized by moving to manual printouts and referring to the physical copies of the transcripts. This was done to zero in on the themes that are further outlined in the results section.

Results

The purpose of this study was to identify the impact of social context on the sexual health of young ACB women. This work is influenced by the theories mentioned above: CRT and Intersectionality. Another goal of this project was to provide a space for young ACB women to discuss their experiences navigating sexual health and to allow participants of a similar background, who do not know each other, to engage in discussions and enable fresh opinions to form (Padgett, 2012). In each of the two focus groups, participants had candid conversations regarding their sexual health and lived experiences as ACB young women in the GTA.

Participants identified four significant themes that represent their narratives of navigating sexual health. The themes were: perceptions and hypersexuality of Black Women's bodies, navigating sexual double standards and gender roles as Black Women, diverse blackness, and experiences of migration concerning sexual health and surveillance on Black women's bodies.

The themes emerged from the codebook and subsequent analysis. Each theme and subtheme will be explored in further detail in this section.

Perception and Hypersexuality of Black Women's Bodies

Perceptions of Black women's bodies. Participants discussed how Black women's bodies are perceived and imagined as not feminine and worthy of protection in the way white women's bodies might be, and they spoke to the implications of this in health care settings.

> One young woman said:
>
> It almost feels like Black women's bodies are not seen as something to take care of, and to nurture, and to handle in a safe and caring way... You know it's not this promiscuous, tough, rough sexualized image of Black women. We are also mothers and sisters. Putting those images out, maybe when we do go to the doctors or healthcare providers, we will be given respect, we will be treated more kindly, and we will be listened to. And, maybe putting those images out will help with that too. (Focus Group 1)

This quote speaks to the narratives surrounding Black women's bodies. The young women also mentioned that Black women are more than just their bodies, that Black women have multiple roles, such as being mothers, sisters, and lovers, and are fully human. These sentiments were echoed throughout the focus groups. Participants also spoke about their bodies and decisions around their bodies not being their own. Young Black women also talked about the lack of autonomy that Black women often feel regarding their bodies. Another young woman said:

> First off, I'd like White men to stop making decisions about my Black female body, but in addition to that, I'd like just once to walk into a conversation and have that start with you know whatever you tell me, I'm going to believe you. And, I'm going to work with you to find out a solution. It's not on you to fight to advocate for yourself, to beg for a service or to beg for support. This is us together, going on this journey. I think that as a starting point would change a lot of conversations. (Focus Group 1)

This quote echoes the opinions of the participants that Black women do not get to make decisions about their bodies. It also speaks to the need to take Black women's needs seriously

and to create solutions working with Black women. Many times throughout the focus groups, the young women spoke of their feelings and experiences being invalidated by a larger society. This is echoed through the need for Black women to continually have to advocate for their health and access to related services and supports. Notably, participants also discussed the perceptions of their sexualities and associated sexual health of Black women.

Hypersexualization of Black women's bodies. Participants also spoke about the hypersexualization of Black bodies through various outlets, including the media. They spoke to how the mainstream representations of Black women and their bodies have led to stigma when accessing health services. One participant noted:

> I feel like with this stigma that Black women face that's mostly based on how Black women are seen in many different ways, in the media, everyday lives. Black women are stigmatized to be viewed as women that are very sexually active, and I guess sexually expressive, and they're comfortable with pregnancy… they'll [doctors]automatically assume you are pregnant, you have an STD because of the things that they see outside of the world with regards to Black women. (Focus Group 2)

This quote outlines how the stigma about Black women and their sexuality has led to the assumption that Black women are more likely to have STIs and be pregnant. The discussions in the focus groups often spoke to how Black women were often misdiagnosed due to the assumptions about Black women's sexuality. The young women also spoke of self-policing their way of dress and behaviours to prevent the perception of being a hypersexual being.

One participant said:

> … the double standard, I find that too, it comes from a place of fear, women, Black women especially are sometimes hyper-sexualized. My mom specifically is very cautious about like what are you wearing, what are you saying, who are you talking to, because people are not just going to paint you as a sexual person. They'll paint you as a Black sexual woman, and that is somehow worse. I find that sometimes, even if I wanted to express my sexuality, I couldn't because it would be perceived as being promiscuous or not that even being promiscuous is a bad thing. (Focus Group 1)

This quote outlines the hypersexualization of Black women's bodies coming from a place of fear. This participant spoke about how their mother wanted to protect them from being labeled as a sexual being at a young age, and how the repercussions of this labeling are negative. This quote also speaks to how Black women are judged more harshly than their white counterparts in terms of expressing their sexuality.

