

Exploring Black-Canadian Parent-Youth Sex Communication

By

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DEDICATION

This thesis is dedicated to my mother who inspires me to be the best that I can be each
and everyday

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GLOSSARY OF TERMS

African heritage: African heritage refers to individuals who are of African descent.

Afro-Caribbean heritage: This term refers to individuals who are of African descent originating from the Caribbean.

AIDS: Acquired Immune deficiency syndrome (AIDS) refers to the signs, symptoms, and medical conditions that arise from HIV infection.

Black: Black refers to individuals who are of African descent.

Black-Canadian: Black-Canadian refers to individuals living in Canada who are of African-Caribbean and African heritage

Christianity: In this thesis Christianity refers to Catholic, Protestant, Christian Orthodox and Christian ministries.

HIV Endemic countries: Endemic countries refer to countries in Africa, the Caribbean and Asia which have an HIV prevalence rate of 1% or higher amongst those aged 15- 49 years and one of the following; a male-to-female ratio of 2:1 or less among HIV infections; HIV infection rate greater than or equal to 2% among women receiving prenatal care; or 50% or more HIV cases are due to heterosexual transmission.

HIV: Human Immunodeficiency Virus (HIV) is a virus that weakens the body's immune system's ability to fight infections.

Parent(s): The term parent refers to biologically or non-biologically related individuals who play an active role in the upbringing of youth.

Peers: Individuals belonging to the same age, social or ethnic group.

School-based sexual health education: Also known as sex-ed, school-based sexual health education refers to sexual health education courses provided by both Canadian elementary and high schools.

Abstract

Black-Canadian populations are disproportionately affected by HIV/AIDS. In particular, Black-Canadian youth are noted to be at a greater risk of HIV infection due to their sexual risk behaviours. Many international studies indicate that open parent-youth sex communication may counter the potentially negative impact of peers, mass media and inadequate sexual health education programs on youth sexual risk behaviour. However, there is a paucity of Canadian studies on Black-Canadian parent-youth sex communication and ways to enhance this communication. As such, a qualitative based exploratory study was conducted using a community based research approach to determine the state of Black-Canadian parent-youth sex communication in Toronto, Ontario. Data was collected through 17 Key Informant interviews; that is individuals who work in Black Toronto communities and are knowledgeable about the subject matter. The results noted several factors which affect Black-Canadian parent-youth sex communication such as religion and cultural taboos surrounding the discussion of sexual health. The impact of these factors along with potential implications of this study on Black-Canadian populations and recommendations to enhance Black-Canadian parent-youth sex communication are discussed.

Keywords: youth; Black-Canadian; HIV; sexual risk behaviour; parenting; parent-child sex communication

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CHAPTER 1

INTRODUCTION

This chapter presents the findings of an exploratory study focused on determining the current state of Black-Canadian parent-youth sex communication in Toronto, Ontario. As such, a detailed account of the study, participant recruitment methods, data analysis and recommendations will be presented. In order to place the significance of this study into perspective, an overview of the state of Black youth sexual health will be discussed below.

Approximately half of the estimated 33 million people living with human immunodeficiency virus (HIV) and/or acquired immune deficiency syndrome (AIDS) reside in Africa with the second highest HIV/AIDS prevalence originating in the Caribbean (Global HIV epidemic, 2008). Globally, youth aged 15-24 years account for 45% of all new reported HIV infections (United Nations Children's Fund (UNICEF), 2009). In Canada, 21% to 23% of all HIV infections reported from 1998 to 2008 were from individuals aged 15 -29 years (Public Health Agency of Canada (PHAC), 2010a).

Black-Canadian populations are particularly vulnerable to HIV/AIDS as these populations have a greater number of youth aged 15-24 years than the general population, have disadvantageous levels of social determinants of health, and many are recent immigrants from HIV/AIDS endemic countries (PHAC, 2009). Social determinants of health refer to a number of factors that impact an individual's health and well-being. Some of the social determinants of health include income, lack of access to culturally relevant health services, racism and housing (PHAC, 2009). While there are a substantial number of Black individuals with HIV who are recent immigrants, between 20-60% of

Black immigrants may be infected in their post-migration to Ontario (Remis, Swantee, Schiedel, & Liu, 2007).

A positive HIV/AIDS diagnosis in Black Canadian populations often occurs before the age of 40 years (PHAC, 2009) which falls within the age range (15 to 49 years) of individuals' most productive period of life (Daly, 2000). According to the Public Health Agency of Canada (2010a) sexual risk behaviours are noted as one of the factors that leave Canadian youth vulnerable to HIV infection. Sexual risk behaviours refer to sexual related activities such as less condom use and multiple sex partners (Pettifor et al., 2011) that increase an individual's chance of pregnancy and sexually transmitted infections (STIs).

The negative sentiments many Black Canadians with HIV/AIDS face within their own communities coupled with an unwillingness to access health care facilities due to fear of racial discrimination may prevent them from seeking medical care. Further, lack of transportation may also pose a barrier to medical treatment for many Black Canadians with HIV/AIDS (Cox, Scharer, Baliko, & Clark, 2010; Gardezi et al., 2008). As the signs and symptoms of HIV can be very mild or nonexistent, most HIV positive individuals are unaware they have become infected (UNAIDS, 2008). Further, an HIV-infected person is extremely infectious during the first six weeks post-infection and may unknowingly put others at risk for infection (Cox et al., 2010). If left untreated, the time between HIV infection and the manifestation of AIDS is approximately 10-15 years (UNAIDS, 2008). Due to the length of time that can elapse between HIV infection and the manifestation of AIDS, many older adults in Canada may have been infected with HIV at a young age (PHAC, 2010b). Some North American studies note that one of the factors which place

Black youth at a greater risk of infection is the initiation of sexual risk behaviours at an earlier age than their non-Black peers (Bachanas et al., 2002; O'Donnell, Myint, O'Donnell, & Stueve, 2003; O'Donnell, O'Donnell, & Stueve, 2001). Further, other factors such as peers and mass media can negatively influence youths' perception of sexual activity, thereby increasing their risky sexual behaviours (Boyce et al., 2006; Busen, Marcus, & vonSternberg, 2006; Jaccard, Blanton, & Dodge, 2005; L'Engle, Brown and Kenneavy, 2006). However, the impact of these factors on youths' sexual activity may be countered by HIV education in the form of HIV intervention programs.

Some HIV intervention programs have been shown to reduce sexual risk behaviours (Hayes et al., 2005; Kirby, Laris, & Roller, 2007; Mueller, Gavin, & Kulkarni, 2008) as well as peer (Kirby et al., 2007) and mass media influence on youths' perception of sexual activity (Pinkleton, Austin, Cohen, Chen, & Fitzgerald, 2008). Participants who received HIV/AIDS education through schools or health care organizations were more knowledgeable, willing to wear condoms, and reported fewer sexual partners (Kirby et al., 2007; Mueller et al., 2008; Villarruel, Jemmott III, & Jemmott, 2006). However, most of the effects of these programs only lasted a few months (Kirby et al., 2007; Villarruel et al., 2006).

Parental communication has been found to be an integral component of youths' sexual health education (Caron et al., 2004; Klein et al., 2005; Roberts, Foehr, & Rideout, 2005) and is an extremely cost effective way to deliver sexual education to youth in a culturally relevant (Eisenberg, Sieving, Bearinger, Swain, & Resnick, 2006) and age appropriate fashion (Eisenberg et al., 2006; Robert, & Sonenstein, 2010). Studies have shown that parent-youth sex communication can influence condom use (DiClemente et

al., 2001; Whitaker, & Miller, 2000), delay sexual activity (Aspy et al., 2007), and cause youth to be more resistant to peer influence concerning their sexual behaviours (Whitaker, & Miller, 2000). Sexually active youth with open lines of communication with their parents were more likely to use contraception such as birth control (Aspy et al., 2007) and feel more confident negotiating condom use (DiClemente et al., 2001). While there are a number of U.S. based studies that address parental communication there is a paucity of Canadian research which addresses parental communication. In particular, no Canadian research has specifically reviewed Black-Canadian parent-youth sex communication. Thus, the aim of this study is to explore the state of Black-Canadian parent-youth sex communication in Ontario using a community based research approach. This approach involves working together with community members and agencies to develop and implement the study as well as to analyze the study findings. This study will focus specifically on Black populations in Toronto, Ontario. As such, the objectives of this study are to explore the main challenges Black parents and youth face in discussing sex, dating, relationships and HIV; the role of male versus female parental gender in the dynamics of communicating health and sexuality information to daughters and sons; whether there are differences in sexual behaviour related to parental communication by ethnicity and religion; and the sexual health education needs of Black parents and youth.

CHAPTER 2

LITERATURE REVIEW

This literature review presents an overview of the factors which influence youths' sexual risk behaviours. First, the impact of parent-youth sexual communication on youths' sexual risk behaviours will be reviewed. Second, the impact of gender on sexual risk behaviours will be assessed. Third, the effect of parental and youth gender on parent-youth sex communication will be discussed. Fourth, the efficacy of parent-youth sexual intervention programs will be examined. Finally, the effects of peers, mass media and school-based sexual education programs on youths' sexual risk behaviours as well as teen pregnancy and STIs will be explored.

Parent-youth sexual communication

Youth sexual risk behaviours can be impacted by the quality and quantity of parental communication and the parent-youth relationship (Aspy, 2007; Cox et al., 2010; Dilorio et al., 2000; Huebner, & Howell, 2003; Hutchinson, J. Jemmott, L. Jemmott, & Braverman, 2003). Parents who discuss specific contraception methods, the consequences of sex such as STIs and unplanned pregnancy are more likely to have youth who delay sexual activity (Aspy et al., 2007; Baptiste et al., 2006; Cox et al., 2010; DiClemente et al., 2001; Dilorio et al., 2000; Hutchinson et al., 2003; Li, Feigelman, & Stanton, 2000; Robert, & Sonenstein, 2010; Romer et al., 1999) and lead those who are sexually active to use condoms as well as additional contraceptive methods (Baptiste et al., 2006; DiClemente et al., 2001; Dilorio et al., 2000; Hutchinson et al., 2003; Li et al., 2000; Romer et al., 1999). Moreover, increased parental communication has been linked to greater self-efficacy for condom use and refusal of sex (DeVore, & Ginsburg, 2005).

High self-efficacy for condom use is linked to regular condom use. Self-efficacy refers to the degree to which an individual believes in their own ability to carry out a specific behaviour (Sayles et al., 2006). Conversely, a lack of parental communication has been found to reduce female youths' condom use and safe sex discussions with a male sex partners (DiClemente et al., 2001).

The level of parent-child closeness also impacts sexual risk behaviour. Youth whose parents actively participate in their lives tend to have less sexual partners (Eisenberg et al., 2006) and unprotected sexual intercourse (Hutchinson et al., 2003). For example, Warren-Jeanpiere (2006) noted that Black-American female youth who have a close relationship with their mothers are more positively impacted by mother-daughter sexual health discussions compared to female youth who do not have a close relationship with their mothers.

Gender and sexual risk behaviours

Over 50% of the global population that is HIV positive are women and girls. In areas like sub-Saharan Africa, women 15-24 years are up to eight times more likely than men to be HIV positive (UNAIDS, 2010). In the U.S. the rate of HIV infection among Black women is 14.7 times greater than the rate for White women whereas the rate of HIV infection among Black males is 5.9 times greater than the rate for White men (Centre for Disease Control, 2008).

Peer and non-peer reviewed articles show a similar disparity level in HIV infection among Black men and women in Canada (PHAC, 2010d; Robertson, 2007). In Canada, one of the groups most affected by HIV are young women aged 15-19 (PHAC, 2010c). HIV positive test reports from 1998 to 2008 found that 6.6% of Black males and

18.8% of Black females tested positive (PHAC, 2010d). Similar findings were noted in Black populations in Ontario; the province in which this study is located. From 1981 to 2004 it was noted that Black men accounted for 7.4% of all AIDS cases while Black women accounted for 38.5% of all AIDS cases in Ontario (Remis, & Liu, 2006).

The disproportionate rate of HIV infection among Black-Canadian women in Ontario highlighted in the statistics can be attributed to a number of factors. Most Black-Canadian communities rarely acknowledge the presence and risk of HIV infection in their communities (Gardezi et al., 2008; Roberston, 2007; Williams et al., 2009) thereby giving many Black-Canadian women a false sense of security. This may cause Black-Canadian women to have a low level of sexual health awareness (Roberston, 2007) and knowledge concerning the principal mode of HIV exposure (Williams et al., 2009). Factors such as vaginal practices and female genital mutilation found in some Black cultures may also increase women's risk of HIV infection (Brady, 1999; Branstein, & Van Wijgert, 2005; McClelland et al., 2006; Myer et al., 2004). Vaginal practices refer to practices such as wiping the vagina to remove vaginal fluids, douching, intravaginal insertion of liquids such as water, cleansing or medicinal products and inserting herbal or non-herbal preparations to narrow or tighten the vagina (Braunstein, & Van Wijgert, 2005; Janneke et al., 2008; McClelland et al., 2006; Myer et al., 2004). Female genital mutilation refers to procedures that involve the partial or complete removal of external female genitalia or other injury to female genital organs for non-medical reasons (World Health Organization (WHO), 2010).

In addition to the physical characteristics of women, the dynamics of intimate relationships in Black-Canadian communities can also place Black-Canadian women at

risk of HIV/AIDS exposure. Young Black-Canadian women are more likely to practice unsafe sex in heterosexual dating relationships and use sex as a way to develop their relationships than their older Black female peers (Newman, Williams, Massaquoi, Brown, & Logie, 2008). Further, poverty and economic dependency especially among many of these women may lead them to engage or remain in unhealthy relationships (Newman et al., 2008). The lack of financial resources may lead to a greater dependence on their partner and reduce Black women's effectiveness at negotiating safe sex and/or monogamy (Williams et al., 2009).

Although there is a lack of Canadian articles that specifically review Black-Canadian youth sexual orientation and HIV risk, a joint Canadian-U.S. study noted that gay, lesbian and bisexual youth are disproportionately impacted by HIV infection due to risky sexual behaviours (Saewyc et al., 2006). While the risk of female-to-female HIV transmission is low, many lesbian and bisexual female youth may engage in risky sexual activities with males which may expose them to HIV (Saewyc et al., 2006). In Canada, gay, bisexual and other men who have sex with men (MSM) are the sexual orientations most at risk of HIV infection. In particular, the risk of HIV infection among MSM has increased over the years (PHAC, 2010e) while the impact of HIV/AIDS on the gay community has decreased since the mid-eighties in Canada (PHAC, 2007). MSM have been noted to engage in risky sexual behaviours such as unprotected anal intercourse (PHAC, 2010e). In 2008 MSM accounted for the largest number of new infections at 44% and for 45.1% of positive HIV tests among adults (PHAC, 2010e). From 1980 to 2004, it was noted that 21.2% of Black individuals who tested positive for HIV in Toronto were MSM (Liu, & Remis as cited in PHAC, 2009).

Parental gender and parent-youth sex communication

A few studies indicate that parental gender impacts parent-youth sex communication (Aspy et al., 2007; Cox et al., 2010, Dilorio et al., 2000; Hutchinson et al., 2003). Studies have found mothers are more likely to discuss sex with their youth than fathers (Aspy et al., 2007; Cox et al., 2010, DiClemente et al., 2001; Dilorio et al., 2000; Kirkman, Rosenthal, & Fieldman, 2002; Hutchinson et al., 2003; Wilson, & Koo, 2010) and are often directly or indirectly given the responsibility to discuss sex with their youths by their male partner (Kirkman et al., 2002). Additionally, in terms of same gender (mother-daughter) and cross gender (father-daughter) parental communication, mothers are more likely to speak to their daughters than sons whereas the reverse is true for fathers (Dilorio et al., 2000; Kirkman et al., 2002). A study noted that fathers who spoke to their youths about sex spoke more to their daughters about dating and relationships than their sons (Wilson, & Koo, 2010). While limited research exists which specifically reviews the reasons which deter father-youth parental communication, it has been noted that mothers tend to feel more comfortable discussing sex with their youth than their male counterparts. This level of comfort may enable mothers to discuss sex more with their youth (Dilorio, et al., 2000). Additionally, the approach mothers and fathers use to discuss sex varies.

Both genders use a number of different strategies to discuss sex with their youth (Cox et al., 2010; Kirkman et al., 2002). A study which used focus groups to review mother-child communication themes about sex and sexual risk behaviour noted that Black-American mothers tend to use verbal and/or nonverbal communication to discuss sex with their youth (Cox et al., 2010). Conversely, another study noted that fathers who

speak to their youth about sex may use a lecturing or problem-solving approach (Kirkman et al., 2002). In particular, mother-daughter parental communication is more likely to incorporate factual and value-based information while father-daughter parental communication often focuses on passing on values rather than facts. As such, daughters tend to receive more information concerning sexual instruction than sons (Dilorio et al., 2000).

Many researchers have noted that Black parents who openly discuss sexual health with their youth positively impact their youths' sexual behaviours (DiClemente et al., 2001; Dilorio et al., 2006; Hutchinson et al., 2003). For example, a study found that infrequent Black-American parent-youth sex communication was linked to Black-American youths' non-usage of contraceptives in the last six months (DiClemente et al., 2001). It was also linked to less communication between youths and their sexual partners, the chance that contraceptives were not used in the past month and a lower self-efficacy to negotiate safe sex with their partners. Similarly, Ali, & Ajilore (2011) noted that Black youth whose mothers discussed sex were less likely to initiate sex at an early age compared to those who did not have sexual health discussions with their mothers.

Although the above mentioned studies noted the importance of Black parent-youth sexual communication on youth sexual risk behaviour, they did not discuss reasons why Black parents fail to discuss sex with their youth in detail (Archibald, 2007; DiClemente et al., 2001; Hoffman et al., 2008). Most studies which reviewed the significance of parental gender in parent-youth communication focused on mothers and their youth (Aspy et al., 2007; Cox et al., 2010, DiClemente et al., 2001; Dilorio et al., 2000; Hutchinson et al., 2003). Some studies which discussed father-youth sex

communication noted that this communication appeared to be lacking (Cox et al., 2010; Wilson, & Koo, 2010). The study which noted mothers may use verbal communication and/or nonverbal communication to speak to youth about sexual health did not discuss the impact of these two strategies on Black-American youths' sexual health knowledge (Cox et al., 2010). The studies that noted the benefits of parental communication did not explicitly review the contents of Black parental communication discussions and why it was not commonplace (Aspy et al., 2007; Cox et al., 2010, DiClemente et al., 2001; Dilorio et al., 2000; Hutchinson et al., 2003). While these studies indicate that parental gender does have an impact on parent-youth sex communication there is a lack of research which specifically focuses on Black parent-youth sexual health discussion and factors that prevent this discussion from taking place.

Parent-youth sex communication intervention programs

Although the literature indicates there are few Black parents who speak to their youth about sex (Anderson et al., 2008; Anderson, Elam et al., 2009), there are intervention programs that can support this conversation. As no Canadian based Black parent-youth sex communication intervention programs were found, several U.S. and international Black parent-youth sex communication intervention programs will be discussed. These countries were chosen as their Black populations share many cultural and social similarities as Black-Canadian populations, such as having recent immigrants from Africa and the Caribbean, and socially stressed racialized societies. These programs include the Collaborative HIV/AIDS Prevention and Adolescent Mental Health Project (CHAMP), the Mother/Daughter HIV Risk Reduction intervention (MDRR), Keepin' it R.E.A.L! And the Informed Parents and Children Together (ImPACT) paired with an

adolescent risk-reduction intervention called Focus on Kids (FOK). These programs were selected as each reflected commonly used techniques in parent-youth intervention programs and yielded similar results. Some of the programs such as ImPACT-FOK are part of the Diffusion of Effective Behavioural Interventions Project (DEBI) developed by the U.S. Centre for Disease Control. This project provides community-based service providers, state and local health departments with user-friendly kits of interventions that have shown positive behavioural and health outcome research results (Diffusion of Effective Behavioural Interventions, n.d.).

1. CHAMP: The Collaborative HIV/AIDS Prevention and Adolescent Mental Health Project (CHAMP) is a researcher-community partnership program that initially sought to address the rates of youth HIV exposure in urban minority neighbourhoods in Chicago. CHAMP's family interventions are developmentally grounded and focus on youth prior to and during their transition into puberty. It includes education and skill building activities to fortify family-level characteristics that relate to sexual risk behaviour, such as parental monitoring, discipline effectiveness, conflict resolution, support, and parent-youth sex communication frequency and comfort. Further, CHAMP teaches youth social problem-solving skills such as recognizing risks, refusal and how to effectively address sexual peer pressure.

The CHAMP program was implemented in South Africa, and Trinidad and Tobago (T&T) and these programs yielded a number of findings and recommendations. In both studies participating parents were mostly mothers. In the South African study a significant posttest difference was found in AIDS

transmission knowledge between the intervention and comparison group parents. Parents and youth in the intervention group noted an increase in the frequency in talking about sensitive issues, reported more positive attitude toward those with AIDS than the comparison groups posttest. In T&T most parents' and youths' HIV/AIDS knowledge, confidence getting and using condoms and the frequency of conversations about HIV/AIDS increased posttest. Additionally, researchers found that the frequency of conversations about gangs and youths as well as aspects of parental monitoring such as television watching and knowing their youths' best friends decreased (Baptiste et al., 2006).

2. Mother/Daughter HIV Risk Reduction intervention (MDRR): The mother/daughter HIV risk reduction intervention (MDRR) focuses on increasing Black-American mother-daughter sexual health communication. It uses a community based approach which instructs mothers how to teach their daughters HIV risk reduction knowledge. This method was compared to two control interventions: the mother/daughter health promotion intervention (MDHP) and the HIV Risk Reduction intervention (HERR). The MDHP is presented by mothers and provides information related to nutrition and exercise while the HERR uses female health professionals to deliver the same HIV risk reduction information as found in MDRR.

The MDRR study yielded a number of findings and recommendations. The MDRR and HERR interventions had similar impacts on female youths' self-efficacy to refuse sex and use condoms, condom attitudes, HIV

transmission knowledge, intention to refuse sex and use condoms and have sex in the last six months. These findings noted that mothers were just as effective as health professionals in teaching HIV risk reduction intervention. Immediately and six month posttest MDRR and HERR youth had significantly better scores on HIV knowledge, condom attitudes, intention to use condoms and self-efficacy to use condoms than female youth in the MDPH intervention (Dancy et al., 2009).

3. Keepin' it R.E.A.L!: Dilorio et al. (2006) reviewed a mother-youth HIV intervention called Keepin' it R.E.A.L! And its ability to delay sex among youth and improve mother-youth sex communication. This review focused on the efficacy of two programs focused on predominantly Black-American youth and their mothers within Keepin' it R.E.A.L!: The life skills program, social cognitive based intervention as well as a control intervention. The life skills intervention is guided by problem behaviour theory which is based on the belief that problem behaviours simultaneously occur in youth and that these behaviours are based on common underlying psychological characteristics or predispositions. In the life skills program youth and their mothers attended separate sessions with the exception of parts of the first and last sessions. These sessions occurred seven times over a 14 week period. Youth sessions started with a stress reduction exercise followed by a discussion of a type of risky behaviour. Academic performance was discussed in the sixth session and youth received take home activities at the end of each session.