Navigating Sexual Double Standards and Gender Roles as Black Women

Sexual double standards. Participants discussed how men and women are held to different standards in regard to sex and sexuality. They spoke about how men in their lives were educated about safe sex and where to access condoms, whereas they, as young women, were advised against having sex or participating in sexual activity. One young woman said:

> …my parents are of an African background too. With my mom, it was always don't have sex. It was never, why, and this is how, it was always don't do it, don't get pregnant type of thing. I do remember one instance where she spoke to my brother, and she was asking him if he knows about condoms and stuff and where to get it. I think a lot of it too is the double standards, where it's okay for a boy child, it's okay as long as he is using condoms, but daughters cannot have sex. (Focus Group 1)

This quote showcases the stark differences in how women and men are socialized to think about sex. The men are permitted to have sex as long as they are using condoms, but the young women are shamed in discussions about sex. Participants also spoke about how it is not just a generational holdover and that their partners also believe in upholding the same standards for their male children. Another young woman said:

> Even now, even talking to my boyfriend, the same thing. He's like, no, we have a daughter, we can't have any boys come over but if it's the son, yes, you know, give them some condoms. I'm just like why the double standard. I think that's part of it too. (Focus Group 1)

The quotes above both showcase the dichotomy that exists between men and women regarding sexuality and sexual health. Participants noted that men were permitted to talk openly about sex

and to have sex; however, with young women, sex was viewed as taboo and not a topic of discussion. These gendered double standards also relate to the gender roles that exist between men and women. Also to the lack of information about sex and sexuality made available to young ACB women.

Gender roles. Along with double standards related to gender, young women also spoke about the pervasiveness of gender roles in their everyday lives. They spoke of the societal pressures of being a young Black woman, and the expectations to seek marriage and to be the 'ideal woman' for a partner. One young woman said:

> I also feel it's the transition of life in university. I thought that was my time to have fun and be myself and do all these crazy things, but then, when you graduate, I'm adulting... This is what I shouldn't do. I should look for a husband…And, then, even ideals of relationships, he wants me to be this or she wants me to be this or I should please them this way by doing this. Yes, I think that's a huge issue too with health, sexual health if you want protection, but you don't want to make your partner feel uncomfortable, or if you're having a battle between that, you could be health-conscious and your partner. (Focus Group 1)

This quote exemplifies the young women's feelings toward traditional gender roles, in which they felt that their time to have fun was during their post-secondary education. However, as soon as that ended, they were expected to become adults and to seek the ideals of relationships. This quote also speaks to the gender dynamics within sexual relationships, in which women feel they cannot negotiate condom use because it would appear that they do not trust their partners. Participants also noted that, in many relationships with male partners, there was a dynamic that did not allow for negotiation, especially condom negotiation within heterosexual relationships. This dynamic was exacerbated when the male partner provided financial support.

One young woman noted:

> Most of it, it's small things, and then, it works itself up to bigger things and situations but still at the end of the day, if you're forced to do something in exchange for something else, then that is still a level of prostitution, and I feel a lot of the youth don't understand

> that. You're so lucky, he does X, Y, Z or you know right after, he's not giving me $300, but it's not a real, platonic relationship. This is happening; you're doing in exchange right. The different levels of it. (Focus Group 2)

Participants also noted that traditional Western gender roles were very much enforced in their daily lives. The quote above signifies that in a heterosexual relationship, when the male partner provides financial support, it is often seen as a romantic gesture. However, participants made mention of the lack of power that comes with such relationships, and that in turn affects negotiation, especially in the realm of sexual health.

Surveillance of Black Women's Bodies

Participants also reported their Black bodies being watched continuously and surveilled. Participants spoke about their experiences of being over-monitored, either covertly or overtly, in their daily lives. This caused young women to feel like they were being judged more harshly than their non-racialized counterparts. One young woman said:

> I don't know. I feel when it's with people that are not necessarily my race; I feel it's a different kind of judgment versus if it's the ones that are kind of in the same culture. I don't know, that sounds kind of contradictory, but at the same time, it's you know what I mean. It sounds contradictory; I feel more comfortable around people that look like me versus to be judged by people that have no idea of what's going on. (Focus Group 2)

This quote showcases the general observations made by the participants. They felt more comfortable with people who were of the same race as opposed to someone of another culture. The young women felt the judgment from others outside of their race was harsher. The overall sentiment was that they would rather be judged by someone who looked like them than someone who did not. However, some participants did note that there were privacy concerns when meeting with someone who was of their same ethno-racial background because of the chance that their personal information would get back into the community. One participant noted:

> I feel if it's people of the same culture, I'd be more hesitant. If it were a different culture, I'd probably be more open a little bit more. I don't know. Some people give you that look or demeanour, and you look like every single auntie. (Focus Group 2)

Both quotes signify that no matter where Black women are, they are constantly surveilled and watched by people who look like them and people of other races. This makes it difficult for young Black women to access services and information regarding sexual health.

Diverse Blackness and Experiences of Migration concerning Sexual Health

Participants also spoke about how the Black community is often viewed as a monolith. However, within the Black community, there are many different social locations and contexts. The common thread connecting participants was their Black identity. However, there is diversity in Blackness. One young woman said:

> The fact that although we're all Black folks in this room, there are different experiences of Blackness based on country of origin, culture, where you're situated, how long you've been situated in Canada, all of those things I think matter a lot. (Focus Group 2)

This quote explains Blackness in Canada. Black people in Canada come from different cultural experiences, immigration experiences, and ethnic backgrounds. Often this is left out of the conversation of Blackness and who is considered Black. The experiences of every Black person differ based on their lived experience, and it is essential to acknowledge this. This also highlights Black women's full diversity, as well as being diverse in our humanity. Black women cannot be compartmentalized and lumped into categories.

Participants spoke about their experiences with sexual health based on their familial origins. One young woman said:

> My experience is very different because my mom was the first woman in my family to be born in Canada, and she takes great pride in that. I am half Trini, half Jamaican. I was encouraged to explore myself... I think it's, there's a big difference when our family comes from the country, rather than just being born in Canada. (Focus Group 1)

This quote speaks to the experience of the young woman being very different than other Black women in the room because she came from a family where her mother was born in Canada. This makes her experience with learning about sexual health much different than young women who are newcomers or have first-generation immigrant parents. This quote does not signify that people born outside of Canada have less knowledge on sexual health. It explemifies that people who come from other cultures may not feel as comfortable speaking about sex and sexuality due to culture and religion.

Discussion

The results of this study demonstrate that there are diverse experiences of Blackness in the GTA, and these experiences often impact young ACB women's experiences of gender roles, which are dictated by the larger society, perceptions of Black women's bodies, and surveillance of Black women's bodies. All themes work together to shape how young ACB women navigate sexual health.

Participants spoke to different Black experiences based on migration and positionality. Participants expressed that, often, Blackness is seen as a monolith, and that all ACB people are assumed to have similar life experiences regardless of migration stories and positionality. Existing sociological research on Black identity does not discuss the nuances of being Black in North America (Dei, 2018). Place of birth, social class, migration story, and/or multiracial origins all impact experiences of Blackness. Research that focuses on Black identity often fails to focus on sociocultural identities (Charles et al., 2015). Additionally, a study conducted on first and second-generation African and Afro-Caribbean immigrants suggests that they do not

consider themselves culturally homogeneous with Black people born in North America or multigenerational Black people. Hence, they have different notions on what constitutes the Black identity (Charles et al., 2015; Johnson, 2016; Warner, 2016; Waters, Kasinitz & Asad, 2014). This study contributes to the literature in that it explicitly addresses the complexity of being Black within the context of sexual health. Based on the diverse experiences of ACB young women, their experiences navigating sexual health can, accordingly, be very different.

Given the framing of gender in the Western context, it is essential to note that these findings are rooted in heterosexuality and patriarchy. It is also important to note that colonization has impacted the conceptualizations of gender that are observed in the West. How gender is framed may differ when speaking to communities that view gender as more holistic. Research surrounding gender roles and Black women's sexual health is scarce. One of the issues is that studies on this topic rarely included the narratives of Black women. When sexual double standards are discussed, the focus is on mainly on white women (Fasula, Carry & Miller, 2014). Black women's experiences are very different as they face multiple layers of social oppression due to gender, race, and class.