The Keepin it R.E.A.L.! Study yielded a number of findings and recommendations. The findings noted an increase in intimate behaviours and the initiation of sex over the 24 month study. An increase in youths' confidence in refusing sex and positive outcome expectations linked to not engaging in sexual intercourse was seen across the treatment and control groups. This indicated that participants in the treatment groups were just as likely to delay sex or feel more confident and expect positive outcomes as control group participants. While there number of sexually active youth participants was small and varied over the study, sexually active youth in the LSK had a greater increase in condom use over time compared to those in the SCT and control groups. No changes in youths' comfort level discussing sex with their mothers were noted over time. At 24 months posttest, more sexually active youth participants from the SCT and LSK groups indicated they planned to stop being sexually active until they were older as compared to youth in the control groups. Mothers who participated in the SCT and LSK groups were more likely to discuss sexual health and report an intention to discuss sexual health topics in the future. Further, mothers were more comfortable discussing sexual health. Both mothers and youth were found to have an increase in HIV knowledge over time.

4. Informed Parents and Children Together (ImPACT) and Focus on Kids (FOK): Researchers collaborated with community members and agencies to determine the efficacy of a parental monitoring intervention called the Informed Parents and Children Together (ImPACT) paired with an adolescent

risk-reduction intervention called Focus on Kids (FOK) with and without boosters in a Black-American population and only FOK over 24 months. Both FOK and ImPACT are based on a social cognitive model known as the Protection Motivation Theory. Protection motivation theory states that environmental and personal factors combine to produce a potential health threat. This potential threat activates two cognitive pathways; a threat and coping-appraisal pathway. The threat-appraisal pathway reviews the factors linked to a threat such as perceived intrinsic and extrinsic awards accompanying the behaviour minus the perceived level of and susceptibility to a threat. The coping-appraisal pathway reviews an individuals' ability to avoid the risk of danger which includes both self-efficacy and efficacy of the reaction compared to the cost of the reaction. These two pathways merge to create protection motivation which may cause protective action if activated.

Focus on Kids is a risk-reduction intervention that focuses on decision making, goal setting, communicating, consensual relationships, negotiating, and information concerning abstinence, safe sex, drugs, alcohol and selling drugs. This format includes discussions, homework, games and videotapes. Focus on Kids booster sessions were provided to youth at several months post-intervention. Informed Parents and Children Together includes the use of a video adapted to the Black-American population which emphasizes several aspects of parental monitoring and communication. The video is followed by parent-youth role play of a confrontational situation which is then critiqued by facilitators based on the main points of the video. The facilitators then provide

a condom demonstration. The control intervention called Goal for IT for ImPACT consists of a video that discusses the process of forming and implementing career goals followed by a short scripted discussion. No control boosters were offered.

The ImPACT and FOK study yielded a number of findings and recommendations. At 24 months 494 youth remained in the study. Youth who participated in the ImPACT plus FOK showed a greater decrease in risk behaviours compared to FOK only participants. Youth risk behaviours were also lower among those whose parents participated in the ImPACT intervention. Additionally, booster sessions were found to provide youth with further protection against most risky behaviours (Stanton et al., 2004).

All of the aforementioned Black parent-youth sex intervention programs noted a number of themes and challenges in parent-youth sexual health communication. With the exception of the study by Stanton et al., (2004), the majority of parents who participated in the interventions were mothers. The studies noted a decrease in many risky sexual behaviours, an increase in HIV transmission knowledge, condom use and condom self-efficacy in youth intervention participants (Baptiste et al., 2006; Dancy et al., 2009; Dilorio et al., 2000; Stanton et al., 2004). Two studies noted that Black-American mothers and youth who participated in the interventions were more comfortable discussing sex with one another (Baptiste et al., 2006; Dilorio et al., 2006). While there were a number of positive outcomes in the intervention studies, the researchers faced a number of challenges in the implementation of the programs.

All studies used self-reporting as a measure of parent-youth sex communication (Baptiste et al., 2006; Dancy et al., 2009; Dilorio et al. 2006; Stanton et al., 2004). Self reports refer to reports that are completed by each individual participant. While the overall validity of self reported data in sexual behaviours is high (Dancy et al., 2009), it is always accompanied by some level of risk for reporting bias. Although all of the studies noted a continuation in the reduction of sexual risk behaviours several months post-intervention, only one program which included a sexual education booster session (Stanton et al., 2004) noted the most amount of sexual risk behaviour reductions greater than six months post intervention. Moreover, parents and youth were recruited to participate. As such, parents and youth who participated in the intervention programs may not truly reflect the sentiments of their peers in their respective communities as their participation denotes interest in their youths' sexual health. These parents may have spoken to their youth and youth may have talked to their parent about sex without having participated in these programs. Additionally, due to the length of time between some program follow ups, researchers may have lost participants due to attrition (Dancy et al., 2009; Stanton et al., 2004) thereby potentially reducing the pool of participants and quality of data collected. As none of the studies were Canadian based, it is unknown if these studies would yield the same findings with Black-Canadian youth and parents.

Mass Media and peer influence on sexual risk behaviours

Mass media

Mass media portrayal and peers' view of sex and sexuality are positively correlated with youths' sexual risk behaviours (Braun-Courville, & Rojas, 2008; L'Engle et al., 2006; Roberts et al. 2005). Mass media refers to all forms of public communication

such as television, magazines, music, movies, video games and the Internet (L'Engle et al., 2006; Roberts et al., 2005) and is an integral part of most youths' lives (Collins et al., 2004; L'Engle et al., 2006; Roberts et al., 2005). Canadian youth often look to mass media for information concerning sex and sexuality (Canadian Federation for Sexual Health (CFSH), 2007; Toronto Teen Sex Survey, 2010). In the U.S. it was found that youth spend an average of six to eight hours a day using some form of mass media (L'Engle et al., 2006; Pardun, L'Engle & Brown, 2005). Mainstream media such as television often portrays youth sexual behaviours as commonplace (Strasburger, 2004) and rarely provides sexual health education or depicts the consequences of unsafe sexual encounters (L'Engle et al., 2006).

With the unprecedented accessibility to online social networking sites such as Facebook™, posting and watching videos on the internet through a cell phone or computer, it has become easier for youth to be directly or indirectly exposed to sexually charged content (Strasburger, Jordan, & Donnerstein, 2010). For instance, music videos often contain sexual imagery and stereotypes. Further, frequent exposure to music videos (Council on Communications and Media, 2009) as well as various other forms of mass media with sexual content may lead many youth to perceive sex as more important in daily life than in reality and encourage sexual initiation (Collins et al., 2004). Additional studies have noted that youth who watch a lot of media with sexual content (Collins et al., 2004; L'Engle et al., 2006) and who believe that media supports teen sexual behaviour (L'Engle et al., 2006) are more likely to initiate sexual intercourse at a younger age (Collins et al., 2004). Moreover, many youth not only report feeling more pressure from the media to begin having sex but are more likely to overestimate the number of their

peers who are sexually active (Strasburger, 2004). These youth also report greater sexual activity as well as intentions to have sexual intercourse in the near future (L'Engle et al., 2006; Pardun et al., 2005). African-American youth appear to be more vulnerable to mass media (Collins et al., 2004) and peer influence (Voisin, & Bird, 2009). Black-American youth tend to access more mass media (Romer et al., 1999) and spend more than the average of six hours on some form of mass media per day compared to their peers (Brown et al., 2006). This increased exposure to mass media may lead some Black youth to have more favourable views towards sex as several U.S. studies found youth who are exposed to large amounts of mass media with sexual content indicate positive views towards initiating sex (Braun-Courville, & Rojas, 2008; L'Engle et al., 2006), as well as having casual sex and multiple sexual partners (Braun-Courville, & Rojas, 2008). A study noted that Black-American female youths' exposure to sexually explicit movies was linked to greater sexual activities (Escobar-Chaves, & Anderson, 2008). Conversely, another study noted that Black-American youth who watched more TV depictions of sexual risk or safety were less likely to begin sexual intercourse in the next year (Collins et al., 2004). Similar to mass media, peers can also influence youths' sexual risk behaviours.

Peers

Peers have been found to influence youths' sexual health knowledge and sexual activities (Jaccard et al., 2005; Stanton et al., 2002; Toronto Teen Survey, 2010). A Toronto survey noted that many teens view their peers as sources of sexual health information (Toronto Teen Survey, 2010). Some studies have noted that the level of a youth's sexual risk behaviour can be linked to the level of their peers' sexual risk

behaviours (Jaccard et al., 2005; Stanton et al., 2002). For example, a study by Jaccard et al. (2005) noted this level of influence after collecting data from interviews of approximately 200 students from grades seven to 12 from 16 schools in the U.S. Stanton et al. (2002) also noted the importance of peers in a study that obtained data from 383 urban Black Americans aged nine-15 years who had been followed over a four year period as they completed the FOK intervention. Youth who perceive their peers to be sexually active (Potard, Courtois, & Rusch, 2008) or have a carefree attitude towards sex are six times more likely to have participated in some form of sexual activity (Lagana, 1999; Potard et al., 2008) and have multiple sexual partners, thereby putting them at a greater risk of contracting an STI (Potard et al., 2008). Potard et al. (2008) noted this risk through a questionnaire conducted by 100 students who averaged 17 years of age. These students were randomly selected from an urban public high school. Participants were asked questions such as the level of sexual experience and the impact of peers.

Despite the impact of peer influence on youth sexual risk behaviour, studies which reviewed this influence (Jaccard et al., 2005; Lagana, 1999; Potard et al., 2008; Stanton et al., 2002) did not discuss whether differences in the level of youth sexual risk behaviour existed based on the level of interaction between youth and their sexually permissive peers. Additionally, some studies provided conflicting information concerning the impact of peers' sexual activity on youths' sexual risk behaviour. For example, Jaccard et al. (2005) and Stanton et al. (2002) noted that associating with sexually permissive peers can increase youths' sexual risk behaviour and unprotected sex. Conversely, Potard et al. (2008) noted that associating with sexually permissive peers can prompt youth to use a condom at their first sexual intercourse.

Overall, peer and mass media influence on youths' sexual risk behaviour were greatest when parents were not active participants in their child's sexual education (Braun-Courville, & Rojas, 2008; Jaccard et al., 2005; L'Engle et al., 2006; Stanton et al., 2002). The impact of these potentially negative influences was reduced with active parental participation (Jaccard et al., 2005; Kirby et al., 2007; Stanton et al., 2002) and monitoring (Collins et al., 2004; DeVore, & Ginsburg, 2005; Stanton et al., 2004). Parental monitoring refers to parents knowing the location of their youth, peers their youth spend time with and setting rules for their youth. Moreover, parental participation (Jaccard et al., 2005; Kirby et al., 2007; Stanton et al., 2002) and monitoring increased youths' resiliency against taking part in risky sexual activities (Collins et al., 2004; Jaccard et al., 2005; Kirby et al., 2007; Stanton et al., 2002).

The influence of sexual education in schools on sexual behaviour

School-based sexual education programs can greatly assist in the reduction of youth sexual risk behaviours (Robin, et al., 2004; Smylie, Maticka-Tyndale, & Boyd, 2008; The Sex Information and Education in Canada (SIECCAN), 2005). Well constructed and implemented sexual education programs reduce youth's risk of unplanned pregnancy and being diagnosed with an STI (SIECCAN, 2005).

In Canada, school-based sexual health education programs are regulated by provincial governments. In Ontario, elementary sexual health education falls under the Healthy Living section of the elementary curricula (Ontario Ministry of Education, 2010) while high school sexual health education falls under the Healthy Growth and Sexuality section of the Health and Physical Education secondary curricula (Ontario Ministry of Education, 1999; Ontario Ministry of Education, 2000). In elementary school, sexual

health is modified to reflect students' grade levels and focuses on human development and sexual well-being. In high school, students are usually presented with sexual health information which includes physical and relational facets of sexuality, and sexual health described with other aspects of healthy sexual growth in a developmentally appropriate fashion (Meaney, Tye, Wood, & Solovieva, 2009).

While no specific definition of sexuality has been provided by the Ontario Ministry of Education sexual health education curriculum, upon completion of the healthy living strand of the physical health education program, grade nine and 10 students are expected to identify the developmental stages of sexuality through life. They are also expected to understand how to effectively use decision-making and assertiveness skills towards healthy sexuality such as healthy relationships and avoiding STIs. In grade nine, sexual health education is mandatory while it is not in grade 10. In grade 10, students receive information about the many pressures placed on youth to have sex, sexual development through the human lifespan and the consequences of sexual activity.

Additionally, topics such as social skills and decision-making are presented in a general fashion and may be linked to sexuality discussions. In grade 11 and 12, youth who take physical health and education are taught the Health Living strand which discusses healthy growth and sexuality (Ontario Ministry of Education, 2000). Upon completion of the Healthy Living strand these students are expected to have an understanding of sexual and reproductive health (Ontario Ministry of Education, 2000). Although the Ontario provincial government provides schools with the general structure and content of sexual health education, the delivery and implementation of sexual

education programs is often left to the discretion of each school board and ultimately to the teachers (Meaney et al., 2009; Smylie et al., 2008).

The different approaches school boards and teachers take to provide youth with sexual health education results in variations in the topics discussed and classroom time devoted to sexual health education (SIECCAN, 2005; Smylie et al., 2008). For example, in Ontario, there are two main types of school boards: The Public and the Catholic School Boards. In comparison to Public School Boards, Catholic School Boards may present sexual health education with an emphasis on maintaining religious values concerning sexuality and have been found to lag in teaching students important sexual health issues (Meaney et al., 2009). Additionally, McCall et al. (1999) noted that public health systems lack the resources to provide effective support, coordination and referrals to preventative services for students (as cited in SIECCAN, 2005).

Furthermore, the implementation of sexual health programs in most areas of Canada is challenging (McCall et al. (1999) as cited in SIECCAN, 2005). If the sexual health material is presented to students in a boring fashion, students may not incorporate the lessons into their sexual health knowledge (Roberston, 2007). McCall et al. (1999) noted that many Canadian schools lack the necessary teaching and learning materials. Also, most schools fail to provide teachers with adequate sexual health education classroom time (as cited in SIECCAN, 2005). Frappier et al. (2008) noted that 69 % of Canadian youth lacked knowledge about STIs and their outcomes. This finding may be further compounded by variations in teacher sexual health education training (Meaney et al., 2009).

Despite recommendations from the Public Health Agency of Canada and the Society of Obstetricians and Gynaecologists of Canada to provide teachers with specific sexual health education training, it has been found that teachers are not required to attain formal training in sexual health education and most teachers have limited or no sexual health education training (Meaney et al., 2009). This lack of training (SIECCAN, 2005) or a discomfort discussing sexual health may lead teachers to avoid discussing key sexual health issues thereby leading to less effective sexual health lessons (Meaney et al., 2009) and discrepancies in students' sexual health knowledge. This aversion may be linked back to some parental as well as religious protests similar to those encountered by an attempt to revise the Ontario sexual education curriculum. In 2010, the Ontario provincial government proposed a new school-based sexual health curriculum which would have introduced topics such as sexual orientation as early as grade three as well as sexually transmitted infections (STIs) and gender identity during grade seven and eight (Ministry of Education, 2010). Religious leaders' and parental objections to the proposed curriculum were noted as some of the factors which led the Ontario government to retract the new curriculum (The Canadian Broadcasting Corporation, 2010).

While some Canadian studies have noted several areas of the school-based sexual health education programs which require improvement (Meaney et al., 2009; SIECCAN, 2005; Smylie et al., 2008), there is a paucity of Canadian based studies that reviews the impact of culturally appropriate sexual health programs on Black-Canadian youth. Additionally, no guidelines on the impact of students' cultural views of sex and sexuality on the delivery of sexual health education could be found in the Ontario high school physical health and education curricula. As such, it is uncertain how or if students'

cultural views of sex and sexuality are addressed in school-based sexual health education programs in Ontario.

Parental involvement in youth school-based sexual health education programs can significantly reduce youth sexual risk behaviours and increase condom use (Blake, Simkin, Rebecca, Perkins, & Calabrese, 2001; Dilorio, 2006; Halpern-Felsher, Kropp, Boyer, Tschann, & Ellen, 2004; Lederman, Chan, & Roberts-Gray, 2008; SIECCAN, 2005) compared to school-based sexual health education alone (Eisenberg et al., 2006). Parental participation in youths' school-based sexual health education can lead to better parental and youth sexual health knowledge (Smylie et al., 2008).

Parental involvement in school-based sexual health education provides a number of benefits. Parents are a pre-existing (Cox, et al., 2010; Dilorio et al., 2006), cost-effective resource that can be trained to teach youth sexual health education (Dilorio et al., 2006). Dilorio et al. (2006) and Eisenberg et al. (2006) have also noted that many parents are readily accessible and are always available to answer their youths' questions concerning sex and sexuality in a way which reflects their own values, beliefs and expectations. Parents also have the ability to structure and personalize sexual health education based on the youths' level of development, specific contexts or circumstances without a time limit (Dilorio et al., 2006; Eisenberg et al., 2006). Thus, these adaptations may result in youths' perceiving the messages to be more relevant which in turn may be more likely to impact their behaviour (Eisenberg et al., 2006).

Teen pregnancy, STIs and HIV infection

Teen pregnancies and STIs are significant threats to the sexual health and overall well-being of Canadian youth (SIECCAN, 2005). Articles which examined teen

pregnancy noted that most teen pregnancies are unintentional (McKay, & Barrett, 2010) and can cause physical, social and psychological risks to mother and infant (Card, 1999). Youth who become pregnant at 17 years of age or less have a greater chance of having a preterm baby with a low birth weight or larger than the average baby. Additionally, teen mothers are at a greater risk of becoming single parents which in turn places their children at an increased risk of living in low socioeconomic conditions (Martens, Mayer, & Derksen, 2002). Although a Canadian article noted that teen birth rates have declined by 38% from 1996 to 2006 and contraception use has increased (McKay, & Barrett, 2010), a non-peer reviewed article noted that a number of neighbourhoods in Toronto with large Black populations had the city's highest teen birth rates (Robertson, 2007). Further, while Canadian teen pregnancy rates have been declining, STI rates have risen among youth (McKay, 2004).

Chlamydia and gonorrhoea are the two most common STIs in Canada and their rates have risen over the past few years (PHAC, 2010a). An article on STIs stated that chlamydia rates are used as a proxy measurement of the extent of STI infection in youths as it is the most commonly reported STI in Canada (SIECCAN, 2005). The chlamydia rate is highest among female youth aged 15-24 years and men aged 20-29 years (PHAC, 2010a). Chlamydia infections pose a number of health risks if it is not detected or treated (SIECCAN, 2005). Approximately 40-70% of infected individuals do not exhibit any symptoms. In some females, failure to treat chlamydia can result in ectopic pregnancy, infertility and incapacitating chronic pelvic pain. Moreover, individuals with STIs such as chlamydia are at a greater risk of HIV infection and transmission (McDonald, & Wong, 2007). Chlamydia greatly increases an individuals' HIV susceptibility when they are

exposed to the virus (SIECCAN, 2004). While there are there is a paucity of studies that specifically reviewed the rate of chlamydia among Black-Canadian youth, a non-peer reviewed study that cross-referenced a map with highlighted neighbourhoods with Black populations with a map that highlighted areas of reported cases of chlamydia in Toronto indicated areas with large Black populations that had high number of chlamydia cases. This study also noted many young Black-Canadian females have repeat cases of STIs (Roberston, 2007) which may place them at a greater risk of HIV infection. These findings emphasize the need to determine how Black Canadian parent-youth sex communication can reduce these rates.

Although the articles on teen pregnancy, births and STI rates highlight a number of important facts, some information is lacking. For example, there is a void of literature that reviews Black-Canadian teen pregnancy and STI rates. Further, the increase in contraception use noted by McKay and Barrett (2010) may indicate a shift in youths' view of the consequences of sex and increased use of sexual health resources. However, this possible shift and use of sexual health resources were not discussed in detail. Further, the impact of parental involvement in youths' lives were not discussed in these articles. Literature that discussed STIs in Black-Canadian populations only postulated about the rate of STIs among Black female youth in Toronto (Robertson, 2007).

Summary

A review of the literature on parent-youth sexual communication and intervention programs, youth and parental gender, teen pregnancy and STI rates as well as the impact of factors such as peers, mass media and school-based sexual health education on youth noted a number of findings. Literature on parent-youth sexual communication indicated

that this communication can positively impact youths' sexual behaviours. This communication can lead youth to delay sexual activity (Aspy et al., 2007; Baptiste et al., 2006; Cox et al., 2010; DiClemente et al., 2001; Dilorio et al., 2000; Hutchinson et al., 2003; Li, et al., 2000; Robert, & Sonenstein, 2010; Romer et al., 1999) and sexually active youth to have less sexual partners (Eisenberg et al., 2006) and greater self efficacy for condom use (DeVore, & Ginsburg, 2005). In terms of HIV risk it was noted that Black-Canadian men and women are disproportionately vulnerable to HIV infection (PHAC, 2010d; Remis, & Liu, 2006). Black-Canadian women were found to be particularly vulnerable to HIV infection due to a lack of acknowledgement of HIV risk in Black communities, low sexual health awareness (Robertson, 2007), vaginal practices, female genital mutilation (Brady, 1999; Braunstein, & Van Wijgert, 2005; McClelland et al., 2006; Myer et al., 2004), and the dynamics of intimate relationships in Black-Canadian communities (Newman et al., 2008). Further, it was noted that Black-Canadian MSM were most at risk of HIV infection due to risky sexual behaviours (PHAC, 2010e). The intervention programs highlighted the positive impact of parental sexual health education and involvement in their youths' sexual health education. A review of literature on peer, mass media and school sexual health education noted the possible negative impacts these forms of sexual health information can have on youths' sexual health knowledge without parental involvement. Finally, the review of literature on teen pregnancy, STIs and HIV risk noted the possible lifelong negative impact risky sexual behaviour can have on youth.

Although this literature review provided an overview of factors impacting parent-youth sex communication, there was a lack of information which specifically focuses on

Black-Canadian parent-youth sex communication. Further, none of the literature discussed in this review specifically identified factors which prevented Black parents and youth sexual health discussion and the impact of fathers on youths' sexual health knowledge. As aspects of Black-Canadian culture differ from Black-American, Black-Caribbean and African populations it is uncertain if findings from the literature review fully apply to Black-Canadian parents and youth. This thesis will attempt to address several of these voids in the literature by exploring the state of Black parent-youth sex communication, the impact of parental and youth gender and on sex communication, sources of Black-Canadian youths' sexual health information, if students' culture informs school-based sexual health education and if Black parents are supportive of their youth.

CHAPTER 3

METHODS

This chapter will present the findings from this qualitative study which focused on exploring Black-Canadian parent-youth communication on sexual health, HIV, parental support of youth and sources of sexual health information for Black youth in Toronto, Ontario. The impact of parental and youth gender on this communication and school-based sexual health education was also explored.

Conceptual framework

The study used purposive sampling to recruit participants within a community-based research approach (CBR). Purposive sampling is a strategy used to increase the understanding of an individual's or group's experiences or for creating theories and concepts. This understanding is accomplished by choosing "information rich" cases such as individuals or behaviours which provide the most amount of insight into the research question (Devers, & Frankel, 2000). In this study, the information rich cases called Key Informants (KIs) allowed the Investigative Team to better understand the current state of Black-Canadian parent-youth sex communication. An overview of KI selection and demographics will be provided in subsequent paragraphs.

The community based research approach was chosen as it involves researcher-community collaboration which can increase the quality of findings as community members are actively involved in the development and implementation of the study. It also ensures that the needs and priorities of community members are adequately reflected in the research questions and strategies (Pinto, McKay, & Escobar, 2008). Further, CBR has short and long-term benefits for both the researcher and community. In the short

term, these collaborations may provide communities with the necessary training and human resources that communities may have been lacking (Wallerstein, & Duran, 2006). In the long term, this process could lead to individual and community empowerment, build capacity of participating community members (Chutuape et al., 2010) as well as develop locally trained community members, and stronger self-sustaining community organizations (Minkler, 2004; Wallerstein, & Duran, 2006). These members and community organizations could then take the lessons learned from the study and apply it to improve other issues that should be addressed in their respective communities. Furthermore, CBR can produce research findings that are more applicable to the participant's respective population (Minkler, 2004).

Community based research can also strengthen research findings. It increases the acceptability of participant research findings by recognizing the knowledge of individual community members, organizations and stakeholders by incorporating their insight into the research process (Minkler, 2004; Mosavel, Simon, van Stade, & Buchbinder, 2005). As Chutuape et al. (2010) note, community involvement can lead to access of stakeholders from both within and outside particular communities thereby building a larger network to assist with community mobilization on a particular issue. It can also build a positive researcher-community relationship and may lead community partners to be more inclined to collaborate in future studies (Pinto et al., 2008). Further, community involvement can increase community buy-in, thereby increasing participant turnout and the quality and quantity of collected data (Mosavel et al., 2005).

To ensure community involvement was attained in this study, the Study Coordinator formed a Community Advisory Committee (CAC) that included key

stakeholders from Black communities in the GTA. Please see appendix A for the CBR flowchart.

Community Advisory Committee (CAC) member selection

Led by the Study Coordinator, the Investigative Team assisted in the identification of potential CAC members from the Greater Toronto Area (GTA). The CAC members were found either through recommendations from the Investigative Team or by word of mouth. Community Advisory Committee members were selected based on the following criteria:

- a) Involvement in Black communities in the GTA;
- b) Aged 15 years and over;
- c) Current or past work experience with Black youth and/or parents; and
- d) Knowledge of HIV/AIDS.

Successful candidates were then given an invitational e-mail letter detailing the research and their responsibilities (see appendix B).

In order to ensure that the CAC reflected Black-Canadian communities in Toronto, a goal of recruiting seven to 10 CAC members was set. Two of the CAC positions were set aside for individuals of African-Caribbean and African heritage aged 15-24 years. These two positions were designated for youth in order to ensure the inclusion of a youth perspective from the African and African-Caribbean communities in the study. As the study was initially designed to occur over a one year period, the CAC members were informed that they would meet a minimum of three times or as needed over the course of the study. The Study Coordinator also sent the CAC emails during the study to provide them with an overview of the study's progress, meeting times and dates

for upcoming meetings. Meeting times were scheduled using an online scheduling tool known as Doodle. Meetings were often held at a mutually agreed upon location. CAC members received light snacks and refreshments during the meetings. Each meeting lasted approximately 90 to 120 minutes. CAC members who attended the meetings received a \$20 honorarium to compensate them for their time and possible travel expenses.

A total of seven CAC members were recruited. The CAC was asked to provide their feedback and input in the refinement of the KI recruitment strategy, and in-depth interview questions. They also assisted in determining the best dissemination plan for the collected data to Black-Canadian communities, community organizations and academia. Participating CAC members were personally thanked by the Study Coordinator and received a reference letter upon request. Once the CAC was assembled, the Investigative Team and CAC focused their attention on the recruitment of Key Informants.

Study Coordinator

The Study Coordinator for this study was Nakia Lee-Foon. The Study Coordinator conducted community outreach, liaised with community partners and assisted in the recruitment of the CAC and KI. She also scheduled meetings, created the meeting agenda, and led the Investigative Team and CAC meetings. The Study Coordinator also took and sent the meetings minutes to the Investigative Team and CAC. She led the KI interviews and created footnotes from the meetings. The Study Coordinator also transcribed and thematically analyzed the data. A description of the methods used to transcribe and analyze the data will be provided in subsequent paragraphs.

Investigative Team

The Investigative Team consisted of members from the University of Ontario Institute of Technology (UOIT), Dalhousie University, McMaster University, the University of Ottawa, The Teresa Group and TAIBU Community Health Center. The Teresa Group and TAIBU Community Health Centre were our community partners. The Teresa Group is a community based organization that provides support and resources to children and their families impacted by HIV/AIDS. TAIBU is a community based health centre that provides a number of health care and social services to individuals who reside in Malvern; a neighbourhood in Toronto. Further, TAIBU has a complementary mandate to develop and deliver health and social service programs for Black communities in the Greater Toronto Area (GTA). The GTA refers to the City of Toronto, Halton, Peel, York, and Durham regions (City of Toronto Urban Development Services Department, 2003).

Key Informant (KI) selection

A goal of 15 KI interviews was determined by the thesis advisory committee. Key Informants were identified through recommendations by the Investigative Team, the CAC, by word of mouth and by emails sent by the Study Coordinator and Principal Investigator. The Investigative Team and CAC were asked to recommend individuals who fulfilled the following criteria:

- a) A minimum of 15 years of age;
- b) Current or previous experience working and/or volunteering with Black parents and/or youth in Toronto; and
- c) Submitted a resume

Key Informants were also found through an online advertisement posted on a youth frontline workers' website called Frontline: Partners with Youth Network (www.fpyn.ca) (see appendix C for a sample of the advertisement). This website was selected as it is a popular website among many individuals we sought to recruit to participate in the study. Furthermore, the website allows advertisements to be posted for a period of time chosen by the account holder, and sends members an e-newsletter which highlights recently posted opportunities on a regular basis. The minimum age limit was selected to ensure participants had previous work and or volunteer experience pertinent to the study. Resumes were requested to ensure candidates had relevant work and/or volunteer experience which would enable them to provide pertinent responses to the study questions.

Key Informant (KI) interview format

Individuals selected for KI interviews were engaged in a semi-structured one-on-one interview conducted by the Study Coordinator with the assistance of the Principal Investigator. The interviews were tape recorded and notes were taken. The semi-structured interview format was selected as it allowed for the use of a pre-determined question guide, the flexibility to develop additional questions during an interview and for the progression of questions to be directed by participants' responses. Further, the interview format enabled participants to respond to particular questions they believed to be important in more detail (Carter, & Henderson, 2005). Further, this open-ended question format is often utilized on topics that lack information (Carter, & Henderson, 2005). This format is particularly pertinent in this study as there is a void of information on Black-Canadian parent-youth sexual health communication. The one-on-one format

was selected as it ensured the anonymity of KIs as there was the potential for individuals to disclose sensitive information concerning their work and organizations. Additionally, one-on-one interviews allowed the Study Coordinator to ask the respondents for clarification on the content of their responses.

The interview location was selected by the KI and conducted at a mutually agreed upon date and time in the GTA. Allowing the KIs to choose the interview location also ensured interview locations were easily accessible to the KIs. Further, conducting interviews in a setting familiar to participants have been found to place participants at ease (Streiner, & Norman, 2008).

Key informant interview procedures

As per the Review Ethics Board (REB) guidelines at UOIT, all KIs signed a consent form prior to the initiation of the interview and all questions posed by the KIs were answered by the Study Coordinator. Further, participants were informed that their information would be kept confidential (see appendix D for a copy of the consent form). The KIs were informed that the interview was expected to last approximately 30 to 60 minutes and would be audio recorded using two digital recorders. The possible benefits and risks of this study were communicated to participants on the consent form and were verbally reviewed by the Study Coordinator. They were also informed that their participation would assist the Investigative Team in having a better understanding of Black-Canadian parent-youth sex communication. The findings from the interviews would allow for future research and development of Black parent-youth sex communication intervention programs. It was explained that they would receive an overview of the study findings upon completion of the study, and each KI received an

honorarium of \$25 as a token of appreciation for their time. Each participant was offered a copy of the consent form along with the Study Coordinator and Principal Investigator's contact information.

Key Informants were also notified of the possible risks associated with participating in the study and the option to withdraw from the study at any time. Participants were informed that the questions may cause distress and they had the option not to respond to questions without any penalty. They were also informed they could withdraw at any point in the interview. However, all information collected prior to their withdrawal would still be utilized as participant names would be made anonymous, thereby preventing the Study Coordinator from linking the collected information back to each participant (see appendix D for further details).

Key Informant interview questions

An open-ended question KI interview guide was created with feedback from the Investigative Team and CAC (see appendix E for interview question guidelines). The interview guide question order was also reviewed by the Investigative Team.

The feedback from the Investigative Team led the interview guide to be organized in a fashion which prompted interviews to begin with a question that could be easily answered by the KI (see question one in appendix E). The use of a relatively easy question to begin the interview was used in order to build rapport between the KI and Study Coordinator to increase the chance KIs would be willing to discuss more sensitive issues concerning sex and sexuality.

CHAPTER 4

DATA ANALYSIS

Data collection

Data was collected from KI interviews through the use of two digital audio recorders (Panasonic Digital Voice Recorder RR-US490 and SONY digital voice recorder) and interview field notes. The reason for using two digital voice recorders was to ensure an extra copy existed in the event any technical issues arose. Field notes were taken by the Study Coordinator and Principal Investigator in order to have an additional copy of the interviews, make note of key statements made by the KIs, age approximation, ethnicity, gender and other aspects of the interview which could not have been captured by the digital voice recorder. As KIs were not directly asked to provide their age and ethnicity, both were determined either through observation by the Study Coordinator or through self identification by the KI.

Theoretical aspects

A modified grounded theory was used to analyse the collected data. This theory allows researchers to explore the interaction between individuals' experiences and social structure (Wuest, Merritt-Gray, Berman, & Ford-Gilboe, 2002). Grounded theory refers to the process of identifying analytical categories as they emerge from the data (Glaser, & Strauss as cited in Pope, Ziebland, & Mays, 2000). The data is first read multiple times to identify and index themes and categories. Data relevant to each category is reviewed using constant comparison (Pope et al., 2000). Constant comparison is a method used in grounded theory where data is collected in groupings and compared to previously collected data. This comparison informs succeeding data that is collected. These

continual data comparisons enable the Study Coordinator to determine themes based on the data and generate a theory founded on the discovered themes. Essentially, the main premise of grounded theory is that the theory emerges from and is grounded in the collected data (Donovan, & Sanders, 2005). This theory was selected as some Toronto based studies noted the lack of research focused on youth sexual health (Robertson, 2007; Toronto Teen Survey, 2010) and the void of theories on Black parent-youth sexual health communication. Further, based on the literature emanating from the U.S. and other countries that conducted studies on Black populations of African and Caribbean heritage, a modified grounded theory approach was deemed to be the best approach to data collection due to the paucity of theories that encompass the racial, societal and contextual factors that impact Black populations' health. As such, the grounded theory approach to the study was mediated through critical race theory (CRT) lenses.

Critical race theory is a framework that allows researchers to theorize, review and challenge the ways race and racism implicitly and explicitly affect social structure, practices and discussions (Yosso, 2005). Essentially, CRT recognizes the intricate relationships and intersections that are found within race, class, gender and sexuality differences that affects the social world of ethnic minorities (Graham, Brown-Jeffy, Aronson, & Stephens, 2011). This theory originally stemmed from the work of several lawyers, activists and legal scholars in the U.S. during the mid-1970s who noted that new theories were required to address the subtler forms of racism that were gaining ground (Delgado, & Stefancic, 2001). There are a number of tenets that are used to guide the research, methods and pedagogy of critical race theory: racism is ordinary, not aberrational and reproduced in various customs, experiences and negatively impacts the

lives of racial groups; the race problem is difficult to understand and may be impossible to solve due to claims of objectivity that mask the self-interest, power and privilege of Whites; races are categories that society creates, manipulates and re-creates; minority populations are capable of communicating and explaining the meaning and impact of race and racism as they are oppressed; and critical race theorists should also aim to increase social justice. Critical race theory has expanded into other disciplines (Graham et al., 2011) and is now being used in the field of public health to examine the root causes of health inequalities (Ford, & Airhihenbuwa, 2010).

Critical race theory was used in this study as many KIs noted that race and racism often impacted Black parents and youths' ability to access health care, education and employment opportunities. Key Informants' comments were supported by the Public Health Agency of Canada (2009) who noted racism was one of the factors that can increase Black-Canadian populations' risk of HIV infection. Gardezi et al. (2008) also noted the impact of racism on Black populations' access to health care services in Toronto through Black focus group participants' comments. Participants indicated they were hesitant to access these services due to the fear of encountering a racist view that Black populations were carriers of HIV and other illnesses.

Data codings

The resulting audio tapes from all interviews were transcribed and coded by the Study Coordinator. The transcripts were based on interviews conducted from December 2010 to April 2011 with 17 Key Informants. The average length of a KI interview was one hour and six minutes. Any identifying data was removed from the transcripts and the KIs' names were replaced by a code. Transcription validity was verified by cross

referencing the resulting transcripts with the field notes of the Study Coordinator.

Further, the Study Coordinator reviewed each transcript along with the audio recording a minimum of three times to ensure accuracy of the transcript.

Once the transcripts were re-read by the Study Coordinator, the transcripts were then imported into NVivo9. NVivo 9 is a qualitative data analysis software which enables researchers to organize and analyze large volumes of data. Once in NVivo9, the responses for each question from each KI were coded into a node. A node is a tool found in NVivo9 that allows for the grouping of information into particular categories (QSR international, 2010). The contents of each node were then reviewed and preliminary themes were noted. These themes were created using the nine open-ended questions as a guide and based on the amount of KIs who made similar comments in response to a particular question. In order to further visualize any possible additional themes in the data, the Study Coordinator then reviewed the contents of each node a minimum of three times to ensure accuracy. A word frequency search was then conducted on all of the interviews.

A word frequency search is a tool found in NVivo9 which enables the user to view how often words were used in transcripts (QSR international, 2010). This search was conducted in order to determine if there were any additional themes or subthemes. To increase precision in the frequency search a number of words such as a, an, to, the, umm were excluded. In order to determine the context in which frequent words were being used each transcript was opened and the context of the words in each sentence was reviewed. The findings from the word frequency search were then used to conduct a query search.

A query search is a tool in NVivo9 that allows for the input of particular words to be found as well as synonyms of these words in the data provided (QSR international, 2010). All query and word frequency searches were conducted and reviewed a minimum of three times in order to ensure the accuracy of results. The findings from the query search were then read by the Study Coordinator to search for KI comments that reflected additional themes and subthemes. Any additional comment that reflected an identified theme or subtheme was then placed in its respective node.

CHAPTER 5

FINDINGS

Key Informant recruitment

A total of 17 KIs were recruited and interviewed. The methods used to recruit KIs for this study yielded varying rates of success. Despite the wide range of access and popularity of the frontline youth workers' online network, only three KIs were identified as a result of the online advertisement. Key Informant recruitment through word of mouth yielded four KIs. Similarly, direct contact of KI candidates via email by the Principal Investigator or the Study Coordinator led to the recruitment of four KIs. KI recommendations of other KI candidates yielded the greatest amount of KIs at six. Early in the recruitment process the Study Coordinator noted most KIs were female and worked with African-Caribbean parents and/or youth of Christian faith. To ensure multiple perspectives were collected for this study the Study Coordinator began to actively recruit KIs that were male, had experience working with African parents and/or youth of Muslim faith. An overview of the recruitment method results can be found in Table 1.

Key Informant demographics

The selected KIs ranged in age, gender, and ethnicity. Approximately nine (53%) KIs were young adults and eight KIs (47%) were older adults. Ten of the KIs (59%) were female and the remaining seven were male (41%). In terms of ethnicity, 11 of the KIs were of Afro-Caribbean heritage (65%), followed by two of African heritage (12%), two of Caucasian heritage (12%), one (6%) of Indo-Caribbean heritage and one (6%) of mixed Caribbean and other heritage respectively.

The KIs varied in work experience and work location in the GTA. Twelve KIs were youth workers, followed by one (6%) mental health youth worker, one (6%) youth worker whose mandate focuses on work with Black male youth, one (6%) teacher and Black youth advocate, one (6%) religious leader, and one (6%) youth worker that also works with lesbian, gay, bisexual, transgender and queer youth. One KI self identified as a youth worker and a Christian youth minister. An overview of KI demographics can be found in Table 2. In terms of work locations, seven (41%) KIs indicated they work and/or worked with communities in Toronto and/or East York communities, four (24%) in Scarborough, two (12%) work and/or worked in North York, three (18%) work and/or worked in multiple areas of the city and one (6%) KI's work location information was unavailable. See figure 2 for a map of the Toronto area.

It was noted that nine (53%) KIs work and/or worked in locations situated in one of the 13 priority neighbourhoods in Toronto. Priority neighbourhoods refer to neighbourhoods identified by the City of Toronto and the United Way Agency of the Greater Toronto Area that have high levels of poverty and lack social and community services (Hulchanski, 2007). In comparison to the City of Toronto averages, priority neighbourhoods house a larger number of at-risk populations such as visible minorities (66% versus 46%), single parent households (25% versus 20%), newly arrived immigrants (14% versus 11%) and a slightly larger youth population aged 15 to 24 (13% versus 12.7%) (City of Toronto, 2008a). Two (12%) of KIs work locations were and/or are situated in the west end, three (18%) in the north end and four in the east end of the city. Five (29%) KIs did not specify their current or past work locations in Toronto. Two KIs stated that they work and/or worked in multiple priority neighbourhoods and three

KIs stated they work and/or worked in a priority community (see figure 3 for a map of priority neighbourhoods). Although a priority community share many similarities with priority neighbourhoods such as high levels of poverty (City of Toronto, 2008b), recent immigrants (City of Toronto, 2008c), and lone parent households (City of Toronto, 2008d) unlike priority neighbourhoods it has a strong network of community social services (Toronto Community Housing, 2007). A detailed overview of the individual KI demographics including work locations can be found in Table 3.

Key Informant transcript analysis

Each question posed to the KIs yielded a number of themes and subthemes. These themes and subthemes will be presented along with the reasons for posing each question in the subsequent paragraphs.

From your perspective what are some of the main issues or challenges faced by Black youth in Toronto, Ontario?

This question was posed by the Study Coordinator as it was viewed as a question that would assist the Study Coordinator in building rapport with the KIs. It also encouraged the KIs to begin thinking of issues impacting Black populations and allowed the Study Coordinator to transition into more sensitive topics such as Black youths' sexual health and parent-youth sexual health discussion. Further, this question addresses a void in Canadian based research on issues or challenges affecting Black youth.

When asked to discuss some of the main issues or challenges faced by Black youth in Toronto, Ontario, a number of consistent themes were found. The themes included poverty; parent-youth issues; lack of understanding; homosexuality;

employment; education; and access to resources. A review of each theme and identified subthemes will be discussed below.

Poverty

Poverty disproportionately affects Black populations. A review of low income and poverty rates in ethno-racial groups in Toronto noted that Black populations had higher rates compared to White populations (Ornstein, 2006). While there are a number of complex factors which can lead many Black individuals to become poor, anecdotal evidence and research indicates that Black populations' risk of poverty is further impacted by institutionalized racism that may impede their access to resources, adequate housing, and stable employment. The negative impact of poverty on Black populations was noted by 11 (65%) KIs who indicated that poverty was a main issue impacting Black youth in Toronto. Further analysis of KI responses revealed housing as a main poverty subtheme.

Housing

Ten (59%) of KIs indicated housing had a negative impact on many Black youth. In this thesis housing refers to the physical and social conditions Black youth encounter at home. For example, KI10 (a youth worker) stated that poverty often led many Black youth to live in substandard living conditions. He noted that many Black youth in Toronto had multiple family members living in the same residence, thereby leading to a lack of privacy. Further, he noted the impact of housing combined with the communities in which Black youth in Toronto live when he said

. . . they're affected by what they see. If everybody else in the apartment building are living in the same levels themselves too you know and they're not going to other parts of the city and seeing

how other people live, that's all they know. . . (KI10, African-Caribbean Male)

The identification of poverty as an issue impacting Black youth in Toronto is supported by the fact that most of the KIs who identified this issue work and/or worked in locations situated in priority neighbourhoods which have high levels of poverty (Hulchanski, 2007). Further, income has been identified as one of the many social determinants of health which can increase Canadians' overall health (PHAC, 2002) and Black-Canadian populations' risk of HIV/AIDS (PHAC, 2009). Canadians with low incomes have also been found to be at an increased risk of dying earlier and contracting more illnesses than Canadians with higher incomes (Federal, Provincial and Territorial Advisory Committee, 1999). Housing has also been linked to poverty (Federal, Provincial and Territorial Advisory Committee, 1999; PHAC, 2009) and is noted as one of the factors that influences Black Canadian populations' risk of HIV/AIDS (PHAC, 2009). As KIs' comments and anecdotal evidence indicate, despite the impact of poverty on Black youth many are able to excel and enter prominent careers as adults.

Some KIs also identified food insecurity and access to supplemental educational opportunities as issues impacting Black youth. Food insecurity and the lack of educational opportunities have also been noted as factors linked to poverty (Federal, Provincial and Territorial Advisory Committee, 1999; PHAC, 2009) and an increased risk of HIV/AIDS in Black-Canadian populations (PHAC, 2009). Yet despite these challenges many Black youth in Toronto are able to excel and enter prominent careers.

Parent-youth issues

Ten (59%) KIs indicated that parent-youth issues were a main challenge or issue impacting Black-Canadian youth. The KIs referred to parent-youth issues as issues that

arise when youth actions conflict with their parents' expectations. These issues may be caused by intergenerational parent-youth conflicts and difficulties many Black immigrant parents have acculturating to the often Eurocentric values embedded within Canadian culture. Probing questions surrounding the identification of this theme led to a number of subthemes. Single parent households and parental expectations were also noted as subthemes.

Single parent households

Black populations have the highest proportion of female led single parent households than any other minority population in Toronto and many of these single parents have a high rate of low income (Ornstein, 2006). This high incidence may be due to the fact that many Black single parents live in priority neighbourhoods with limited access to affordable childcare, education and adequate employment. Further, Black single mothers must also contend with stereotypes within and outside their communities such as being on social assistance which may impact their self-esteem and in turn the values they teach their children. Over half (59%) the KIs noted the impact of single parent households on youth when they noted it as a challenge or issue impacting Black-Canadian youth. KIs also noted that Black single parent households are often led by mothers with limited to no male parental involvement. KI7 (a youth worker) stated that a lack of male parental involvement can have a major impact on a Black youths' development when she said

. . . Not having the father there . . . Specifically for Black male youth and their fathers I can say it impacts their [Black youths'] behaviour, it impacts their choices . . . you know you can come and ask mummy about certain things but daddy's gonna tell you the real down low on what boys are like. And if that piece is missing then kids are gonna go and find out for themselves . . . So

I think that's, that's what, what the issues are . . . (KI7, Caucasian Female)

KI10 also said

. . . Another big issue I find to is that the mother has let's say three or four kids there may be two or three different fathers in the home so the kids have different dads and it plays a role because what happens is you have one child whose dad {although he's not in the house} is coming around every weekend and you can have another kid whose father is non-existent and it affects that child's self esteem . . . (KI10, African-Caribbean Male)

KI15 (a youth worker who also works with gay youth) also noted single parenthood can impact many Black youths' academic growth and achievement. He stated

. . . But if they're not doing better then I find that if I contact home and there's two parents they [Black youth] have a greater chance of improving. You know what I mean because there's two people in which I can [talk to about their child and] it's a matter [of] connecting. Cause if it's a single mom you rarely ever call home and get her cause she's at work, right. Or if she can't speak [English] there's a language barrier as well. Parents also have this way of like playing [well] we [youth workers] play off the parents. There's the parents who will actually do something and the parents who won't do anything, so there's more of a chance to be able to get something to happen at home if there's two parents . . . (KI15, African-Caribbean Male)

Finally, KI11 (a religious leader) provided a possible reason as to the cause of high rates of single parent households in Black communities in his area. KI11 said, so guess what If I grew up in a home and I saw a single parent and that wasn't an issue, guess what? . . . That [single parenthood] no longer becomes an issue for me. That's something that becomes the norm of my [referring to a Black youth who lives in a single parent household] life . . . (KI11, African-Caribbean Male)

The identification of single parent households as an issue or challenge for Black youth is strengthened by the fact most of the KIs work and/or worked in locations with

high levels of single parent households (City of Toronto, 2008d; City of Toronto, 2008e; City of Toronto, 2008f; City of Toronto, 2008g; City of Toronto, 2008h; City of Toronto, 2008i). The KIs statements that most single parent households are female led is supported by a report from the City of Toronto (2003).