Participants discussed how gender roles impact the ways young Black women are expected to uphold society's standard of seeking marriage and reproducing offspring. Attitudes and behaviours toward sex are often based on culturally and societally determined gender roles (Nguyen et al. 2010). Gender norms influence what is deemed appropriate for men and women's social and sexual interactions. Feminine gender role expectations may lead to a lack of communication about sex and sexuality. This is also rooted in patriarchy, which means that it may lead to young women compromising their needs and boundaries. The assertive masculine role and the passive feminine role, which is present in heterosexual gendered sexual dynamics, is

exacerbated by race. Young Black women often navigate between embracing and rejecting perceptions of Black womanhood (Collins, 2000). This means that Black women often work hard to liberate themselves from negative stereotypes imposed on them in a society that usually does not value Black womanhood.

The perception of Black women's bodies was discussed during the focus groups. Participants expressed that Black women's bodies are often not treated as worthy of protection or care. Perceptions of Black women as undeserving of protection are deeply rooted in the fabric of North American society and culture. This is showcased through early laws, such as practices that did not punish the sexual violence that occurred against Black women (Gross, 2018). It is also important to note that the perception of Black women's bodies as 'masculine' dates from slavery, because 'strong' Black bodies could produce more from hardship and labour. This construction informs modern-day perceptions of Black women's bodies (Slatton, 2012). This impacts Black women by influencing when or how health services and supports are both sought by and offered to them (Andrews et al., 2016). The findings of this study support the perceptions of Black women's bodies as unworthy of protection and nurturing.

Participants expressed that women are often told not to have sex and are not given the proper tools to talk about their sexuality. Then, they are further shamed, stigmatized, or judged for having an interest or engaging in sexual behaviours. Existing research supports this; although men are afforded power to have open discussions about sex, women are deemed responsible for the sexual interactions and any unintended consequences such as pregnancy (Fasula, Miller & Weiner, 2007). Men are able to talk openly about sex, and discussions are often had without judgment and shame. Still, with young women, conversations around sex often revolve around shame and fear about virginity loss and pregnancy. Similar to previous research, the sexual

double standard is often reinforced by parental figures, namely mothers (Axinn, Young-Demarco & Ro, 2011). Mothers take a more proactive role in their sons' sexuality and a more restrictive approach to their daughters' sexual health. Sons were often encouraged to buy and carry condoms, whereas daughters' sexual risk reduction attempts were often met with shame and judgment. Previous research discusses how the socialization of men and women with regard to sex and sexuality may affect their ability to protect themselves from sexual risk.

In keeping with the theme of gender roles, participants also noted that women entered transactional sexual relationships because men were financially supporting them, and this often influenced their decisions regarding sexual negotiation and relationship-seeking. This finding corresponds with the "Let's Talk About Sex for Money" study conducted by Wilson and Flicker (2017). The study found that young Black women often faced sexual objectification and low self-esteem, which led to some young women becoming financially dependent on their partners. This points to a lack of sexual autonomy, which made it harder to negotiate safer sex practices.

Gender roles and sexual double standards impact the hypersexualization of Black women's bodies. Participants spoke of the perception of Black women's bodies as overtly 'sexual', and how that can lead to being misdiagnosed with STIs and being denied proper health care. Current stereotypes of Black women as 'hypersexual' stems from historical representations that emerged from the past. These stereotypes of Black women were utilized to justify the enslavement of and sexual violence against Black women (Prather et al., 2016). Bernard (2016) states that, in our contemporary society, white women, especially middle-class white women, are allowed to openly explore their sexuality in ways that Black women are not able to. This often results in Black women being defined by their sexuality. The perceptions and stereotypes of Black women's bodies, if unchallenged, become preconceptions and generalizations that negatively

affect Black women when faced with difficult situations in their daily lives, such as when accessing services. This study contributes to the literature around perception and hypersexualization of Black women's bodies through the discussions of how these social constructs affect their ability to navigate sex and sexuality. Due to the perception of Black women's bodies, participants expressed frustration that they were always being judged and surveilled by the larger society when accessing services and supports.