A number of KIs noted additional issues linked to single parent households. These issues were the separation of families and the lack of positive Black male role models for Black youth. Based on the KIs' comments separation of families refers to cases where either a youth's father or mother do not reside in the same house and/or the parent-youth relationship is strained. While there is a lack of studies that specifically review the separation of Black families in Canada, some studies have noted that the level of parent-child closeness can impact sexual risk behaviour (Eisenberg et al., 2006; Hutchinson et al., 2003). For example, Black-American female youth who have close relationships with their mothers are more likely to benefit from mother-daughter sexual health discussion compared to those that are not (Warren-Jeanpiere, 2006). Similarly, the lack of positive male role models for Black Canadian youth was noted in a Canadian case study of two Black Caribbean elementary school teachers in Toronto. One Black-Caribbean male teacher participant indicated the importance and need of positive Black male role-modeling. He stated that he often receives many Black troublesome boys as he is a Black male teacher and he believes he can have a positive influence on their behaviour (Martino, & Rezai-Rashti, 2010).

Parental expectations

Ten (59%) of the KIs indicated that parental expectations were noted as an issue impacting Black youth in Toronto. Based on the KI statements parental expectations refer

to the expectations parents have concerning their children's capabilities and/or future accomplishments. These expectations can have a positive impact on Black youths' behaviours. For example, many immigrant families from the Caribbean struggled during the immigration process to Canada and they often do not want their youth to face the hardships that they endured. As such, parents have high expectations for their youth. As KI5 (a teacher) indicated

. . . “And I remember when I came here; I came here when I was 14. I remember my mother marching down to the school and saying to the guidance councillor, “Ok this kid that is from Jamaica, she is university bound. I don't wanna hear any foolishness [nonsense] if there's a problem. You don't make a decision about where she goes because she's university bound. Nobody's gonna talk to my kid about a vocational program, or you know, trade if there's anything you tell me before you make any decisions.” A lot of parents feel that way . . . (KI5, African-Caribbean Female)

Conversely, parental expectations can have a negative impact on youths' self esteem. As KI9 (a youth minister) noted, you have parents that will put you down and you became that . . . [a Black parent may say] “you're not going to be anything, you're not going to be [anything]” and they [Black youth] became that. . .” (KI9, African-Caribbean Female)

The identification of parental expectations as an issue impacting youth is consistent with a number of studies which have suggested that parental expectations have an impact on youths' behaviour (Dittus, & Jaccard, 2000; Sieving, McNeely, & Blum, 2000; Windle et al., 2010). These studies noted that youth may internalize parental expectations which may help to reduce early youth problem behaviours (Dittus, & Jaccard, 2000; Windle et al., 2010). For example, youth who perceived their mothers to strongly disapprove of sexual intercourse were more likely to delay sexual intercourse longer than those who did not perceive this disapproval (Sieving et al., 2000).

Lack of Understanding

Nine (53%) KIs indicated that a lack of understanding was a main issue impacting Black youth in Toronto. Based on the KI statements lack of understanding refers to difficulties the larger society in Toronto have understanding Black youths' behaviour and Black parental-youth difficulties in understanding various aspects of each others' cultures and lives. This lack of understanding in the larger society is best highlighted by experiential and anecdotal knowledge of the common belief that most Black individuals in Toronto are of Jamaican heritage and their behaviours reflect various aspects of Jamaican culture. Conversely, KI9 noted the intergenerational and cultural factors impacting Black parents' lack of understanding when she said

. . . a lack of understanding of the culture. I say that because even when I talk to parents we have the conversation about hip hop and rap and all that kind other stuff. But you know having a conversation with parents about stuff like that. You know [there was] Diana Ross and the Supremes [for parents]; how was it for you [speaking to the parent]?" . . . But they're [youth] also not understanding who they really are, what they can really do and where they come from. So it's on both sides there's a misunderstanding or a lack of knowledge or willingness to know the knowledge. Sometimes a parent forgets what it is to be a youth and so there becomes this generational gap when it is very easy to bridge . . . There's a lack of understanding from the youth their culture, who they are and stuff like that . . . Youth are saying something but they don't understand the meaning behind it what something originated from or why we do the things that we do or how we move the way that we move, umm it would empower them. And then there's also the community seeing what the media wants to give them and labelling everybody as such sees them as and labels them . . . (KI9, African-Caribbean Female)

While there are a lack of studies that have specifically reviewed this theme some studies and grey literature have noted that culture has an impact on Black-Canadians' sexual health behaviour (PHAC, 2009; Lawson et al., 2006; Newman et al., 2008;

Omorodion et al., 2007; Toronto Teen Sex Survey, 2010). For example, African female youth believed African culture prevented women from discussing sexual health issues from their sex partners (Omorodion et al., 2007).

Additional issues noted by some KIs were a lack of understanding due to isolation and that many Black youth lack sufficient sexual health knowledge to understand that oral and vaginal sex are considered to be a form of sex. Based on KI comments a lack of understanding due to isolation refers to the difficulties many Black populations have seeking sexual health information and resources due to the unease of leaving their respective communities. There is some information that has noted one of the reasons which prevent many Black-Canadians from accessing resources outside of their community is the belief these resources do not take their culture into account (Lawson et al., 2006; Tharao et al, 2006; PHAC, 2009). Likewise, there is some information that has noted that some heterosexual couples will engage in anal sex as they believe it will preserve a female's virginity (Robertson, 2007).

Homosexuality

It is said that many Black men experience tremendous levels of homophobia within their ethnic and/or national communities in Canada (Crichlow, 2004). Further, many of these men not only feel unwelcomed in mainstream society due to racism but also within their own ethnic and/or national communities due to homophobia. Within Black communities, 11(65%) KIs noted that parents' understanding around homosexuality as an issue impacting Black youth. This may then impact their youths' actions. For example KI12 (a youth program leader) noted the negative reactions many Black youth he oversees have concerning homosexuality by sharing the following

observation about homosexuality

. . . Normally where homosexuality comes up is where you know kids are kind of slanderous. And I address that, that issue. And, with the athletic programs I think it's almost a regular occurrence . . . even, in, in moments of endearment for you know a peer they'll say "you know what, I like your pants. No homo [a slang used by youth to notify other youth they are not gay]" You know, there's this like you have to indicate that you're not being gay when you complement another guy. I mean like, to me that speaks powerfully to the homophobic sentiment amongst Black youth . . . (KI12, African Male)

This theme is supported by some Toronto based grey literature that has noted homosexuality as an issue in Black communities (Lawson et al., 2006; Robertson, 2007; Tharao et al., 2004). These studies noted the concept of homosexuality was identified as a taboo subject in Black communities in Toronto and is rarely discussed. Further, many Black individuals in Toronto hold negative sentiments towards homosexuality (Lawson et al., 2006; Robertson, 2007; Tharao et al., 2004) and these sentiments have led to the belief that that HIV is a homosexual disease (Lawson et al., 2006). This belief may prevent many Black individuals in Toronto from seeking HIV education (Tharao et al., 2004).

Difficulties finding employment

There is some work suggesting that Black youth experience difficulty in finding employment because of many factors associated with race. One Toronto based study that reviewed racialized communities in a priority neighbourhood noted that Black communities experienced racism more often and intensely in the labour market. Further, systemic discrimination greatly undermines racialized communities' access to stable employment, fair wages, and employment that matches their skills. This study also noted a long history of racial profiling by employers that specifically targeted racialized youth

which had negative long term impacts on employment security for these youth and their parents (Wilson et al., 2011). Fourteen (82%) of the KIs identified difficulties finding employment as a main issue impacting Black youth in Toronto. KI10 (a youth worker) highlighted the difficulties many Black youth face when attempting to seek employment when he said

. . . I mean there aren't a lot of jobs aren't out there for youth at the best of times anyways. And then when you look at kids with limited work experience, limited good references and live in areas where there isn't a lot of access to employment you have a problem. And then when they apply for other jobs they're competing with kids from all over the city . . . (K10, African-Caribbean Male)

KI1 (a youth worker) noted the potential negative impact difficulties finding employment can have on many Black youth when she said

. . . If they [Black youth] aren't able to access these things [jobs] then they try [to] look for like alternate resources or alternate ways to get the things that they want. Long term, so if you [Black youth] don't have a job to make money then you might think then what your other options are? So they might result; resort to crime . . . (KI1, African-Caribbean Female)

KI1's comment was echoed by Wilson et al., 2011 who noted that systemic racial profiling of racialized youth seeking employment can prompt a perpetual cycle of difficulty finding employment and lead them to engage in criminal activities as a source of income. Further, some KIs noted that many Black youths' manner of dressing and vocabulary may impede their ability to procure employment.

Education

Anecdotal evidence and some Canadian based literature indicate students' race impacts teachers' treatment of a student and the severity of punishment given to students for bad behaviour. For example, a review of the Ontario Safe Schools Act which

prescribes mandatory suspensions and expulsions for students' bad behaviour found that students with disabilities and racialized minority students; particularly Black students were disproportionately impacted by the Act (Bhattacharjee, 2003). Nine (53%) KIs also noted these educational impediments impacted many Black students when they indicated that education was an important issue facing Black Toronto youth. The main subtheme gleaned from KI comments' concerning education was the lack of education impacting employment opportunities.

Lack of education impacting employment opportunities

Black youth are dropping out of high school at a disproportionate rate. A 2006 student census in Toronto indicated that there was a 40%, 32%, 26%, 23% drop out rate among African-Caribbean, East African, West African and Canadian Black youth respectively (Africentric Alternative School Support Committee, n.d.). Canadians who have not completed secondary education are more likely to lack employment opportunities (Federal, Provincial and Territorial Advisory Committee, 1999) and in turn gain a lower income (PHAC, 2009). Over half (53%) of the KIs also noted the negative impact a lack of education can have on Black youths' employment opportunities. KI10 noted this issue in the following statement

. . . Black youth are just not finishing school. So even when you're [a Black youth] applying for a job with McDonald's chances are you're going up against a kid that's got high school diploma in the least . . . many of these kids are losing out on jobs because of that lack of education . . . (KI10, African-Caribbean Male)

The identification of education and employment as issues impacting Black youth are supported by the fact that both themes have been noted as social determinants of health for Canadian populations (Federal, Provincial and Territorial Advisory Committee,

1999) and as factors that impact Black populations' risk of HIV/AIDS (PHAC, 2009). Education can increase Canadian's access to health care information and services as well as provide individuals with a sense of control over their life situations. It is also related to employment as those with higher levels of education have greater job opportunities, income security, access to safe living environments and healthier foods (Federal, Provincial and Territorial Advisory Committee, 1999; PHAC, 2009). Further, most of the priority neighbourhoods in which many of the KIs work have high youth unemployment rates compared to the overall GTA's rate (City of Toronto, 2008a).

KIs also noted several additional issues such as peers impacting Black youths' education, lack of sexual health education, limited school-based support for science education, stigma surrounding vocational training, lack of minority representation in school faculty and curriculum, differences in educational expectations between young Black males and females and difficulties accessing the educational system. For example, peers have been noted to influence youths' sexual risk behaviours (Jaccard et al., 2005; Stanton et al., 2002). The lack of sexual health education issue is supported by some Canadian studies that have noted the content and delivery of sexual health education programs provided by the Ontario government is dependent upon the school boards and teachers (Meaney et al., 2009; Smylie et al., 2008). As such, not all Canadian students will receive the same level of school-based sexual health education. There is a paucity of studies that could be found that specifically reviewed limited school-based support of science education, Black youth's gender, educational expectations and Black communities' stigmas surrounding vocational training. However, experiential knowledge supports the identification of these issues; particularly the stigma surrounding vocational

training has been noted to prevent many Black students in Toronto from pursuing vocational careers. The lack of studies on these two issues indicates additional research must be conducted.

Additionally, the lack of visible minority teachers in high schools coupled with a lack of minority representation in the school curriculum may negatively impact Black youths' academic aspirations. There is some information that indicates visible minority teachers are underrepresented in Toronto schools. For example, according to a 2006 Toronto District School Board census, of the 3662 permanent secondary school teachers who responded to the census only 179 of those teachers were Black (Herring, & Associates, 2007). Also, one Canadian study found that one of the reasons two Black-Caribbean individuals became teachers was to address the lack of visible minority teachers; especially Black teachers with whom Black students could relate to (Martino, & Rezai-Rashti, 2010) and use as a source of inspiration to attain their own educational goals. Further, while the school-based sexual health curriculum indicates that high school students should have a number of skill sets such as identifying the developmental stages of sexuality through life (Ontario Ministry of Education, 1999) in grade nine and 10 this curriculum does not explicitly acknowledge the impact of culture on sexual health. While there is a paucity of studies that have specifically reviewed difficulties accessing the educational system a study noted that issues such as racism can limit Black populations' educational opportunities (PHAC, 2009).

Access to Resources

Many Black populations in Toronto live in priority neighbourhoods that lack accessible services (Hulchanski, 2007) that acknowledge and address their needs in a

culturally appropriate fashion. Additionally, access to resources outside these neighbourhoods are often impeded by systemic barriers (Wilson et al., 2011) such as limited public transportation service. Transportation barriers have also been found to prevent many Black-Canadians from accessing resources (Gardezi et al., 2008; Robertson, 2007). The inability to access health services and support networks can impact Black population's vulnerability to HIV/AIDS (PHAC, 2009). Ten KIs (59%) also identified access to resources as a major challenge impacting Black youth in Toronto. According to the KIs statements, access to resources refer to difficulties Black youth encounter when attempting to access services that can enhance their wellbeing and academic success. KI13 (a social worker) highlighted the problems faced by Black youth who attempt to access these resources when she said

. . . in this corner of the world [referring to the northwest area of Toronto] you would think that you were in a completely different part of the world. Many of my kids [who the KI works with] don't go south of the community they just don't. They [youth] don't go south of [street name], they don't go south of [another street], they don't go east of the community or west of the community, right. So there's this very stringent kind of geographical boundary. So accessing services becomes virtually impossible because where are the services? They're in Toronto . . . And so they'll [the youth] come to me and there's a dearth [of resources available but in this part of the city] like there's NOTHING [emphasis placed on the word nothing] available up here. If it is available it's taxed beyond what it can sustain and so many of them go without, right. So if we're talking about sexual health a lot of the great sexual health clinics are in downtown Toronto, right. And I can refer them all I want; they're not going . . . (KI13, African-Caribbean Female)

KI5 (a teacher) also said

. . . People may say [to individuals in Black communities] . . . “why don't you access such and such for help? Why don't you do this and that?” But one of the things people complain about is “you can say that the services are available but I can't get to them.

Transportation is a real problem for me.” These aren’t really things you think about [For example] how the city’s laid out stops people from where they’re going and where you need to be. Even with things like [an individual may say] “well the TTC doesn’t run at this time when I need it to run.” (KI5, African-Caribbean Female)

While many KIs indicated there was a lack of services readily accessible to many Black youth there were a small number of KIs who believed the services were available but lacked the necessary programs to adequately address issues impacting Black youth.

KI11 (a religious leader) emphasised this inadequacy when he said

. . . The resources [are present but the focus is on] managing the problem. So you know what? Let’s manage to make sure you know what? Crime can stay down. But in order to bring change you need to go to the root cause of the problem and begin to change from there . . . (KI11 African-Caribbean, Male)

Other issues identified by some KIs associated with this theme were language barriers impacting access to resources and parent-youth communication, one size fits all approach to community services and the lack of resources with long term solutions to issues facing Black youth. The language barrier issue is supported by some grey literature that has found language barriers prevent many individuals from Black populations in Toronto from accessing HIV programs (Roberston, 2007), medical care and diagnosis (Lawson et al., 2006). The one size fits all issue is supported by a non-peer reviewed article which indicated that due to the diversity within Black populations in Toronto, there is a need to develop culturally appropriate sexual health care programs for Black youth (Toronto Teen Survey, 2010). Key Informants’ comments coupled with experiential knowledge indicates many youth focused programs attended by Black-Canadian youth often focus solely on physical activity and academic achievement. One U.S. parental monitoring intervention study noted the positive impact resources with long term solutions can have on youth. This study found that African-American youth who

underwent the intervention as well as booster sessions several months post-intervention were further protected against risky behaviours than those who did not receive these sessions.

Crime

While rates of crime have decreased in Toronto in recent years (Wallace, 2009), crime and racial profiling by law enforcement continues to impact many Black youth in Toronto. This profiling leads to high levels of criminalization of racialized youth, decreases chances of gaining legal employment for youths with criminal records (Wilson et al., 2011) and may lead many youth to distrust the police. The racialization of crime is also seen in the media. For example, one Toronto based study found the vocabulary used by the media to discuss a crime that involved Black perpetrators included phrases like “cultural deviance” and “Jamaican or Black crime” (Henry, & Tator, 2000). Ten (59%) KIs also noted the impact of crime on Black youth in Toronto. KI15 (a youth worker who also works with gay youth) highlighted this impact when he said

. . . two youth, one youth who was currently one of our students was murdered and the other youth was a former student was murdered, right. There was another youth worker who was [murdered] so a lot of those things don’t get reported but like they have a significant impact on the community and the work that we [youth workers] do . . . (KI15, African-Caribbean Male)

Despite the impact of crime in some priority neighborhoods, anecdotal evidence indicates that there are many thriving businesses in these neighbourhoods.

In your opinion what are some of the main challenges Black parents or youth face in discussing sex, dating and relationships? (PROBE) What about HIV? Are there any challenges? If so what are those challenges and who are they talking to about it?

The Study Coordinator posed these questions to each KI as there is a void of Canadian based research which reviews the challenges impacting Black parent-youth sexual health discussion. While there have been some Canadian studies that have looked at HIV and the challenges discussing HIV/AIDS in Black communities (Lawson et al., 2006; Gardezi et al., 2008; Newman et al, 2008; Robertson, 2007) none have specifically reviewed HIV discussion among Black parents and youth and sources of sexual health information for Black youth.

Fifteen (88%) KIs noted that Black parents and youth have difficulties discussing sexual health issues with one another. The main themes found from these questions were lack of in-depth sexual health conversations; lack of discussions concerning teen pregnancy; parental discomfort discussing sexual health with youth conversation; parental fear that discussing sex with lead youth to engage in sexual activity; difficulties discussing sexual diversity; and lack of discussions concerning HIV.

Lack of in-depth sexual health conversations

Eleven (65%) of the KIs noted Black parents do not have in-depth sexual health conversations with their youth. One respondent said

. . . so it stands out for me the fact that they're [Black youth] not able to communicate with their parents openly about sexuality to you know any type of sexual act all the way to having sex. And a lot of these children come from single parent families . . . and they [the parent] don't want their children to make the same mistakes that they did. So I think their [the parents'] approach is just by ignoring it or not talking about it that it's not gonna happen or they think that by discussing it with their children that their children are gonna see that [sex], that's [having sex] now something that's acceptable for them to do. . . (KI8, Caucasian Female)

The relevance of this theme is strengthened by findings of studies and grey literature that noted most Black parents in Toronto (Robertson, 2007) and parents in the U.S. (DiClemente et al., 2001; Dilorio et al., 2006; Hutchinson et al., 2003) do not discuss sex with their youth. Further, Gardezi et al. (2008) noted that many Black populations in Toronto rarely discuss sex, sexuality, physical and psychological health issues at home. Experiential knowledge indicates this lack of discussion mirrors cultural taboos surrounding the discussion of sex and sexuality embedded in many Black populations in Toronto.

Lack of discussions concerning teen pregnancy

Twelve (71%) KIs indicated there is a lack of Black parent-youth discussion on teen pregnancy. If in the event there was any discussion concerning early pregnancy nine (53%) KIs stated the discussion focused on warning their youth not to become pregnant or cause a pregnancy. As KI7 (a youth worker) said

. . . it's very much "don't make meh find out yuh pregnant [said to female youth], don't make me find out dat yuh breed a gyal out there [got a girl pregnant], if yuh gwan have sex [if you are going to have sex], wrap it up, and don't bring home no diseases [said to male youth with a Jamaican accent]." You know it would be the negative . . . (KI7, Caucasian Female)

While there are limited articles that could be found which specifically reviewed this theme anecdotal evidence indicates that many Black parents fear Black teen pregnancy and having their daughters fulfill stereotypes of the "Black teen mom on social assistance" held by the larger population. Further, teen pregnancy may be an issue in Black Toronto communities as a non-peer reviewed article noted there may be high Black youth pregnancy rates in areas with large Black populations (Robertson, 2007). This rate may indicate a lack of parent-youth discussion concerning pregnancy.

Parental discomfort discussing sexual health with youth

Nine (53%) KIs indicated that Black parents' level of comfort discussing sexual health impacted Black parent-youth sexual health discussion. As KI1 (a youth worker) said . . . I think for most of us, or all of us I think parents were never really comfortable at all or they would make assumptions and they'd just throw things out there . . . (KI1, African-Caribbean Female)

Parental fear discussing sex will negatively impact youths' behaviour

Parental fear discussing sex was noted as a main subtheme of parental discomfort discussing sexual health with youth. Almost half (47%) of the KIs identified this subtheme as an issue which impacted Black parent-youth sexual health discussion in Toronto. According to the KIs' statement parental fear refers to the fear many Black parents have that discussing sexual health with their youth will lead their youth to engage in sexual activity. One respondent highlighted this fear in the following statement

. . . I would think that they're scared. [a parent may think] "If I go and talk to my son about this [sex] does that mean he's going to start doing it [having sex]?" . . . Our parents [referring to KI9's own parents] said the same thing "I want you to be young and pure and innocent for as long as you can be. If that means that it's 30, Praise the Lord!" But, some of them don't [wait that long to have sexual intercourse]. . . As a parent you might have fear and you want to keep your child as clean as possible and sometimes there's that fear that "if I open them up to it [discussing sex] am I opening them up to it [having sex]?" . . . (KI9, African-Caribbean Female)

While there is a lack of Canadian based peer reviewed studies which specifically

review parental fear and discomfort impacting Black parent-youth sexual health discussion in Toronto, these factors are supported by some Toronto based non-peer reviewed studies. A study by Robertson (2007) highlighted the impact of parental discomfort when it suggested parents that are uncomfortable discussing sexual health could enrol their daughters in youth-focused sexual health programs. Lawson et al. (2006) noted that Black populations in Toronto are generally reluctant to discuss sexual health topics like sexuality. This reluctance may be due to cultural taboos concerning sexual health discussions in Black populations which in turn makes it difficult to discuss sexual health and HIV prevention methods (Lawson et al., 2006). Robertson (2007) also noted that many Black parents feared discussing sex with their youth would lead their youth to engage in sexual activity.

Difficulties discussing sexual diversity

Eleven (65%) of the KIs indicated that homosexuality was a difficult topic for many Black parents to discuss with their youths. As KI8 (a youth worker) stated

. . . And you know even issues surrounding homosexuality, it's definitely something that you do not talk about . . . and it's usually the mother I guess that [may talk about sex] . . .

Study Coordinator: . . . why do you think that, that's completely; no [discussion about homosexuality], it's a complete no?

KI8: I think from, from my experiences I've one or two specific instances can think of and usually religion was involved. So umm I guess the closeness of whatever religion they were coming from it was just something that you don't even broach that subject it's not [an]option, it's not even discussed, it's not something that you know the child is ever suppose to consider as an option. If they were to discuss something like that with their family, it would be shut down right away. And if they were to discuss any inclination to doing something like that, that would be a fight and they can't be around; they would have to leave the house basically . . . (KI8, Caucasian Female)

Homophobia

Homophobia was identified as a subtheme of difficulties discussing sexual diversity. Nearly half (47%) of all KIs indicated this subtheme impacted Black parent-youth discussion about sexual diversity. KI12 (a youth worker) noted this when he said . . . when it [homosexuality] is discussed at home it [the discussion] often comes from a place of you know almost a discriminatory thing where the only time I can recall hearing about sex at home is through you know a homophobic expression . . . (KI12, African Male)

KI8 (a youth worker) also provided an example

KI8: . . . I had a woman, a young girl that I dealt with from a Caribbean background. And she told her mother that she was in fact gay and had been having relationships with women. And her mother said “I’m just going to pretend that I didn’t hear that.” And for the rest of the time that she was living at home, she [the mother] didn’t acknowledge it [her daughter was a lesbian] and if she [the mother] did she [the mother] would be like “ohh that’s her [daughter’s] friend.” And she (the mother) wouldn’t acknowledge the fact that she [her daughter] was [a lesbian] . . .

Study Coordinator: Where do you think that’s [negative sentiments surrounding homosexuality] coming from? . . .

KI8: From the parents. With Caribbean culture there is, there’s a sense of shame that comes with homosexuality . . . (KI8, Caucasian Female)

The identification of this theme and subtheme is strengthened by a study by Lawson et al. (2006) who noted that Black communities in Toronto are generally reluctant to discuss sexuality and do not discuss homosexuality. Many Black communities deny the existence of homosexuality in their respective communities and have negative sentiments towards homosexuality (Gardezi et al., 2008; Lawson et al., 2006; Newman et al., 2008; PHAC, 2009). These negative sentiments often reflect the

commonly held beliefs concerning homosexuality from the parents' or families' country of origin. These sentiments may prevent Black parents and youth in Toronto from discussing homosexuality with one another.

Additional issues noted by KIs were cultural views of homosexuality, negative reactions towards homosexuality and negative consequences of coming out in Black communities. Some KIs also noted lesbianism garnered a less severe reaction than male homosexuality and some Black parents feared their youth would become gay by associating with individuals who were gay. African-Caribbean cultures' and Black populations' negative view of homosexuality were also noted by several peer and non-peer reviewed journals (Gardezi et al, 2008; Lawson et al., 2006; Newman et al., 2008; Robertson, 2007). Further, KIs comments concerning "coming out" in Black communities is supported by some grey literature which notes that Black gay men often do not come out as they fear they will be ostracized from their communities (Toronto Teen Survey, 2010; PHAC, 2009). While there is a paucity of studies that specifically reviewed lesbianism and Black parental fear of their youths' becoming gay, experiential knowledge supports these themes. As such further research should be conducted to review Black communities' views of lesbianism and factors which promote negative views of homosexuality.

Lack of HIV/AIDS discussions

Some information has been found that has noted that many individuals within Black populations did not discuss HIV/AIDS. This lack of conversation is partially attributed to the larger Canadian society's view of Black populations as carriers of HIV and other diseases. Within Black communities, assumptions that HIV is a gay disease

(Lawson et al., 2006; Gardezi et al., 2008) or the result of promiscuity and prostitution can prevent many Black individuals from discussing HIV. Further, Black individuals that are HIV positive not only face stigma and discrimination within the health care system but also within their own communities. Many of these individuals may not disclose their HIV positive status to others for fear of being ostracised from their communities (Lawson et al., 2006; Robertson, 2007). Sixteen KIs also noted a lack of Black parent-youth discussions about HIV/AIDS. This theme yielded the following main subthemes; no conversations about HIV/AIDS; impact of the Black Toronto communities' view of HIV/AIDS on parent-youth HIV discussion; and HIV/AIDS is a homosexual disease.

No Conversations about HIV/AIDS

Over half (59%) the KIs noted that most Black parents do not discuss HIV with their youth. A KI commented on this lack of communication when she said

. . . And the idea is like I said, if you're Christian or if Muslim you're not gonna get HIV. [A parent would think] "I don't need to talk about that with you [the youth]". If I [the parent] raise the conversation, it like just brings up so many negative, disgusting [connotations and] you know [the parent may believe] "if I don't talk about it [HIV then] it's not real, and I don't need to talk about it. Because you're [the youth] not the type of person for it to happen to, so why should I have, why should I have this conversation?" . . . (KI5 African-Caribbean, Female)

Impact of the Black Toronto communities' view of HIV/AIDS on parent-youth

HIV discussion

Over half of the KIs (53%) suggested that HIV/AIDS is a taboo subject in many Black Toronto communities and this sentiment may prevent many Black parents from discussing HIV with their youth. This subtheme is highlighted in the following statement.

. . . I mean as far as HIV and AIDS there's so much ignorance about it in certain communities. I'm sure were the parents have less

information than the children even have. They [parents] might say “cousin so and so had AIDS, he was bad and dirty and he got cast out of the community and we don't talk to him anymore.” But that's really it . . . I think there's a stigma definitely that goes along with it . . . I think it's [HIV/AIDS] just seen as a dirty thing and parents have a hard time envisioning their children being involved in something like that . . . (KI8 Caucasian, Female)

HIV/AIDS is a homosexual disease

Seven (41%) KIs noted that many Black parents and youth did not discuss HIV/AIDS due to the belief that only homosexuals are susceptible to this STI. This sentiment is echoed in the following statement

. . . My experience so far has been that the expectation would be that if you had HIV then it must be because you're gay. So I think in a lot of parents view their children aren't gay so they don't need to have that conversation. So it [discussing HIV/AIDS] doesn't need to happen. It would be like you know they [parents] would have a conversation about Sickle Cell, but they would never need to have a conversation about another blood disorder called HIV because “my child is Black but certainly isn't gay. And we don't raise gay children” . . . (KI7, Caucasian Female)

These subthemes are supported by some peer and non peer-reviewed journals. Several Toronto based studies have also noted the difficulties Black populations have discussing HIV (Roberston, 2007; Lawson et al., 2006; Newman et al., 2007; PHAC, 2009). For example, the emphasis placed on HIV and homosexuality may lead many Black women to disregard HIV prevention messages and their risk of infection (Newman et al., 2007). This view may lead many in Black communities to believe they are not at risk of HIV infection.

Key Informants also noted that parent-youth HIV/AIDS discussion is often used to prevent Black youth from engaging in sexual activities and Black parents lack sexual health knowledge necessary to have effective parent-youth sex discussions. While there is

limited information on these issues experiential knowledge indicates HIV/AIDS discussion is often used as a deterrent by some parents. Additionally, Frappier et al. (2008) who found many Canadian mothers who spoke to their youth about sexual health reported they were unable to find all the sexuality and sexual health information they wanted.

Sources of sexual health information for Black youth in Toronto

Many Black youth have identified racism as a key factor that prevented them from accessing sexual health services (Toronto Teen Survey, 2010). Also, many Black youth may interpret the lack of culturally competent services and service providers as a form of racism. Experiential knowledge and some evidence indicates that many service providers may present information in a generic fashion or may be reluctant to discuss culturally sensitive issues for fear of offending visible minority youth or being labelled as racist. Further, many Black youth may not access sexual health services for fear of being judged by service providers and being seen by others within the community accessing these services and being gossiped about. Racism, a lack of culturally competent services and service providers as well as the fear of being judged for accessing sexual health services within and outside Black communities lead many Black youth to seek alternate sources of sexual health information. Fifteen (88%) KIs stated that Black youth sought alternate sources of sexual health information. A review of KI responses led to the identification of several commonly used sources of information by Black youth; peers; friends; school; and mass media.

Peers

Over half (53%) of KIs noted that peers are a source of sexual health information for many Black youth in Toronto. The following quotes highlight the heavy reliance Black youth have on their peers' sexual health knowledge and the possible consequences of this reliance

. . . Every kid goes to peers; they're not going to run to talk to mom and dad about X, Y, Z. Most kids go to other kids. The difference between our [Black] communities and others is that when the answers aren't satisfied by the peer group other communities often feel enough self agency to then seek out professionals or people who would have the information outside of their circle. But in the Black community as a whole our Black young people as a whole DON'T [seek out sexual health information]. [Instead youth assume that] "if my friend doesn't know [information about certain sexual health topics] then it isn't so. Because I don't go to those other places . . . [a youth may say] "I have a family doctor, when I can't see my doctor there's a walk in clinic. And when I do walk into those agencies that are for us, like you know [name of agency] . . . I feel super uncomfortable because I feel dumb in these spaces, I feel Black in these spaces . . . So if I don't identify with my parents, I ain't gonna identify with this . . ." (KI3, African-Caribbean Male)

KI1: . . . So umm for the most part they talk amongst themselves and then sometimes if they feel comfortable enough like they talk to a service provider or something like that. Most of the time those conversations happen when they're being challenged so like "oh my gosh I think I might have an STI!" then that's when I'll speak to the public health nurse," . . .

Study Coordinator: So it's almost like only when it's a worst case scenario.

KI1: Yes
(KI1 African-Caribbean, Female)

Friends

Nine (53%) the KIs noted that Black youth viewed their friends as credible sources of sexual health information. KI8 (a youth worker) highlighted this view when she said . . . I mean in certain communities, one person will say something like in groups

of friends and that will spread like wildfire and then that will become truth. And then everyone will think that, that's factual. (KI8, Caucasian Female)

School

Almost half (47%) the KIs noted that many Black Toronto youth view schools as an important source of sexual health information. This is noted by KI12 (a youth worker) who said . . . it's school. I'd say that the majority of sexual health information [youth] are getting is coming through the classroom. . . (KI12, African Male).

Mass Media

Thirteen (76%) KIs noted that many Black youth often turned to mass media as a source of sexual health information. The KIs identified television and the internet as the main mass media sources of sexual health information among Black youth.

Television

Nine (53%) KIs identified television was a source of sexual health information for Black Torontonians youth. As KI15 (a youth worker who also works with gay youth) stated

. . . So you'll hear students repeating things that they've heard on TV or lines and they don't even know what those things mean . . . I think that's the biggest danger is that it's happening really late because . . . students are exposed to these things at a very, very young age {this is going to sound like I'm getting very old} but things like Family Guy [an animated television show] you know what I mean. And now [the show is] playing at a really early time so now you find that a lot of young people are watching it and . . . they're repeating the things and you [Black youth] don't even know what you're saying . . . (KI15, African-Caribbean Male)

The Internet

Almost half (47%) the KIs noted that many Black Toronto youth view the internet as an important source of sexual health information. KI6 (a youth worker) noted the ease of accessibility Black youth have to the sexual health information via the internet when she said . . . everyone has an iPhone or a BlackBerry® and they're [Black youth] using it . . . They're using it and that's where they're getting their information from . . . They would probably know to search more for "when I'm with a boy what to do?" . . . (KI6 Indo-Caribbean, Female)

The identified alternate sources of information are strengthened by several peer and non-peer reviewed articles that have noted that many Black youth use these sources for their sexual health information (CFSH, 2007; Flicker et al., 2009; Omorodion et al., 2007; Robertson, 2007). For example, youth who watch large amounts of media with sexual content are more likely to overestimate the number of peers who are sexually active (Strasburger, 2004).

Some KIs also identified family members, schools, and music such as reggae, dancehall and hip-hop as additional sources of sexual health information. While several studies have identified music as a source of sexual health information for youth (L'Engle et al., 2006; Pardun et al., 2005) there is a lack of information on the impact of these music genres on Black-Canadian youths' sexual health knowledge. Key Informant comments and experiential knowledge indicate these music genres inform many youth's view of sex and sexuality. Additionally, there is some evidence that indicates youth seek sexual health information from family members and schools (Flicker et al., 2009).

Some KIs also noted that many Black females turn to Black male youth for their sexual health information. Key Informant comments indicate many Black female youth

believe Black male youth have more sexual health knowledge as they believe parents are more likely to discuss sex with male youth and/or males are more likely to seek sexual health information.

Additional findings

Most KIs noted they had more experience assisting Caribbean youth and parents than African youth and parents. This difference is supported by Statistics Canada that found almost 60% of individuals of Caribbean (Statistics Canada, as cited in Statistics Canada, 2007a) and 41% of individuals of African origin in Canada reside in Toronto (Statistics Canada, as cited in Statistics Canada, 2007b). Key Informants who had experience working with parents and youth from both cultures noted differences in African and African-Caribbean parent-youth sex communication. This finding further dispels a commonly held societal belief that “all Black people are the same” (Robertson, 2007) and also highlights the cultural variations that further impacts Black parent-youth sex communication. Probing questions concerning the difficulties Black parents and youth face discussing sex, dating and relationships also led to the identification of additional themes which will be discussed below.

Differences in the level of sexual health discussion between African and African-Caribbean parent and their youth

Eleven (65%) KIs stated that there are differences in African and African-Caribbean parent-youth sexual health discussion. KI10 (a youth worker) highlighted this difference when he said

. . . I find the African ones [African parents] basically tell their kids . . . [they] mainly start off with “don’t talk to boys, I don’t [want to] hear you talking about boys, I don’t want to see you hanging around one.” Where the, more of the West Indian

[meaning Caribbean] ones, the parents seem to be a lot more ok with the boyfriend. I mean they'll mention the fact that they don't want to see their daughter come home pregnant . . . (KI10 African-Caribbean, Male)

Additionally, KI12 (a youth worker) noted these differences when he said

. . . There's a fellow from Jamaica whose father would tell him about sex-ed how it's ok at his age to engage in [sex] and have multiple partners. It was a non-issue for him [the father] and his father would say "look, I mean [you're] a man, a man must test" I can't remember the exact analogy; it sounded [like] "every fisherman must test the waters" or some, something of that nature. I mean that was something he brought [from his country of birth] . . . [On the other hand with], African fathers to their sons . . . I think the emphasis isn't so much around sex as it is marriage. I mean it's more important in my [African] community to be married and then have children. It's actually heavily emphasized . . . (KI12 African, Male)

KI10 (a youth worker) also noted that there were differences between African and

African-Caribbean parents' view of teenage pregnancy. He said

. . . because what happens is a lot of times I find is, a lot of West Indian [meaning Caribbean] mothers are afraid that their daughters will follow in their footsteps they had their kids young without finishing school. They see their daughters now doing the exact same thing and they know how hard it is for them so they take that approach . . . As opposed to African ones where there's not that guilt piece or that worry piece cause they didn't, they didn't get pregnant early. It's just that we [Africans] don't believe in pre-marital sex and pregnancy and so not to bring dishonour on the family, "we don't want you to have sex or, get pregnant" . . . (KI10 African-Caribbean, Male)

While there is a paucity in Canadian studies that have specifically reviewed differences in sexual health discussion between African and African-Caribbean parents and youth, anecdotal evidence coupled with KI statements indicate there is a high probability there are distinct differences between the two groups. Future studies should review African and African-Caribbean parent-youth sexual health discussion to

determine the distinct differences in content of this discussion and how best to address these differences in parent-youth sexual health programming.

How to enhance Black Torontonians parent-youth sexual health discussion

Almost half (47%) the KIs provided suggestions as to how to enhance Black parent-youth communication. The most common suggestion is discussed below.

Begin sexual health discussions with Black youth at an early age

Four KIs noted that beginning sexual health conversations with Black youth at an early age could reduce Black parent-youth difficulties in having sexual health discussions when youth are older. KI11 (a religious leader) echoed these sentiments when he said

. . . You see, you gotta teach them these things how to be able to manage that [sexual health], in the proper setting. So you need to have that conversation by six, seven [years of age]. Age appropriate for sure. But start talking about it [sex] because what a six year old in Canada knows today about sex I probably was about 12 before I know that . . . (KI11, African-Caribbean, Male)

While there is a paucity of studies that have specifically reviewed the impact of parents initiating sexual health discussion with their youth at an early age, this suggestion may be supported by some studies. The CHAMP intervention program focused on enhancing Black parent-youth sexual health discussion on youth prior to and after puberty (Baptiste et al., 2006). Further, in 2010 the Ontario provincial government attempted to implement a new sexual health curriculum that would have introduced sexual health topics such as sexual orientation in elementary school (Ministry of Education, 2010). Due to a number of factors; particularly pressure from religious groups and some parents, the government decided not to implement the changes until further reviews of the new curriculum could be conducted (Canadian Broadcasting Corporation, 2010).

Additional suggestions from some KIs included having culturally appropriate sexual health discussions, increase Black parents HIV knowledge and discussion about homosexuality. While there is a lack of studies that have been conducted on these suggestions, some of these suggestions have been noted by other researchers. For example, some articles noted that HIV prevention programs and strategies should reflect the needs of Black communities (Gardezi et al., 2008; Robertson, 2007; PHAC, 2009; Toronto Teen Survey, 2010).

Religion

Comments made by KIs during their interview concerning religion and sexual health discussion led to the addition of probing questions concerning the impact of Islam and Christianity on Black parent-youth sexual communication and Black youths' view of sex and sexuality in Toronto. The two religions were selected as it was noted that Islam and Christianity were repeatedly identified by KIs as predominant religions practiced in Black Toronto communities. The KIs' identification of these two religions was supported by Statistics Canada (2001) which noted the two most actively practiced religions by Black populations in Toronto were Christianity and Islam.

Most (88%) of the KIs indicated that religion played an important role in many Black parent-youth sexual health discussions and many Black youths' view of sex and sexuality. The main theme found from KI discussions concerning religion was the use of religion to frame Black parent-youth sexual health discussion.

Using religion to frame Black parent-youth sexual health discussion in Toronto

Twelve (71%) of the KIs indicated that Christianity and Islam framed the way in which many Black parents discussed sex and sexuality with their youth. KI15 (a youth

worker who also works with gay youth) noted this use of religion by Black parents in Toronto when he said

. . . I don't know if Catholic parents are sort of having those conversations. I think that a lot of Muslim parents are having those conversations in respect to their religion, you know what I mean. So what are the requirements, what are the expectations of a woman? . . . What are the expectations of a man that's according to our religion?

. . . So parents will have those conversations because it's very easy, it's all laid out . . . (KI15, African-Caribbean Male)

KI15 (a youth worker) also noted differences in Black Muslim and Christian parent-youth discussion about sexuality and homosexuality when he said

. . . In the Muslim population homosexuality is like it's just a sin; you know what I mean. It's just like no, it's [homosexuality] not really talked about, it's not discussed. It's just wrong. I find that in the Roman Catholic and Christian [there is] a little more flexibility in terms of it [homosexuality] being tolerated . . .

(KI15, African-Caribbean Male)

While there is a paucity of Canadian based studies which specifically review the impact of religion on Black parent-youth sexual health discussion, the impact of religion on Black communities' views of HIV (Gardezi et al., 2008; Lawson et al., 2006; Newman et al., 2008) and sexual health risk (Omorodion et al., 2007) in Toronto has been noted. For example, Newman et al., (2008) noted that church doctrine influenced many Black women's daily lives and practices which may increase their risk of HIV infection. There is also a belief in some sectors in Black communities that HIV is connected to morality and religion (Gardezi et al., 2008; Lawson et al., 2006). Further, Gardezi et al. (2008) noted that religious prohibitions against condom use often impacted attempts to address HIV/AIDS in Black communities in Toronto.

Additional issues linked to religion noted by some KIs was abstinence, using anal sex to maintain abstinence in female youth, using religion to frame Black youths' view of sex and sexuality, and differences in sexual health discussion based on religion. A number of these issues have been noted by some Canadian based research. Robertson (2007) noted Muslim African communities believed that HIV affected Muslim populations less than non Muslim populations as Islam prohibits pre-marital sex and that anal sex is practiced by some heterosexual couples in an attempt to maintain a woman's virginity. Studies also noted many Christian Africans indicate that their religious values impact their sexual experiences (Lawson et al., 2006; Omorodion et al., 2007) and restricted their sexual behaviour.

In your opinion, are schools supportive of Black youth with regards to their cultural approach to sexual education? (PROBE: if they say relationship is not good) How would you suggest improving that relationship? (PROBE: if they say relationship is good) Why is it great?

This question was posed to KIs as schools have been found to be important sources of sexual health information for youth (Flicker et al., 2009) and members of the CAC noted schools were often found to be the main source of sexual health education for many Black youth in Toronto. Further, while Canadian based studies have recommended the implementation of culturally appropriate sexual health services for Black populations (Gardezi et al, 2008; Newman et al., 2008; Robertson, 2007; Lawson et al., 2006) there is a void of Canadian studies that have reviewed if these recommendations have been implemented in high schools.

When KIs were asked if schools were supportive of Black youth in terms of their cultural approach to sexual health education almost all the KIs indicated that this was not the case. Key Informants' comments are supported by a review of the Ontario high school-based sexual health curriculum that found no explicit acknowledgment of the impact of students' culture on sexual health education. The lack of acknowledgment concerning culture in the high school curriculum was also viewed in the lack of visible teachers in many school faculties in Toronto (Martino, & Rezai-Rashti, 2010). Key Informant responses concerning school based sexual health education yielded a variety of themes. These main themes were generic sexual health education programs and barriers to providing relevant school-based sexual health education programs to Black youth in Toronto. KIs also provided suggestions on how to improve school-based sexual health education in Toronto.

Generic sexual health education programs

Eleven (65%) of the KIs noted that sexual health education programs were general and often repeated sexual health information easily accessible to youth. KII6 (a youth worker) echoed the sentiments of many KIs when she said . . . they [Black youth] do know some stuff that they've been hearing obviously in schools which is the STDs and the STIs. Sometimes that gets a little bit boring, right . . . (KI6 Indo-Caribbean Female)

While there have been limited Canadian studies that have specifically reviewed this theme, a study noted that the Ontario high school and elementary school-based sexual health education expectations for students were very general and often focused on the biological aspects of sexual health (Smylie et al, 2008). A review of the Ontario

Ministry of Education grade nine-10 and 11-12 physical health education manual noted that there were no guidelines for teachers on how to deliver a culturally appropriate sexual health education program. The impact of culture on the effectiveness of sexual health education programs have been noted by some parent-youth sexual health intervention programs (Baptiste et al., 2006; Stanton et al., 2004). For example, program sessions of a U.S. based parent-youth sexual health intervention program were converted into an open ended cartoon-based story line when the program was implemented in South Africa due to low parental literacy rates and cultural taboos concerning the discussion of sexuality (Baptiste et al. (2006). Additionally, a study which reviewed revisions made to an intervention for young Black men in Toronto who have sex with men noted the need for culturally appropriate counselling services to assist men who have experienced a trauma (Lewis-Pearl, McCready, Brennan, & Adam, 2011).

Barriers to providing relevant school-based sexual health education programs to Black youth in Toronto

Eleven (65%) KIs stated that there were a number of issues that may prevent the delivery of effective school-based sexual health education programs to Black youth. The main subtheme noted from this theme was: teachers are uncomfortable providing sexual health education.

Teachers are uncomfortable providing sexual health education

Eight KIs (47%) noted that many teachers' ill ease in discussing sexual health with students was a barrier to providing effective sexual health education programs. KI15 (a youth worker who also works with gay youth) noted the impact of teachers' ill-ease when he said . . . I find that when teachers are teaching it [sexual health education] they

just want to get over it you know what I mean they're not really going through it . . .

(KI15, African-Caribbean Male)

While there is a lack of Canadian based journals that have specifically focused on barriers that prevented effective school-based education to Black youth some peer and non peer-reviewed articles support the theme and subtheme. Some studies noted that the content of school-based sexual health education in Ontario is ultimately determined by the school boards and teachers (Meaney et al., 2009; Smylie et al., 2008). Robertson (2007) noted that if a teacher is uncomfortable discussing particular sexual health topics, these topics may not be discussed with students.