Participants felt strongly that their actions and behaviours were monitored and subjected to more scrutiny than their white counterparts. Also, there is evidence that proves that Black bodies are disproportionately targeted by surveillance mechanisms (Gross, 2018 ; Maynard, 2017 ; Leonard , 2009). In *Dark Matters*: *On the Surveillance of Blackness*, Simone Browne examines surveillance of Black bodies by examining the ways that surveillance technologies and practices are racialized and impact racialized bodies. Browne (2015**)** explains that surveillance historically and presently operates through the "white gaze" and discriminately targets the Black body. However, there is a lack of research that explicitly discusses Black women's experiences of surveillance while accessing sexual health services. Yet, though they might not be surveilled in these spaces, ACB young woman may feel they are because they grow up in a context where they are being watched or expected not to engage in sexual activity. This finding is consistent with the "Let's Talk About Sex" (2011) study, in which young Black women discuss their unwillingness to access condoms in public spaces, such as community health centers or at convenience stores, because they consistently feel like they are being watched and scrutinized. It is essential to note that the surveillance "gaze" becomes internalized so that Black women end up navigating the world based on the feeling of being under constant surveillance. They might be

surveilled by others, but they also might end up surveilling themselves because of the internalized gaze.

From the data collected, there is strong evidence of each of the themes under discussion. Participants reported that Black women were often perceived as being 'stronger' and less feminine than their white peers. Participants expressed that Black women are perceived as overtly sexual, which often impacts their ability to access sexual health information and services. Due to the stereotypes surrounding Black women, the participants often felt as though they were surveilled and judged more harshly than their peers. This also tied in with the elements of sexual double standards, which defined Black women's sexuality as negative compared to Black men's. Overall, it was determined that Black women's sexuality was often judged more harshly than that of non-racialized women and men. Black men often experience the effects of racism and white women often experience sexism; however, Black women experience both due to their intersectional identities. The findings are nuanced as participants acknowledged that their experiences with navigating sexual health differed based on their experiences of Blackness.

Limitations

Though this research study contributes to the literature on ACB women and sexual health, there are a few limitations that should be mentioned. The research study is centered on the discussion of sexual health and sexuality, which is a sensitive and highly stigmatized topic for many young people. Though there were several methods employed to allow open discussion, the young women might have felt censored and uncomfortable to speak about issues related to sexual health. Another limitation is the fact that there were only two focus groups; more focus groups might have elucidated other topics and themes. The use of convenience sampling also provides another limitation to the study. Due to the fact that participants would have been from

my personal networks or easily accessible. This would have largely left out the voices of those most marginalized. For example, ACB communities who live in rural areas would not have been accessed for the study. The large age range of participants also provided another limitation. There were obvious power dynamics because of the age make up. In order to give the younger women space to also share, I often steered the larger conversation in their direction and allowed them to have space to speak. Also, this study did not encapsulate the perspectives of ACB youth that identify as sexual and gender minorities because the term "woman" may eliminate specific candidates. This limitation may prevent ACB women of diverse gender identities and sexual orientations from engaging in the study. Lastly, a glaring shortcoming is the exclusion of Black queer and trans women in this study. Though multiple attempts were made to have a comprehensive study, the study is very heteronormative and cisgender.

Conclusion

This article contributes to the scant literature that examines the sexual health promotion of ACB young women in Canada. The goal of this article was to provide a narrative outlining the social contexts in which ACB young women navigate sexual health. By doing so, it fills a gap in previous literature by adding an in-depth perspective on the social factors that affect young Black women's experiences navigating sexual health. The results of this article are relevant because they highlight the importance of understanding the social factors that shape the lives and sexual health of many Black young women. As evidenced by the findings of this study, there are multiple layers of oppression that young Black women face, which impede their ability to navigate sexual health and sexuality safely. Young Black women often have to navigate their sexual health while feeling judged or surveilled due to the perceptions of Black women's bodies and sexuality.

Health care providers, particularly those who work in sexual health, are in the ideal position to address the concerns voiced by the young Black women in this article. One of the most relevant findings of this study is that young Black women felt that, within health care settings, their bodies were not viewed as feminine or as worthy of protection as their white counterparts, and that this often led to judgement and/or scrutiny. However, health care providers and health organizations can provide tangible solutions to these concerns. The first would be to explore alternative routes of sexual health provision through having spaces that are not surveilled. This would enable young Black women to access these services without fear of being judged or scrutinized. Secondly, health care providers can work with young Black women and their communities to develop and implement comprehensive sexual health programming that address power and gender dynamics. Another important finding to reiterate here is that young ACB women feel safer in spaces with Black providers and staff. This highlights the importance of all- Black spaces. This would provide young Black women with space to be involved in decisions and programming regarding their bodies. Lastly, programming and interventions should be developed that focus on larger social and contextual factors that affect Black women rather than focusing solely on HIV prevention. These programs and interventions should also speak to the full diversity of Black women.