Additional issues noted by some KIs were religion, parents as barriers to school based sexual health education and that there was a heteronormative view of school based sexual health education. The KI comments indicate that a heteronormative view refers to the tendency of school-based sexual health education to focus on heterosexual intercourse and relationships. KIs comments concerning the impact of parents and religion was noted when the Ontario government attempted to make changes to Ontario elementary sexual health curriculum. Parental and religious leaders' objections to the proposed changes to the curriculum were noted as some of the factors which led to the government to withdraw the changes (Ferguson, & Benzie, 2010). Additionally, the heteronormative issue noted by some KIs is supported by the fact that the Ontario physical health high school education curriculum does not require teachers to address sexual orientation (The Ontario Ministry of Education and Training, 1999; The Ontario Ministry of Education and Training, 2000).

Suggestions on how to enhance school-based sexual health education

A total of 13 KIs (76%) provided a number of suggestions as to how to enhance school-based sexual health education. The most common suggestions are listed below

Bring external agencies into schools: Five of the KIs noted that schools should bring in different agencies to assist with sexual health education programs. As KI10 (a youth worker) stated

. . . What I have heard from some of the kids that [what] is helpful is when the different agencies whether it be like I dunno [name of agency] or [name of agency] they come in [to high schools] and they run groups and it's [sexual health education is delivered] in a smaller setting where the kids can be very candid about speaking about [sex]. That appears to be more effective than the basic generalised approach [to sexual health education in high schools] . . . (KI10, African-Caribbean Male)

Be candid about sexual health with Black youth in Toronto: Three KIs noted that school-based sexual health programs should be candid and realistic. As KI11(a religious leader) stated . . . nothing helps a teenager like you being real with them. So to be able to talk to a teen and say “guess what? I’m struggling with the same thing,” you know. “I’m tempted the same way and this is how I’m doing it you know.” (KI11, African-Caribbean Male)

There is a paucity of studies that have specifically reviewed these suggestions. The KI comments coupled with the Study Coordinator’s experiential knowledge indicate these suggestions may aide Black students’ sexual health knowledge.

In your opinion are Black parents supportive of youth? [. . .]. Are there differences in support between male or female parents? (PROBE) What about boys? [. . .] Or what about girls?

These questions were posed to KIs as the CAC and Investigative Team noted that parental support plays a vital role in youths’ development and the choices they make.

Further, the Investigative Team and CAC's experiential knowledge indicated that there were differences in the level of support based on parent and youth gender. While some studies have noted the significance of parental involvement in the lives of youth and parental and youth gender on sexual health discussion (Aspy et al., 2007; Cox et al., 2010, Dilorio et al., 2000; Hutchinson et al., 2003) there is a void of Canadian based studies that have specifically reviewed Black-Canadian parents' support of their youth and the impact of Black parental and youth gender on sexual health discussion. Further, in order to develop an effective Black parent-youth sexual health intervention program in the future, the role of gender in parent-youth sex communication must be assessed.

Eighty eight percent (15 of 17 KIs) of all KIs indicated that Black parents are supportive of their youth. However, systemic barriers and race-based discrimination not only negatively impacts racialized minority parents' search for stable employment (Wilson et al., 2011), access to services, and education but also the level of support Black parents can provide their youth. As KI10 (a youth worker) said

. . . I think that all Black parents want their child to do well . . .
 But it's what the degrees are. Like for example someone like myself or you (referring to the Study Coordinator), we might put education first. Many of them [Black parents], education is on their list but it's a lot of times not their number one thing
 Often times for them [Black parents it] is just trying to get by day to day. You know, type of thing. And as long as their kid goes to school and doesn't get in trouble, that's a successful day, that's a successful time. It's not so much the, A on a test or if they completed their homework. The fact that the kid went to school and there was no call from the principal and the kid wasn't in trouble and the kid didn't get arrested. That's considered for some of them [the parent] a successful day at school . . . (KI10, African-Caribbean Male)

While most KIs indicated that Black parents are supportive of their youth none of the KIs provided information on how this support was provided and KIs were not probed

further on this topic. Additionally, when asked if there were differences in the level of support based on parental and youth gender KIs identified a number of differences. An overview of responses concerning these differences will be discussed in subsequent paragraphs.

Differences in support between Black mothers and daughters compared to fathers and daughters in Toronto

Twelve (71%) KIs noted that there were differences in the level of support between mothers and daughters. In terms of sexual health, the main subtheme gleaned from the KIs' responses concerned mother-daughter sexual health conversation.

Minimal Black mother-daughter sexual health conversation in Toronto

Ten (59%) KIs noted that mothers had minimal sexual health conversations with their daughters. If Black mothers did have a conversation with their daughters it often focused on the negative consequences of sex. As KI8 (a youth worker) said

. . . And then the girls; their mothers are just like “no, like you’re not having sex, you don’t have sex, you could get exposed you don’t do this, you don’t do that.” They [Black mothers] don’t discuss; I mean birth control, you know STDs or pregnancies because they’ll be like “don’t, don’t come home pregnant.” I think there’s a lot more emphasis on the mother-daughter is the mother telling the daughter not to engage in sex . . . (KI8, Caucasian Female)

Differences in support between Black fathers and daughters versus mothers and daughters in Toronto

Sixty five percent (12) of the KIs noted that there was a difference in the level of support between fathers and daughters compared to mothers and daughters. The main subtheme noted was minimal sexual health conversation.

Minimal sexual health conversations

Almost half (47%) of the KIs indicated that fathers had minimal sexual health conversations with their daughters. If fathers spoke to their daughters about sexual health it often focused on warning daughters not to get pregnant. Further, fathers were often noted to attempt to prevent their daughters from dating. This attempt is highlighted in the following quote

. . . Well the dad-daughter thing is you know what? “You go nowhere, you stay away from boys; they’re trouble.” They [Black fathers] tend to be, sometimes tend to be paranoid so overprotective that they are despots often. In that the phone rings and it’s a boy and [the father will say to their daughter] “what are you doing!” And they accuse the girl of doing things they haven’t even done. And then the girls then end up having relationships with boys behind their dad’s back . . . (KI13, African-Caribbean Female)

Differences in support between Black mothers and sons versus fathers and sons in

Toronto

Eighty two percent (14) of the KIs indicated that there were differences in the sexual health conversation between Black mothers and sons versus fathers and sons. These subthemes will be discussed in subsequent paragraphs.

Minimal or no conversations about sex

Nine (53%) KIs noted that most Black Torontonians do not have sexual health conversations with their sons. As KI10 (a youth worker) stated

. . . I don’t hear the moms as much talk to the sons as much they just want to make sure that it [their son’s relationship with their girlfriends] was an ok relationship that there wasn’t any kind of abuse or anything like that along, those, you know along those lines . . .

Study Coordinator: Abuse by the girl or the boy?

KI10: Both. Where if they’re getting into arguments, there’s no physical type of thing because that brings police and those kinds

of things. We want to make sure that when there are problems they're able to work it out without any type of problems . . .
(KI10, African-Caribbean Male)

While KIs indicated that Black fathers were not receptive to their daughters dating, KI10 noted that many Black mothers were receptive to their sons having a girlfriend. KI10 said

. . . I find a lot more of the West Indian [Caribbean] mothers are much more open to their sons having girlfriends and actually do strike up a relationship with the girls that their sons go out with. The African mothers that I know . . . like I have a good friend of mine; she's African. And her son had a girlfriend and she didn't even know. But she'd tell me "no no, no, no I don't want my son having a girlfriend, he's gotta concentrate on school . . ." (KI10, African-Caribbean Male)

Differences in levels of support between Black fathers and sons compared to Black mothers and sons in Toronto

Eighty eight percent of KIs (15 of 17) noted that there are differences in sexual health discussion between fathers and sons compared to mothers and sons. The main subtheme concerning Black father-son sexual health discussions gleaned from the KIs comment is discussed below.

Sexual health conversations encourage promiscuity

Almost half (47%) of the KIs noted that if Black father-son sexual health conversations occurred, these conversations often encouraged Black male youth to engage in promiscuous behaviour. This sentiment is noted in following KI comments

. . . [father-son sexual health conversation] it's more like "have sex with girls, have sex with lots of girls but just don't get any girl pregnant and don't give any girl money." You know, that's their advice. "Be aware that these girls are gonna try to get you."
(KI8, Caucasian Female)

. . . a lot of Black fathers in the home push out; they don't mind, fuck around . . . So Black fathers are pushing on their Black sons, wink, wink, nudge, nudge . . . and that's what White fathers are doing [that] too. . . now the difference between the Black son and the White son is that the White son has a lot of options, right. This "wink wink nudge nudge" is in addition to umm a very full and bright possibility of the future . . . [A White father will say to his son] "fuck the girls, go to school, get a good job, earn that money, buy that house, have that car, get those kids, marry this girl, take on a mistress, duh duh duh da; like they're [White male youth] seeing themselves in the bigger picture . . . I don't want to categorize all of us, but you know let's just generalize for the moment . . . So you have [a young Black male youth] who is being you know whether his father is being direct with him or say you know "have you hit that yet?" whether he's [the father] being indirect so there's actually story telling. You know that Black fathers love to story tell. [Black father will tell his son] "You know when I was your age I had Tina and duh duh duh da and duh duh duh da" whatever. He's [the father] teaching, he's teaching [a] particular way of being a man in the universe . . . (KI3, African-Caribbean Male)

KI12 (a youth worker) also noted the blasé attitude of many African-Caribbean fathers concerning their sons' sexual behaviour when he said . . . the Caribbean guys that I know their fathers tend to talk about it [sex] in a boastful way. Sex is something that is boasted about. I mean it's kind of just like [the Black father tells his son] "well hey you know you have tools use them you're not getting any younger," kind of thing . . . (KI12, African Male)

The role of fathers in the lives of Black youth in Toronto

Nine (53%) KIs stated that many Black fathers in Toronto have limited to no involvement in their youths' lives. Comments made by the KIs indicated that if the father is actively involved in their youths' life their parenting style is often relaxed. KI10 (a youth worker) explained many Black fathers' relaxed parenting style in the following statement

. . . The fathers are very laissez faire . . . They don't get, they don't get stressed over things because they don't get the responsibility [chuckles]. You know. So it's easy if you get your kid once a month on the weekends and you take them to a ball game and you call that parenting. But you're not there when the kids' got a cold . . . (KI10, African-Caribbean Male)

KI8 (a youth worker) also discussed many Black fathers' parenting style when she said . . . if the father's not as involved I find and if the father is like a friend that he hangs out with [the kids] once in a while. It's more like "have sex with girls, have sex with lots of girls but just don't get any girl pregnant and don't give any girl money." You know, that's their advice . . . (KI8, Caucasian Female)

While there is a void of Canadian studies that have specifically reviewed these themes and subthemes, several international studies have noted parental and youth gender does impact sex communication (Aspy et al., 2007; Cox et al., 2010, Dilorio et al., 2000; Hutchinson et al., 2003). Further, cultural taboos concerning sex, sexuality, HIV (Gardezi et al., 2008) and stereotypes concerning Black male and female youths' sex and sexuality within the larger populations may influence the content and level of Black parent-youth communication. Although KI comments indicate that many Black mothers have minimal sexual health discussions with their sons and daughters several studies indicate that mothers are more likely to discuss sex with their youth (Aspy et al., 2007; Cox et al., 2010, DiClemente et al., 2001; Dilorio et al., 2000; Kirkman et al., 2002; Hutchinson et al., 2003). The lack of sexual communication between fathers and their youth of either gender has been noted in some studies (Kirkman et al. 2002; Wilson, & Koo, 2010). As there were limited discussions from KIs concerning Black male sexualities and the factors that influence these sexualities, future studies should review Black sexualities in

Toronto to determine the factors which may prevent fathers from discussing sex and sexuality with their youth.

There is a paucity of studies that specifically review the role of fathers in Black youths' lives in Toronto. The KIs' comments and the Study Coordinator's experiential knowledge indicates that while many Black fathers have limited involvement in their youths' lives there are some fathers who play an active role. Further, a number of Black father-child focused organizations have developed in recent years to address the lack of male parental involvement. Organizations such as Black Daddies Club provide Black fathers with father-child bonding activities and a continuous support system to share their challenges and/or experiences with other Black fathers (Black Daddies Club, n.d.).

Some KIs also noted that Black mothers are more supportive of their female youth pursuing education than their male youth, and that Black fathers do not directly discuss dating with their daughters but use a number of strategies such as fear to prevent them from dating. These additional findings are supported by studies and experiential knowledge. For example, some studies found that fathers who discussed sexual health with their daughters mainly focused on dating and relationships (Wilson, & Koo, 2010) and many fathers believed their main role was to ensure daughters were instilled with the view that their fathers; not men outside the home would provide for them (Akers, Yonas, Burke, & Chang, 2011).

What needs to be done to enhance parental support of Black youth in Toronto

Ten (59%) KIs provided a number of suggestions concerning how to increase Black parental support of youth. The main suggestion offered by KIs is discussed below.

Have more candid sexual health conversations

Nine (53%) of KIs suggested Black parents should have more candid sexual health conversations with their youth. As KI13 (a youth worker) stated

. . . But how rich would a conversation be [between a Black mother and their youth] with a mother who had a child at 16 or 17[yrs]. Wouldn't you [referring to a Black parent] want to talk to that child about how you got here? . . . And it's not to say that YOU [emphasis placed on the word you] won't make the same mistake but at least help me [a Black youth] figure out what about the pitfalls are. Because we're [Black parents] not acknowledging how we got here when not having a conversation about "I screwed up." And church is good but it's not gonna solve it [Black youth having sex], . . . keeping them busy isn't gonna solve it: because they're gonna find a way [to engage in sexual activity]. Children are good at that. Keeping them informed is [important]. And so if we say it takes a village to raise a child, let's create the village. Because we can't talk about a village if there's nobody's there . . . (KI13, African-Caribbean Female)

This suggestion is supported by several studies that have noted the benefits of open parent-youth sexual communication (Aspy, 2007; Cox et al., 2010; Dilorio et al., 2000; Huebner, & Howell, 2003; Hutchinson, Jemmott J. B., Jemmott L. S., & Braverman, 2003). For example, parents who have discussions with their youth about contraceptive methods and the negative consequences of sexual activity such as STIs are more likely to have youth who postpone sexual activity (Aspy et al., 2007; Baptiste et al., 2006; Cox et al., 2010; DiClemente et al., 2001; Dilorio et al., 2000; Hutchinson et al., 2003; Li et al., 2000; Robert, & Sonenstein, 2010; Romer et al., 1999) or cause sexually active youth to use contraceptive methods (Baptiste et al., 2006; DiClemente et al., 2001; Dilorio et al., 2000; Hutchinson et al., 2003; Li et al., 2000; Romer et al., 1999).

Additional topics discussed concerning differences in Black parent-youth support in Toronto

The main topic which arose during the discussion of parental support and the impact of the impact of Black parental and youth gender on Black parent-youth support was single parenting. This topic is discussed below.

Single parenting impacts Black parent-youth sexual health communication

Twelve (71%) KIs noted that most single parent Black households were led by single by Black mothers. KI10 (a youth worker) noted this when he said . . . I don't know if it's a West Indian [Caribbean] thing or what but the mothers seem always to be the backbone, the fathers are very laissez faire . . . They [Black fathers] don't get stressed over things because they don't get the [same] responsibility [as Black mothers have] . . . (KI10, African-Caribbean Male)

Over half of the KIs (53%) indicated that many Black households in Toronto are led by single mothers who are often left to discuss sexual health with their youth. Stereotypes within and outside Black communities concerning single mothers coupled with additional systemic barriers such as a lack of affordable childcare, and juggling employment with childcare in Toronto can impact Black parent-youth sexual health communication. In particular, KI1 (a youth worker) noted the impact of single parenting on Black parent-youth sex communication when she said

. . . Dad is removed, far removed or Dad doesn't even exist in most families. So that means that that side of the conversation [Black father-youth sexual health communication] doesn't happen that often or doesn't happen at all. So you're [Black youth] missing something and so I guess not all the times will mom have all the answers or the perspective that they're [Black youth] looking for. That doesn't necessarily mean that she can't or won't give it [answers about sexual health], that it's impossible. You [Black youth] might want or need both sides and it's not an option for you. But I kinda don't want to blame it on that [single parenting] because there are definitely like many successful single parents but maybe a lot of youth or children

want to have both sides of the conversation . . . (KI1, African-Caribbean Female)

Generally, even within heterosexual two parent households some studies indicate mothers are often the primary source of sexual health education for youth (Kirkman et al., 2002; Wilson, & Koo, 2010). For example, a Canadian based study noted that many Canadian mothers believed it was their responsibility to discuss sexual health with their youth (Frappier et al., 2008). Further, some KIs' comments coupled with the Study Coordinator's experiential knowledge indicate youth from single parent households can attain high levels of education and have successful careers. An overview of all the themes and subthemes gleaned from the questions can be found in table 4.

Summary

In sum, the questions posed to the KIs revealed a number of issues impacting Black youth, Black parent-youth sex communication, school based sexual health education, and differences in support based on parental and youth gender. These questions also led to the identification of additional issues such as religion impacting sex communication and differences in the level of sexual health discussion between African and African-Caribbean parents and their youth. KIs noted the main issues impacting Black youth in Toronto were parental expectations, education, employment, homosexuality, lack of understanding, difficulties finding employment, crime, parent-youth issues and poverty. In discussing Black parent-youth sex communication KIs noted the main issues impacting this communication was a lack of in-depth sexual health conversations and discussions concerning teen pregnancy, parental discomfort discussing sexual health with youth, difficulties discussing sexual diversity and homophobia. When school-based sexual health education was discussed, many KIs noted that this education

is generic and there are barriers to providing relevant school based sexual health education to Black youth. KIs noted that school based sexual health education can be improved by having external agencies provide sexual health education in schools and being candid about sexual health. Finally, KIs indicated that there were differences in sex communication based on parental and youth gender and that parents should have more candid sexual health conversations with their youth.

CHAPTER 6

CONCLUSION

Parent-youth sex communication is a vital component of youths' sexual health education. As the KI comments highlighted, there is a lack of Black parent-youth sex communication and culturally appropriate resources available to assist Black youth in Toronto. Given the high STI and possible pregnancy rates among Black youth in Toronto, this study is of particular significance. The KIs' comments provide researchers with a starting point that will assist researchers in determining factors which prevent Black parent-youth sex communication. The study findings may inform current sexual health education programs and increase Black communities' awareness of youth sexual health issues and the importance of open Black parent-youth sexual health discussions.

This study explored the state of Black parent-youth sex communication in Toronto through interviews with KIs who work or worked with Black parents and/or youth in the GTA using CBR. This approach ensured that the findings were applicable to Black communities in Toronto and increased the chances the findings would be accepted by Black community members. Using CBR to determine additional issues impacting Black parent-youth sex communication would most likely be the best approach to collecting, analyzing and disseminating the study findings to agencies and Black communities.

A review of the KI recruitment results and demographics yielded a number of findings. Although an online advertisement for KIs was placed on a popular website for youth workers, the most effective mode of recruitment was through recommendations from participating KIs. In this mode of recruitment, KIs acted as gatekeepers for their

respective work communities. Gatekeepers refer to individuals such as community leaders and experts that can provide researchers with access to individuals in their respective community. Participating KI recommendations not only increased the chances succeeding KI candidates met the KI criteria but also enabled the Study Coordinator to have some access into the youth worker community. Further, slightly over half the KIs were younger adults and the remainder were older adults. Of the 17 KIs 10 were women and seven were men. Most of the KIs were of Afro-Caribbean heritage, followed by African, Caucasian, Indo-Caribbean and mixed Caribbean heritage. These demographics enhance the study findings as most work locations identified by the KIs have large Black populations and many of the KIs indicated that they work and/or worked with students and/or parents of the same ethnicity and/or gender. Further, many of the KIs were close in age to the Black parents and/or students they assist and/or assisted. The KIs' work locations coupled with their lived experience as members of a Black community or constant direct experiences with members of Black communities in Toronto, age and gender most likely increased their contact with Black students and/or parents thereby enhancing the reliability of their responses to the study questions.

In reviewing the question pertaining to the main issues or challenges impacting Black youth in Toronto, a number of themes were noted. The KIs identified the main issues or challenges as poverty; parent-youth issues; parental expectations; lack of understanding; homosexuality; difficulties finding employment; education; access to resources; and crime. These issues have been noted to impact youth in various Canadian, international and grey literature. Additionally, as a member of a Black community in Toronto the Study Coordinator has witnessed the impact these themes can have on Black

youth. As the Study Coordinator did not extensively probe KIs about these themes, further studies are needed to specifically determine how these issues impact Black youth and how to effectively address them.

Several main themes were also noted when the KIs were asked to identify some of the main challenges Black parents or youth face in discussing sex, dating and relationships with one another in Toronto. The themes were lack of in-depth sexual health conversations; lack of teen pregnancy and HIV/AIDS discussions; parental discomfort discussing sexual health with youth; and difficulties discussing sexual diversity. While all these themes should be reviewed in-depth in future studies, a particular focus should be placed on the HIV/AIDS discussion theme as it was the only theme noted by almost all the KIs. Further, the high rates of HIV infection among the Black communities in Toronto emphasises the need for greater review of the current state of Black parent-youth HIV/AIDS discussion and possible factors which may prevent this discussion from occurring.

The KIs noted that youth relied on various sources for their sexual health information. The most common sources used by Black youth were identified as peers; friends; school; and mass media. These sources have been noted by many studies and experiential knowledge indicates these sources are important avenues for sexual health information for many youth. Due to the void of studies that specifically review the impact of these sources on Black youth in Toronto, future studies should review how Black youths' culture may influence their interpretation of sexual health information garnered from these sources. Further, experiential knowledge indicates that most Black youth in Toronto are not only exposed to North American mass media but also to mass media

from their country or their family's country of origin. Additional studies should be conducted to determine how or if these additional sources of mass media impact Black youths' sexual health care information.

Further, probing questions related to parent-youth difficulties in discussing sex, dating and relationships led to the identification of additional factors which may impact Black parent-youth discussions. The main factors found to impact this discussion was religion and differences in the level of sexual health discussion between African and African-Caribbean parents and their youth. While some studies have reviewed the impact of religion on Black communities' views of sex and sexuality and differences in sexual health discussions in African and African-Caribbean communities there is a void of studies that specifically review the impact of these factors on Black parent-youth sexual health discussion. Further studies should be conducted to determine if there are differences in sexual health discussion between Black parents and youth of these two cultures and how culture informs Black parents' views of sexual health and discussion with their youth. Additionally, the KI comments, studies and anecdotal evidence suggest that religion often informs Black parent-youth sexual health discussion. As such, future studies should review how religion informs Black communities' views of sex and sexuality, possible differences in these views between those who practice the two most common religions in Toronto; Islam and Christianity and how or if religion and culture combine to influence Black parent-youth sexual health discussion.

When KIs were asked if schools were supportive of Black youth in regards to their cultural approach to sexual education most KIs indicated this was not the case. Probing questions concerning school-based sexual health education yielded a number of

main themes such as generic sexual health education programs; and barriers to providing relevant school-based sexual health education to Black youth. Most KIs who indicated schools did not provide culturally supportive sexual health education programs did not elaborate on their answer. This sentiment coupled by the main themes indicate further studies should review the current state of school-based sexual health education and how or if culture is taken into account when delivering these programs. Also, possible barriers preventing the implementation of culturally appropriate school-based sexual health education, how cultural views of sex and sexuality can be incorporated in school-based sexual health education and ways to better engage Black students when delivering these programs should be reviewed.

Finally, when KIs were asked if parents were supportive of Black youth most KIs indicated this was the case. When KIs were then asked if there were differences in support based on Black parental and youth gender a number of main themes were noted. These themes included differences in support between mother and daughters compared to fathers and daughters; Black fathers and daughters versus mothers and daughters; Black mothers and sons compared to fathers and sons; Black fathers and sons compared to Black mothers and sons; and the role of fathers in youths' lives. Due to the lack of studies on these themes and KI comments which counter findings of some studies which review the impact of parental and youth gender on sexual health discussion, future studies should review the impact of Black parental and youth gender on sexual health discussion. Also, the lack of studies that specifically review Black father-daughter and father-son sexual health discussion coupled with anecdotal evidence noting a lack of father-youth sexual health conversation indicate that a particular emphasis should be placed on reviewing

Black father-youth sexual health discussion. Additionally, future studies should examine the reasons which prevent Black fathers from discussing sexual health with their youth and reasons which lead some Black fathers to have these discussions as well as the content of these discussions. Overall, these themes as well as the previously stated themes and findings gleaned from the KI questionnaire were reviewed using critical race theory.

A review of the themes using the tenets of critical race theory yielded a number of observations. The first tenet states that racism is ordinary, not aberrational and reproduced in various customs and experiences, and negatively impacts the lives of racial groups. Many KIs indicted that racism is a constant factor that negatively impacts Black-Canadian youth, parents and their access to resources, education, employment and sexual health discussion. The second tenet states that the race problem is difficult to understand and may be impossible to solve due to claims of objectivity that mask the self-interest, power and privilege of Whites. The third states that races are categories that society creates, manipulates and re-creates. The second and third tenet were noted in this study as many KIs indicated that cultural and parent-youth sex communication differences between African and Black-Caribbean populations are not acknowledged in many sexual health programs as many organizations provide generic programs they believe are effective for all participants. Some KIs noted this lack of acknowledgement may be due to the fact that many organizations tend to place African and Black-Caribbean populations into one category; Black. Finally, the last tenet states that critical race theorists should also aim to increase social justice. As such, a number of recommendations that may be used to inform future research in Black-Canadian parent-

youth sex communication and school based-sexual health programs have been included. These recommendations can be found in subsequent paragraphs. The study findings will also be shared with KIs and community health organizations that serve Black populations in the GTA.

Strengths and Limitations

The CBR approach used in this study has a number of strengths. The aid of the Investigative Team and CAC in identifying KIs may have reduced initial participant distrust. Distrust may have been further reduced as the Study Coordinator is member of a Black community in Toronto. Utilizing a CBR design ensures the collected data and findings will be directly relatable to Black-Canadian communities (Mosavel et al., 2005). The use of critical race theory to analyze the interviews ensured the findings reflect the lived experiences (Ford, & Airhihenbuwa, 2010) of Key Informants and their Black clients. Similarly, using grounded theory allowed for the in-depth review of KIs' comments concerning issues impacting Black parent-youth sex communication. Additionally, the use of data analysis software NVivo9 allowed for greater accuracy and analysis of the data. This allowed for a better understanding of relevant themes and subthemes that arose.

Despite these strengths, this study has some limitations. Purposive sampling may not allow for a true reflection of the community as only those who are interested in the study participate. As in any health or social sciences study CBR can be timely to set up, maintain and may not work in all communities (Mosavel et al., 2005). Further, participating stakeholders may have their own agenda and undermine the objectives of the study. As participants have the right to pass questions they are uncomfortable

answering, the data may become skewed. There is also the risk of interviewer bias when administering the questions to focus group members. Interviewer bias can occur when the interviewer subconsciously or consciously cause participants to answer questions in a certain way (Bowling, 2005). While we did have several male KIs we could have recruited for more male participants. However, several studies and experiential knowledge indicates it is more difficult to engage men in sexual health research. As most of the KIs were of Afro-Caribbean heritage and they indicated that most of the parents and/or youth they assist were of Afro-Caribbean heritage, it is uncertain if these findings can be applied to African populations in Toronto. Further, we did not engage KIs that work and/or worked with African and Muslim communities in Toronto. As such, future studies should focus on Black parent-youth sex communication in these communities. Finally, it is uncertain if these findings reflect all Black populations as not all Black populations in Toronto reside in priority neighbourhoods.

Recommendations

The findings of this study indicate that there is a void of information on Black parent-youth sex communication in Toronto. In order to effectively address the numerous disparities noted by KIs a list of recommendations has been compiled. Recommendations have been separated into six categories.

Create Black parent and youth focus groups

1. Determine if disparities noted by KIs are issues that are relevant to Black youth and parents through parent and youth focus group interviews.
2. Actively recruit African parents and youth for focus groups to gain more information about African parent-youth sex communication and explore sex

communication differences noted by KIs between African and African-Caribbean parents and their youth.

3. Actively recruit Black fathers to gain more information on Black fathers' impact on Black youths' sexual health education.

Address Black parents' sexual health knowledge

1. Explore Black parents' sexual health knowledge and their views on the importance of their youths' sexual health knowledge.
2. Address disparities in Black parents' sexual health knowledge through culturally appropriate sexual health resources for parents.

Explore Black parents' and youths' views of HIV/AIDS

1. Review the impact of culture on Black parents' and youths' views of HIV/AIDS.
2. Explore Black parents' and youths' knowledge of HIV/AIDS and determine effective ways to enhance this knowledge.
3. Address possible myths about HIV/AIDS in Black communities.

Target religious leaders

1. Determine how or if Black communities' religious leaders discuss sex and sexuality with their congregations.
2. Determine the barriers which may prevent Black religious leaders from discussing sexual health and possible strategies to address these barriers.
3. Engage Black community religious leaders in the development of culturally appropriate sexual health education programs for Black parents and youth.

Review current school-based sexual health education programs

1. Review the current Ontario Ministry of Education's sexual health education curriculum and explore gaps in the current curriculum.
2. Review the implementation of school-based sexual health education programs in Toronto and explore how the current curriculum can be modified to better reflect the cultural views of the Black student body.
3. Explore Black parents' and youths' views of school-based sexual health education through focus group interviews.
4. Explore Black parents' expectations of school-based sexual health education.
5. Determine how school-based sexual health education can be modified to better engage Black students.
6. Explore the impact of incorporating external community agencies in the delivery of school-based sexual health education to Black students.
7. Review current sexual health training programs for teachers and address possible gaps in these programs.
8. Review teacher's views of sexual health education and develop programming to better educate teachers on sexual health education.
9. Determine how or if Black communities' religious leaders discuss sex and sexuality with their congregations.

Review Black parents' level of support for their youth

1. Explore the type of support Black parents provide their youth.
2. Review possible differences in the level of support provided to youth based on parental gender.

3. Explore barriers which prevent Black mothers and fathers from engaging in sexual health discussions with their youth.

While these recommendations indicate Black-Canadian youth and parents face a number of community and externally based barriers which impact their sexual health discussions, some U.S. and international studies indicate these barriers can be overcome through parent-youth sexual health intervention programs. The findings from this study and recommendations will ultimately aid researchers in developing a Canadian based Black parent-youth sexual health intervention program and inform Ontario Ministry of Education policies on sexual health education. These findings may also aid community organizations in developing more culturally appropriate programming that address the needs of Black communities in Toronto. Overall, this study can be used as an impetus for future work and/or discussions for sexual health research and programming on a domestic and nationwide level.

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Figure 1. Map of Toronto Area

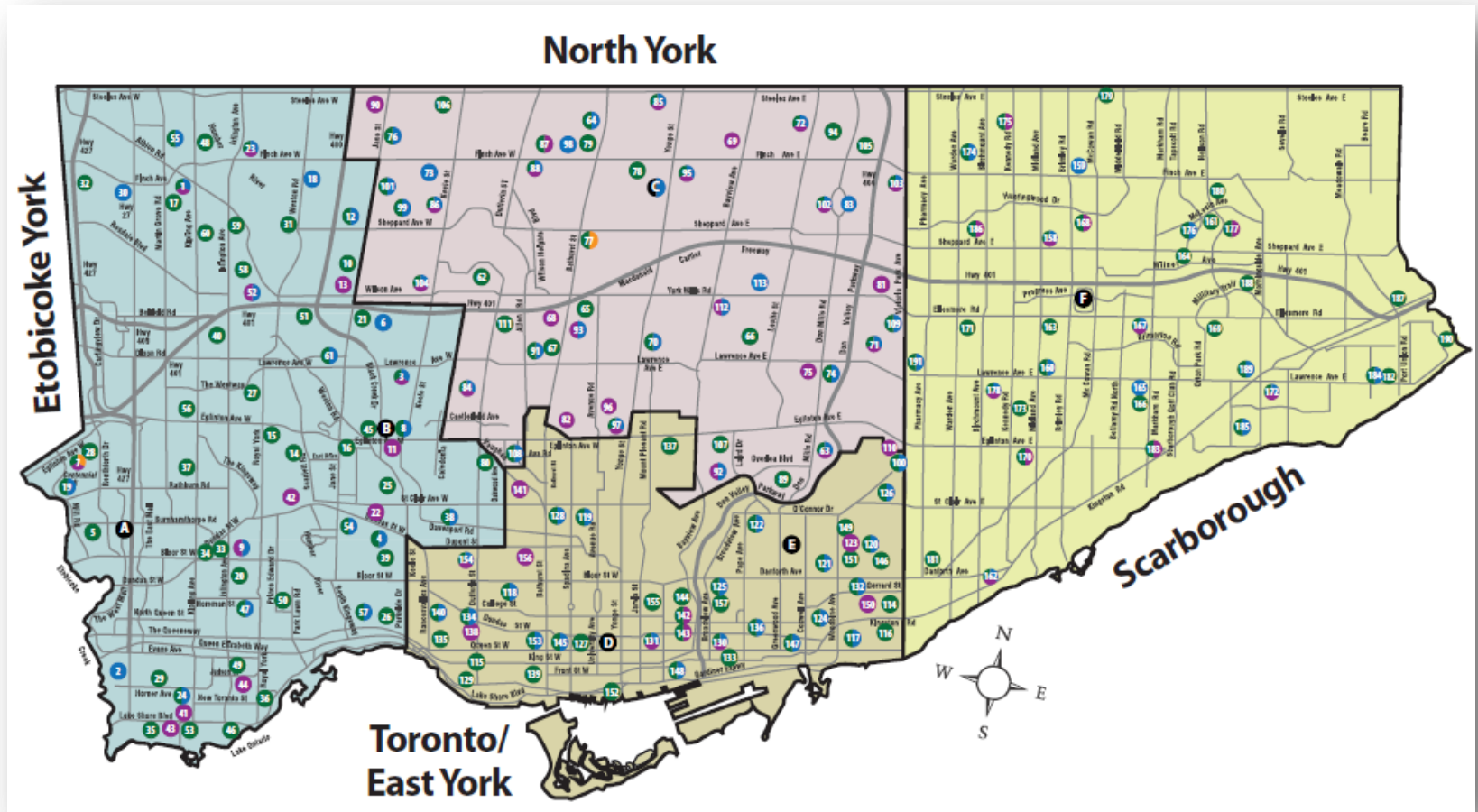
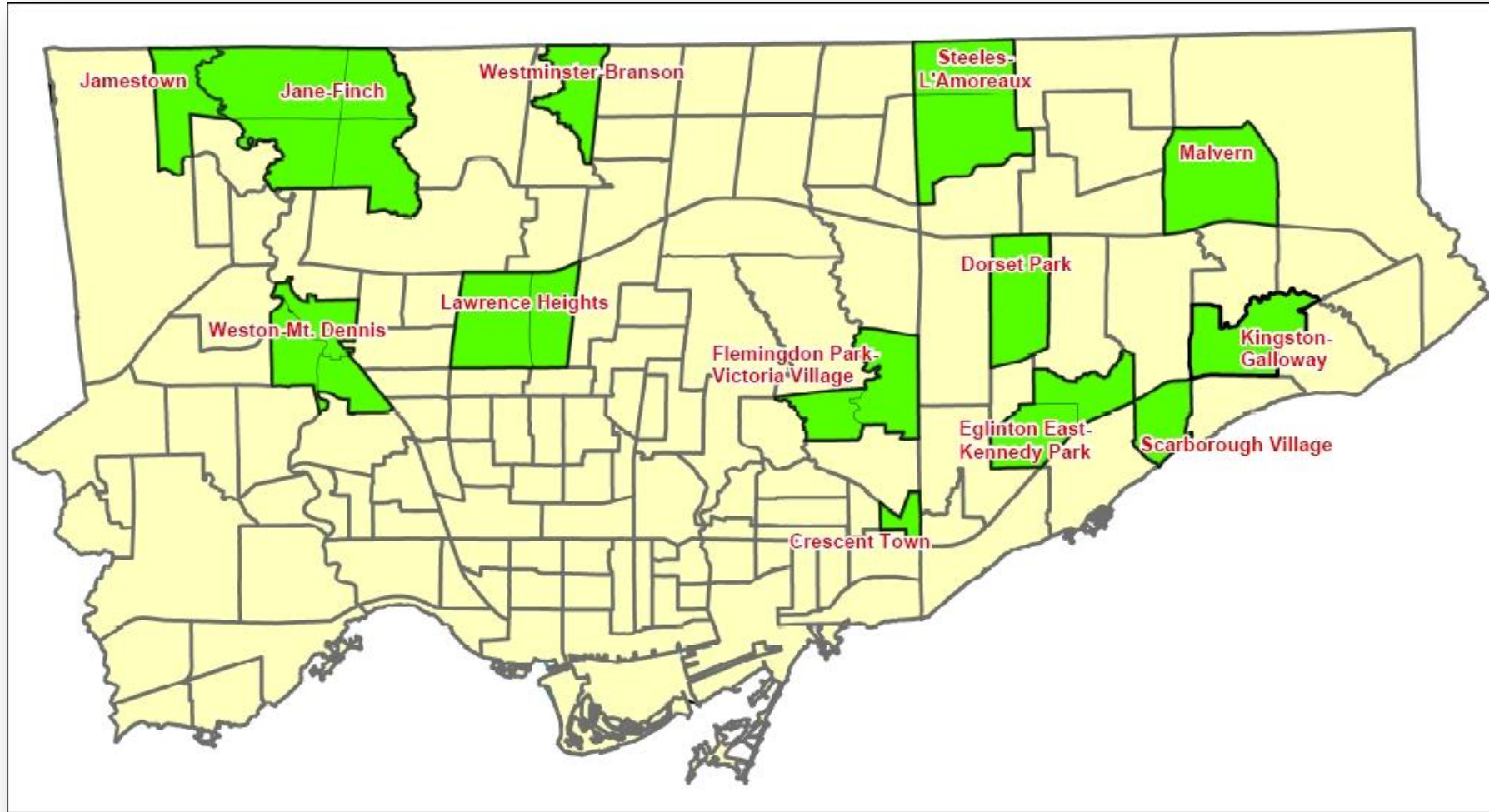


Figure 2. Map of City of Toronto 13 Priority Neighbourhoods



Legend: = Priority neighbourhoods in Toronto

Table 1. *KI Recruitment Method Results*

KI	Fpyn.ca	Word of Mouth	Direct contact by PI or SC	KI recommendation
KI1	Y			
KI2	Y			
KI3			Y	
KI4				Y
KI5			Y	
KI6	Y			
KI7			Y	Y
KI8				Y
KI9			Y	
KI10		Y		
KI11			Y	
KI12		Y		
KI13				Y
KI14		Y		
KI15		Y		
KI16				Y
KI17				Y

Legend: fpyn.ca= frontline youth worker website; KI = Key Informant; PI= Principal Investigator; SC= Study Coordinator; Word of Mouth= recruitment through Investigative Team and Community Advisory Committee Members; Y= Yes

Table 2. Key Informant Demographics Overview

Key Informant Demographics	Information	Outcome (n=17)
Age	<ul style="list-style-type: none"> • Young adults • Older adults 	9 8
Gender	Male Female	7 10
Ethnicity*	<ul style="list-style-type: none"> • BC • A • IC • C • MX 	11 2 1 2 1
Occupation	<ul style="list-style-type: none"> • YW • Mental Health YW • Black Male YW • Teacher, Black youth advocate • Religious leader • LGBTQ YW and YW 	12 1 1 1 1 1
Current/Past Work Location(s) in Toronto	Toronto/East York Scarborough North York Multiple locations in Toronto Not available	7 4 2 3 1

Legend: A: African; BC: Black-Caribbean; C: Caucasian; IC: Indo-Caribbean; MX: KI of mixed heritage; YM: Youth Minister; YW: Youth Worker; ~ Individual is of mixed heritage; *Please note ethnicity designation is based on KI self-identification or by Study Coordinator observation.

Table 3. Individual Key Informant Demographics

KI	Age group	gender	Ethnicity *	Occupation	Current/Previous Work Location
KI1	25-35	F	BC	YW	Multiple Areas
KI2	40	F	BC	Mental Health YW	n/a
KI3	20-25	M	BC	Male YW	Toronto/East York
KI4	35-40	M	BC	YW	Multiple Areas
KI5	35-40	F	BC	Teacher, Black youth advocate	Toronto/East York
KI6	35-45	F	IC	YW	Scarborough
KI7	35-40	F	C	YW	Scarborough
KI8	25-35	F	C	YW	Scarborough
KI9	25-30	F	BC	YM	Toronto/East York
KI10	35-40	M	BC	YW	North York
KI11	40-50	M	BC	Religious leader	Kingston-Galloway
KI12	25-30	M	A	YW	Toronto/East York
KI13	35-45	F	BC	YW	Multiple Areas
KI14	25-30	F	A	YW	North York
KI15	25-30	M	BC	LGBTQ YW, and YW	Toronto/East York
KI16	25-30	F	A	YW	Toronto/East York
KI17	25-30	M	MX~	YW	Toronto/East York

Legend: A: African; BC: Black Caribbean; C: Caucasian; IC: Indo-AC; MX: Of mixed heritage; YM: Youth Minister; YW: Youth Worker; ~ Individual is of mixed Afro-Caribbean heritage; * Please note ethnicity designation is based on either observation by the Study Coordinator or by self-identification.

Table 4. Main themes and subthemes found from Key Informant Interviews

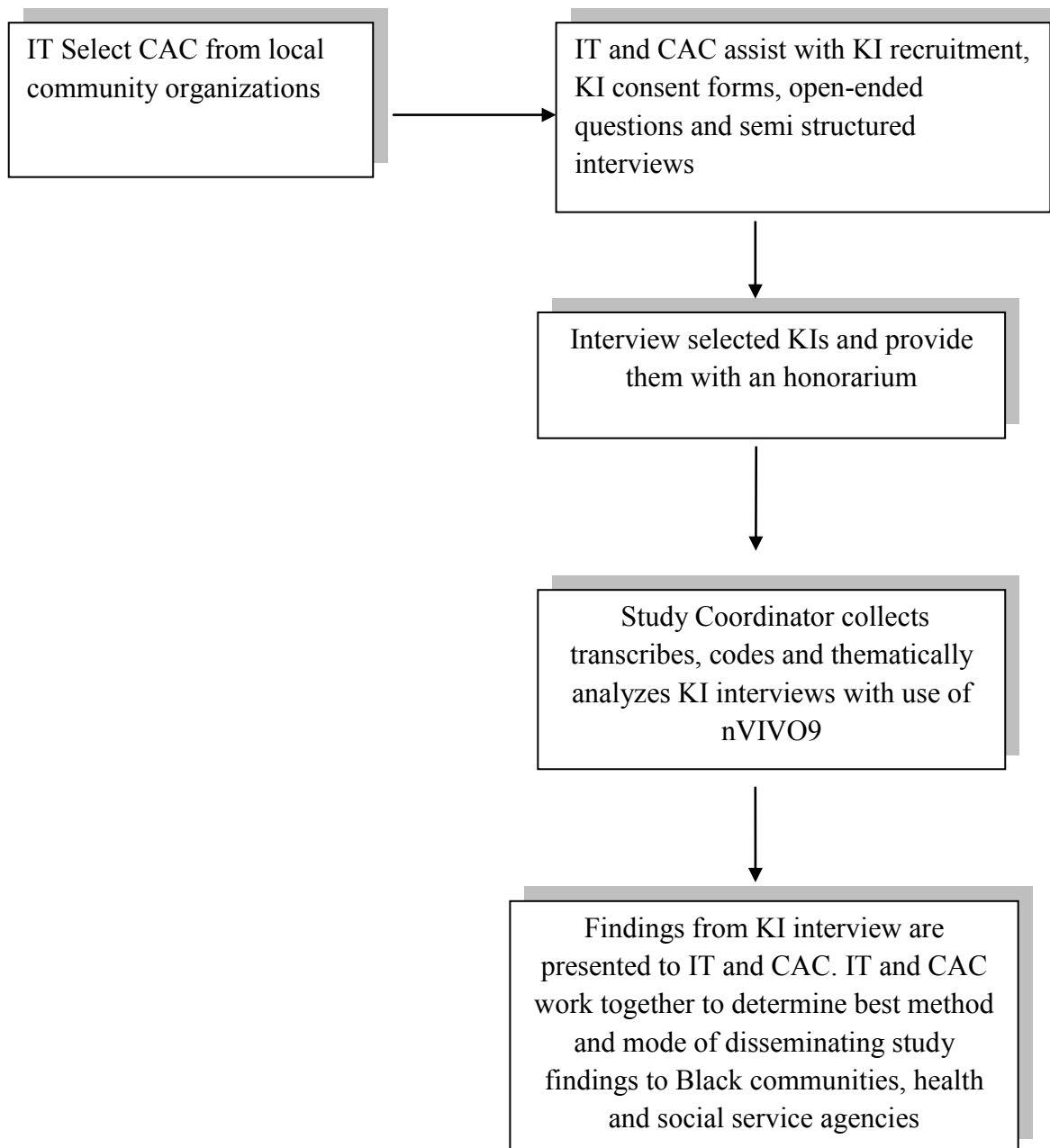
Question	Main Themes	Main Subtheme
From your perspective, what are some of the main issues or challenges faced by Black youth in Toronto, Ontario?	Parental expectations Education Employment Homosexuality Lack of understanding Difficulties finding employment Crime Parent-youth issues Poverty	<ul style="list-style-type: none"> • Single parent households • Parental Expectations • Housing
In your opinion what are some of the main challenges Black parents or youth face in discussing sex, dating and relationships?	Lack of in depth sexual health conversations Lack of discussions concerning teen pregnancy Parental discomfort discussing sexual health with youth Difficulties discussing sexual diversity Homophobia	<ul style="list-style-type: none"> • Parental fear discussing sex will negatively impact youths' behaviour

Table 4. Main Themes and Subthemes from Key Informant Interviews Continued

<p>In your opinion, are schools supportive of Black youth with regards to their cultural approach to sexual education? (PROBE: if they say relationship is not good)</p> <p>How would you suggest improving that relationship? (PROBE: if they say relationship is good) Why is it great?</p>	<p>Generic sexual health education programs</p> <p>Barriers to providing relevant school based sexual health education programs to Black youth in Toronto</p> <p>Bring in external agencies into schools</p> <p>Be candid about sexual health with Black youth in Toronto</p>	<ul style="list-style-type: none"> • Teachers are uncomfortable providing sexual health education
<p>In your opinion are Black parents supportive of youth? [. . .]. Are there differences in support between male or female parents? (PROBE) What about boys? [. . .] Or what about girls?</p>	<p>Differences in support between Black mothers and daughters compared to fathers and daughters</p> <p>Differences in support between fathers and daughters compared to mothers and daughters</p> <p>Differences in support between Black mothers and sons compared to Black fathers and sons in Toronto</p> <p>Differences in levels of support between Black fathers and sons compared to Black mothers and sons in Toronto</p> <p>The roles of fathers in the lives of Black</p>	<ul style="list-style-type: none"> • Minimal Black mother-daughter sexual health conversation • Minimal Black father-daughter sexual health conversation • Minimal or no conversations about sex

Table 4. Main Themes and Subthemes from Key Informant Interviews Continued

	youth in Toronto Single parenting impacts Black parent-youth sexual health communication	
What needs to be done to enhance parental support of Black youth?	Have more candid sexual health conversations	

Appendix A.*Flowchart of community based research design*

Legend: CAC: Community Advisory Committee; IT: Investigative Team; KI: Key Informants; NVivo9: data analysis software

Appendix B.*Community Advisory Committee Information package****Parent-Child Communication on Sexual Health and HIV:
The Experiences of Black Ontarians and Nova Scotians***

Co-Principal Investigators: Clemon George, PhD (University of Ontario Institute of Technology)

Jacqueline Gahagan, PhD (Dalhousie University)

Research Manager: Nakia Lee-Foon

Community Advisory Committee Information Package**Project Overview**

The purpose of this project is to bring together academic and community partners in the design and development of effective communication models to assist parents and professionals in meeting the sexual health needs of African Canadian youth, as a part of a HIV risk reduction strategy.