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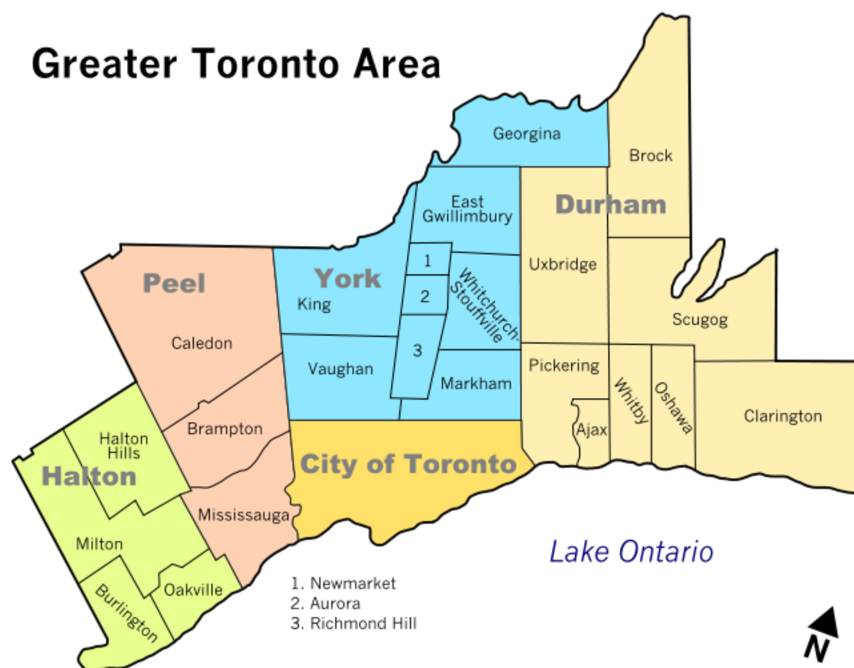
Appendix A
Greater Toronto Area



Appendix B.
Focus Group Guide

Create comfortable environment.
Introduction of Research Coordinator
Welcome participants.
Overview of the topic.
Ground rules.

1) When I say the word sexual health, what comes to mind? What does sexual health mean to you?

   What does your sexual health include?

2) What are the most important sexual health issues facing young, Black women in the GTA? What are the pressing issues?

   Probe : Can you explain why these issues might be occurring? What is at play?

3) When you think about safe spaces, places and people to talk about sexual health - who/where/what is included in that list? Where do you go to discuss your sexual health?

   4) When you think about safe spaces, places and people to talk about sex?

   Probe : School, friends, parents ?

6) What about STIs and HIV/AIDS?

7) What sexual health programming is available to you to discuss these issues of sex, sexual, STI's etc.?

8) Where do you go for sexual health services ? Probe: Why do you go there? What prevents you from going to certain places?

9) How would you improve the state of sexual health programs available to Black youth? What would you change/include etc.? What kind of sexual health programs or campaigns would be useful for Black youth like yourself?

10) About HIPTEEns Intervention - describe HIPTeens and probe about what would be useful and NOT useful about such an intervention. What needs to change to improve it to make it relevant to Black youth?.

11)How would you like to receive information on sexual health?

12)What is the best way to engage ACB youth and get them involved in sexual health issues?

13)Any final comments about sexual health and how it affects us as Black women?

Appendix C.
Demographic Survey

1. How old are you?

    ____

2. What is your sexual orientation (heterosexual, lesbian , bisexual, queer, etc):

    ____

3. What is your martial status?

    ____

4. What area in the Greater Toronto Area do you reside in?

    - Durham Region
    - Peel Region
    - York Region
    - City of Toronto
    - Halton Region

5. Do you know where to access sexual health services in your respective region?

    - Yes
    - No

    5b. Explain

    ____

    ____

6. Have you accessed sexual health services in your respective region?

    - Yes
    - No

    6b. Why or why not

____

____

7. Where are services/places you can access sexual health information and resources in the GTA?

____

____

____

8. What are some of the most important sexual health related issues faced by African, Caribbean, and Black (ACB) youth in the GTA?

____

____

____

9. What are some of the most important elements of effective sexual health programming and information for ACB youth?

____

____

____

10. How would you improve existing sexual health programing for ACB youth?

____

____

____