The project will consist of forming a Community Advisory Committee (CAC), conducting key informant interviews, and facilitating a focus group with Black youth. A community-based research approach, which places the community at the center of the research process, will be employed. Given this, the CAC has been established to provide a voice for the community and will advise the research team on all aspects of the project including study design, recruitment, and interpretations of findings, dissemination, and follow-up initiatives.

Key informant interviews will engage individuals from Black communities and organizations, AIDS organizations, other health related organizations, school health educators, youth group leaders, religious community leaders, as well as youth from within the community. Key Informants will be chosen based on their knowledgeable of youth parent dynamics and who can provide insightful leads on how to investigate youth need.

The focus group will consist of up to 10 community members to discuss the challenges that Black parents and children face in communicating issues of sex, sexuality and HIV risk reduction in the contest of geography, ethnicity and HIV; to determine best recruitment options with regards to community and institutional feasibility and to gauge the broader community willingness to address gay sexuality within the family structure.

Community Advisory Committee Overview***Purpose of the Community Advisory Committee***

The overall purpose of the CAC is to ensure the interests of the community are represented throughout the study. In doing so, the community will have a sense of

Appendix B.

Community Advisory Committee Information package continued

ownership and support for the research being conducted. The CAC will help to ensure that activities carried out appropriately, and in the best interest of the community and project.

Role of the Community Advisory Committee

The CAC has been designed to provide representation from the community to ensure their interests are represented throughout the project. The committee will share opinions and perspectives, offering advice to the Research Team and its input will enable a planning process that is open, transparent and meaningful to the community.

Input from the CAC to the Research Team throughout the project will be in the form of information, feedback, and recommendation which will be used by the Research Team in study design, outreach to AIDS Service Organizations and other relevant community organizations, advertising, recruitment of participants, interpretation of research findings, dissemination activities, and follow up initiatives. Additionally, the committee will be instrumental in advising the Research Team on the best avenues for broad community engagement and communication of critical information. Final decision-making authority in all project-related matters will lie with the Research Team with key input from the Community Advisory Committee.

Duties of the Community Advisory Committee

Meet as required at various stages of the project with the member of the Research Team:

- Provide advice on key project matters to maintain community's best interest;
- Review and comment on results of project activities carried out by the Research Team;
- Review reports, as required, and provide feedback and recommendations;
- Recognize that some information shared during this project may be sensitive, and when used outside the meetings may jeopardize the integrity of the project results.

Meetings

Meetings shall be held as required as agreed to by the CAC and Research Team as determined by the project requirements. (Preferably 3 meetings over a 1 year term - this phase of the project)

Meeting Times and Locations

Meetings will be held at the TAIBU Community Health Centre, 1371 Neilson Road, Scarborough when available. Timings for meetings will be determined as agreed by the Advisory Committee and Research Team.

Appendix B.

Community Advisory Committee Information package continued

Meeting Minutes

A written summary of discussion and comments from each meeting will be prepared by a member of the Research Team with the assistance of the CAC. Meeting minutes will describe highlights of the meeting, areas of agreement, disagreement or decision, and recommendations or options. Meeting minutes will be regularly circulated to the CAC and Research Team members.

Contact Information

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Research Manager
Email: nakia.lee-foonglasgow@uoit.ca

Clemon George
Principal Investigator
Email: Clemon.george@uoit.ca
Ph: (905) 721-8668 ext. 3659
Fax: (905) 721 3179

Appendix C.*Key Informant Advertisement*

Call for Key Informants for Black parent-youth sex communication project.

Are you a parent/caregiver of a Black youth?

Are you a community organization or a health-related organization worker, a school health educator, youth group leader or Religious community leader who works with Black parents/youth?

If yes, we would like to hear your views about the sexual health care and social issues facing Black youth and their parents for a project on Black parent-youth sex communication.

Those chosen to take part in this project will be interviewed once for 30-60 minutes and receive \$25 for participating.

All information collected will be made anonymous.

If you are interested in taking part in this project, please send a copy of your resume by Wednesday November 24th to nakia.lee-foonglasgow@uoit.ca.

For more information on this project please email nakia.lee-foonglasgow@uoit.ca

Appendix D.
Key Informant Consent Form

CONSENT TO PARTICIPATE IN RESEARCH

Researchers from the University of Ontario Institute of Technology (UOIT), Dalhousie University and our community partners are asking you to participate in this study. Clemon George of the University of Ontario Institute of Technology and Jacqueline Gahagan from Dalhousie University are the project directors. If you have any concerns about the study, please contact Clemon George at clemon.george@uoit.ca.

Purpose of the Research

The study is about health behaviour and parents connectedness to their children. The information you give will be used to develop better health education programs for young people and their parents.

Procedures

By volunteering to participate in this study, you are being asked to participate in an interview. You will be asked questions about your knowledge of health care services for Black parents and youth, Black parent-youth communication, your identity, experiences you may have in child rearing, knowledge of HIV and youth's sexual relationships. The meeting will be audio-taped and will last approximately 30-60 minutes. You will have access to the final report produced by the research team.

Confidentiality

All information that you provide will be treated with the strictest confidence. The tapes or written notes of the meeting will be kept in a secure place where only members of the research team will have access to them. They will be used strictly for research purposes. You will not be identified by name in any documents related to this research. The researchers will attach a code rather than your name to any records associated with your participation in this study. **The interview tapes will be kept only until the data is transcribed (that is, the recording is typed on paper)**, after which they will be destroyed. Any information about you obtained in connection with this study will remain confidential and will be stored to preserve your anonymity.

Potential Risks and Discomforts

There are potential risks with talking about some of the issues that will come up in the interview (e.g., negative experiences you may have had with your children, etc.). Some participants may feel uncomfortable discussing these issues. The research team will be available after the interview to discuss any personal issues or concerns that may arise during the interview.

Potential Benefits of the Research

Findings from this research will be helpful in developing outreach and HIV prevention programs for Black parents and their children.

Appendix D.**Key Informant Consent Form Continued****Payment for Participation**

A \$25 honorarium will be provided upon completion of the interview.

Participation and Withdrawal from the Research

You can choose whether to participate in the research or not. If you volunteer to participate, you may withdraw at any time without consequences of any kind. You may also refuse to answer specific questions in the interview and still remain in the study. If you decide to withdraw from the research, please contact Clemon George. The recorded tape and transcript of your interview will be destroyed if you withdraw from the study. The researcher may withdraw you from this research if circumstances arise that warrant doing so.

Rights of Research Participants

You may withdraw your consent at any time and stop participating in the research without penalty. However, as the data collected is anonymous (no names are associated with the transcripts) we will not be able to withdraw your information as we will be unable to link back the data to you. This study has been reviewed and received ethics clearance from Research Ethics Board at the **University of Ontario Institute of Technology and Dalhousie University**. If there are any ethical concerns regarding this study, please contact the University of Ontario Research Ethics Officer at compliance@uoit.ca.

I understand the information provided for the study Parent child communication on sexual health and HIV: The experiences of Black Ontarians and Nova Scotians. My questions have been answered to my satisfaction and I agree to participate in this study. I have been offered a copy of this form.

Participant's signature

Date

In my judgement, the participant is voluntarily and knowingly giving informed consent and possesses the legal capacity to give informed consent to participate in this research study.

Signature of interviewer

Date

Participant accepted and received a copy of the signed consent form.

Participant did not accept a copy of the signed consent for

Version: December 4th, 2010

Appendix E.
Key Informant Interview Guide

[Prior to being interviewed, all key informants will be briefed on the study, consented and offered a copy of the consent form]

1. Are you engaged in or work with any organizations that work with black youth? Can you tell us about your experiences with these organizations? If yes, are you comfortable with naming a few of those organizations? (PROBE) Can you tell me about the work that they do?
2. From your perspective, what are some of the main issues or challenges faced by Black youth in Toronto, Ontario?
3. In your opinion what are some of the main challenges Black parents or youth face in discussing sex, dating and relationships? (PROBE) What about HIV? Are there any challenges? If so what are those challenges and who are they talking to about it?
4. In your opinion, are schools supportive of Black youth with regards to their cultural approach to sexual education? (PROBE: if they say relationship is not good) How would you suggest improving that relationship? (PROBE: if they say relationship is good) Why is it great?
5. In your opinion are Black parents supportive of youth? [. . .]. Are there differences in support between male or female parents? (PROBE) What about boys? [. . .] Or what about girls?
6. What is the most important thing you would want to or would like to learn as a result of this study?

Thanks for providing all of that information . . .

7. We wanted to interview you because you work with or on behalf of Black parents or youth and you understand the issues surrounding youth and parents [. . .]. Are there community members or other people who work with Black youth or their parents we should also interview?
8. For SERVICES PROVIDERS: Could you suggest the best mediums that would be impactful for recruiting participants for this study?
 -FOR PARENTS: What do you think are the best ways to reach participants for this study?

-FOR YOUTH: how best can we reach other young people like yourself?

9. Are there any other questions that we should be asking?

Appendix F.*High school Sexual Health Presentation*

In order to have an understanding of youths' overall sexual health knowledge, the current state of sexual health education in schools, and to increase Black-Canadian communities' awareness of the study and services provided by TAIBU the Study Coordinator and a representative from TAIBU provided free sexual health education presentations to high school youth during gym class.

Participant Recruitment

Teachers and/or principals from various high schools across the GTA were contacted via email or by phone by the Study Coordinator concerning the possibility of presenting a sexual health program in their gym classes. The Study Coordinator and the TAIBU representative presented the program to schools that approved their presentation.

Presentation Format

The presentation was constructed through collaboration between the Study Coordinator, Principal Investigator and the TAIBU representative. This collaboration led to the creation of a presentation founded on audience participation.

The presentation was provided in a gender neutral fashion. The presentation began with an ice breaker followed by information on birth control, sexually transmitted infections (STI), contraceptives and sexual health care services in Toronto provided in a true or false format. The ice breaker involved participants identifying themselves and answering a question related to sex and/or sexual health. Prior to the commencement of the presentation, each student was provided with a double sided card with the words TRUE on one side and FALSE on the other.

Students were also given the opportunity to write anonymous questions which would be drawn from a hat by the presentation team and answered at the conclusion of the presentation time permitting. Sexual health education pamphlets, condoms and sexual health care clinic resources were also provided to students to take with them. Students were also encouraged to ask questions at any point during the presentation. They also were informed that the presentation would last approximately one hour. The teacher was requested to remain in the room for the duration of the presentation to maintain classroom decorum. The presentation script and advertisement can be found in appendix G.

Informed Consent

Prior to the initiation of the presentation, every effort was made to ensure students provided informed consent to attending the participation. The Study Coordinator provided students with an overview of the presentation and possible resulting risks and benefits that may result from the presentation.

Appendix F.*High school Sexual Health Presentation continued****Risks and Benefits***

Students were informed that although there were no physical risks associated with the presentation some students may feel uncomfortable discussing sex, sexuality and sexual health.

If in the event they felt uncomfortable they had the option to be removed from the presentation and be provided an alternate work assignment from their teacher.

They were also informed that some of the benefits of remaining in the class for the presentation would be increased knowledge about sex, sexuality and sexual health. This knowledge could protect them against STIs, early pregnancy and assist them with proper condom usage and disposal.

Data Collection

Field notes were taken by the Study Coordinator of students' reactions towards discussions about sex, sexuality and the level of sexual health knowledge. (These notes were reviewed by hand and common themes noted.)

Appendix G.*DRAFT- High School Sexual Health Education Presentation GUIDE***Introductions-Instructors**

TAIBU representative - (you may introduce yourself or have an introduction made for you)

Nakia – (you may introduce yourself or have an introduction made for you).

(Both of us) Why are we here? What are we here to talk about? Sexual health & well being

Ice Breakers: ask for students' name and what they think is the sexiest part of the human body

Time: 5 min or less

(Both of us) Introduce sex and ground rules

Sex can be super complicated so no questions are dumb questions. So please feel free to ask a question at anytime during our presentation . . . but we may limit the time for questions to ensure that we cover everything. Please don't pick on your friends; you may think it's a dumb question but there's probably 3 or more people here that were thinking the same thing or wanted to know the same thing. Anonymous sex questions: explain this (paper→ hat) answer 1-2 questions at the end.

First, those of you who do not feel comfortable talking about sex may leave the room.

SEX. We are going to talk about an interesting topic that many of you have heard about . . . It's all about sex.

First. What is sex anyway? Sex: Refers to anal or vaginal sexual intercourse/penetration. Why do people have sex? 1-2 responses→ our explanations

Sexual activity: refers to oral sex & anything that doesn't involve penetration/intercourse.

Now, what do you know about sex (street version)? 1-2 answers

Where do you get your information about sex? (PROBE: friends, internet, movies, parents)

-If students do not answer this question, instructors could answer this question first.

Time: 5-10 minutes

Start-True and False (PowerPoint presentation)

Time: 20-30 min

Appendix G.

DRAFT- High School Sexual Health Education Presentation GUIDE continued

T or F Ground rules

(Both of us) You've probably noticed that there's a piece of paper with the word True – False on either sides. We're going to ask to a few questions to see how much you know about sexual health. So if you think the following statements are True flip your paper to the True side, False flip it to the other or if you don't know the answer or don't feel comfortable answering it then don't put up the paper. Onto the first statement. . . .

(Both of us) T or F- All my friends are having sex.

F- Less youth are having sex now that in the past few years

Before I ask the next question does everyone know what birth control pills are?

(Nakia) T or F- Birth control pills protect me from STIs so we don't need to use condoms

F- Birth control only reduces the chance of pregnancy and does not protect against STIs and HIV/AIDS. The best way to prevent STIs is by using a condom (male or female) during sex or sexual activities. Sexual activities: Refers to sexual acts that do not involve vaginal or anal penetration. Sexual activities include oral sex and heavy petting.

Birth control is not the only form of contraceptives; there are a few other options beyond male condoms and the pill.

Also just cause you're on birth control doesn't mean you're having sex.

Most of you would have heard about birth control. Birth control has been around for centuries in many forms.

- The earliest attempts at birth control came from ancient Egypt where Egyptian women put a mixture of crocodile dung, honey, and sodium carbonate (what we use today as water softener) into their vaginas to prevent pregnancy.
- In the mid 19th century condoms started to be made out of rubber. Men were told they could be washed and used until they fell apart.

From the 1920's to the 60's the most popular female contraceptive was Lysol disinfectant (the stuff you use to clean your kitchen) douching (rinsing of the vagina). Eventually people realized Lysol not only failed as a form of birth control but also killed or caused severe burns to women that used it. Until 1969 it was illegal in Canada to sell or advertise birth control.

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- Intrauterine system (IUS): It's a T-shaped piece of plastic that has progestin; a hormone that tricks a woman's body into thinking it's already pregnant. The IUD is put into the uterus and can only be done by a health care provider (like a doctor or nurse).

-Intrauterine Device (IUD): Similar to the IUS except it has copper wire wrapped around the T-shaped plastic.

-The Shot: It's an injection that has progesterone (a hormone that tricks your body into thinking it's already pregnant). The injections have to given by a health professional in the arm or butt every 12-13 weeks.

-The Pill: The most popular form of prescribed birth control. It's a pill that comes in a pack of 21, 28 or 91 and must be taken every day at the same time. It has estrogen and progestin (these hormones make it harder for sperm to fertilize an egg). This form has 1 hormone-free week pill.

-The Patch: a patch is put on the skin and releases estrogen and progestin through the skin over time. The patch can be put on the butt, upper outer arms, lower stomach and back. Patches are put on once a week for three weeks then one week without the patch.

-The Ring: (No not the movie) a.k.a NuvaRing, is a small flexible ring which has estrogen and progestin in it that's placed into the vagina for 3 weeks then taken out for 1 week.

-The Sponge and Spermicides: The sponge is a soft, one time use foam device with spermicide in it. Spermicides can be found as creams, jellies, tablets, foams and Films and have a chemical in that can kill sperm. The sponge and spermicide can be bought over the counter at places like Shopper's Drug Mart.

-Female Condom: this is a soft polyurethane sheath that's placed into the vagina. It traps the sperm, preventing it from fertilizing the egg.

Diaphragm and cervical cap: It's a latex cap that covers the cervix and stops sperm from getting in. The Cap is a deeper shape but does the same job. Spermicide is placed in the diaphragm and inserted into the vagina. The cap is inserted into the vagina without spermicide and covers the cervix.

MEN

Male Condom: (I'm sure you've heard a lot about this so we won't go into too much detail). Condoms come in different sizes, shapes, colours (some even glow in the dark), flavours and thicknesses! And is placed on an erect penis. Some condoms have spermicide in them

Withdrawal method or Pulling out: A man pulls out from a woman's vagina before ejaculation. Both partners have to agree on this method.

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-Abstinence: Both partners choose not to have any sex or sexual activity.

Does everyone know what plan B is before we start?

T or F – Plan B can stop me from getting pregnant and from getting an

STI

T&F- Plan B can prevent you from becoming pregnant if taken 72 hours after unprotected sex has occurred. It can't stop you from getting STIs.

(TAIBU representative) STI (sexually transmitted infections): STIs are sexually transmitted infections that people get through unprotected sex or sexually activity. I'm sure you guys have heard the term STD (sexually transmitted diseases). Well STDs and STIs mean the same thing. –some STIs can't be seen or felt but others can. Some symptoms will clear on their own but that doesn't mean you're fine. If there are any weird bumps or burning sensations when peeing go see a doctor!!

There are four groups of infections: Bacterial, viral, parasitic and fungal

Bacterial: Chlamydia, Gonorrhoea, Syphilis

Viral Infections: Genital Herpes, HIV, Hepatitis B or Hep B, HPV (The human papilloma virus)

Parasitic Infections: Trichomoniasis a.k.a trick, Pubic Lice or Crabs, Scabies: (no not rabies!)

Fungal Infections: Some people call these infections caused by fungal STIs.

Yeast Infection or Candidiasis: It's a fungal infection of the vagina caused by an overgrowth of yeast called Candida, which is normally found in the body. Girls that have this normally have a cottage cheese like discharge. Some guys can develop signs of yeast infection after having sex with a girl with a yeast infection. This is treatable.

T or F- I can't get an STI if I don't have sex.

F- You can get an STI from any form of unprotected sexual activity. STI rates are highest in those aged 15-19. Toronto has some of the highest rates of STIs compared to some other places in Canada. Black youth are at an even higher STI risk than any other cultural group in Toronto. Black girls are especially vulnerable to STIs. Sexual activities: Refers to sexual acts that do not involve vaginal or anal penetration. Sexual activities include oral sex and heavy petting.

T or F- I'd be able to tell if me or my friends had an STI

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T&F- while some STIs are pretty visible on the human body others aren't. Chlamydia is the one of the most common STIs affecting teens but most people that have it don't even know they do for years and years. To make sure 100% you must get tested

Gonorrhoea: <http://www.youtube.com/user/sexandu#p/u/20/qgAnOSbc6rU>

T or F- All STIs can be cured

F-While there are some STIs like Chlamydia that can be cured, some STIs like Herpes can only be treated to prevent flare up and the person will always have it and the possibility of passing on their STI to another person

HPV genital warts: <http://www.youtube.com/user/sexandu#p/u/19/LSMNMpG0-2o>
Introduce chart on STI (curable & not so curable etc)

T or F- There is a cure for HIV/AIDS.

AIDS- (acquired immune deficiency syndrome). It's a disease caused by HIV which weakens the immune system's ability to defend itself against illnesses and infections.

HIV- (human immunodeficiency virus). HIV is a virus that leads to AIDS. It takes over cells in the body and uses them to grow more HIV. HIV can be spread through body fluids.

-to learn more about what HIV/AIDS is you can Google it or come talk to us after class.

F- While there are a few drugs that can be used to decrease the effects of HIV/AIDS, there is currently no cure for HIV/AIDS.

T or F-HIV/AIDS isn't something we have to worry about in Canada

F-HIV/AIDS is a worldwide problem. Youth aged 15-24 makes up half of all new HIV cases in the world.

T or F- I can tell if someone has HIV/AIDS

F-You can't tell if someone has HIV/AIDS. The only way to tell if someone has HIV is to be tested. Some people who have HIV will not get any symptoms for 10 or more years.

(NAKIA) T or F- I have to get permission from my parents and my Health Card to get STI testing/condoms and birth control pills

F-STI testing can be done anonymously without getting your parents' permission and your health card at most sexual health care clinics in Toronto and from your doctor. You can also get condoms for free and birth control pills at a reduced rate or free from sexual health care clinics in Toronto. Here's some information about how to get services without your health card if you can't get access to it.

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Do I need ID? <http://vimeo.com/7710949>

T or F-Getting tested for STIs cost money, take a lot of time and are super painful.

F-STI testing is free at your doctor's or at sexual health care clinics in Toronto. Tests can be done in a few minutes and can be as simple as taking a blood test.

(BOTH OF US) T or F- I'd rather talk to my friends or do research on the internet than my parents about sex

(Probe) Why do you only talk to your friends? Use the internet?

(PROBE) why do you talk to your parents? → This may be a good way into discussing parent-youth sex communication

(BOTH OF US) Q&A period from Students:

Time: 10-15min

Leave the floor open to students to ask any questions they may have about sex, sexuality and sexual activities.

And answer questions written down on papers by randomly selecting a few questions.

If all else fails mini quiz them → HIV/AIDS, contraception, & STIs

(BOTH OF US) How you can prevent getting STIs and HIV/AIDS

It's up to each individual to decide when you are ready to have sex or sexual activity. Regardless STIs are still a very serious problem in Canada especially amongst youth. While condoms and birth control can prevent pregnancy and STIs if used properly there are also a few other things you can do to prevent STIs.

(ONLY IF TIME PERMITS) Now let's talk about healthy sexuality. What do the following mean to you?

- Sexual responsibility in society
- Child rearing/caring

Sexual abuse: The Canadian Dept of Justice define sexual abuse as "as when an older child, adolescent or adult takes advantage of a younger child or youth for sexual purposes, including for participation in prostitution, pornographic

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performances and in the production of pornography. Sexual abuse can occur with on children of all ages, from birth to adolescence”.

-Economic survival/ life changes and lost

Conclusion

(Both of us) Before we go, we just wanna leave you with this. . .

http://www.sexualityandu.ca/flashvideo/english/contraception_m_eng.html

Thanks for your time. If there’s anything you’d like to talk about that we haven’t discussed during our presentation you can ask us after. You can also visit www.taibuchc.ca if you’re looking for health care services.

Also there are a few pamphlets that we have with info about sex, health care services in Toronto that you can look at but please don’t take them.

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Let's talk about Sex !!!

**Let's talk about the issues affecting
YOUTH in the GTA!!!**

For this and other health services, give you a call

**Nakia 416-550-7606 or Vijay 416 644 3536 or email at
TAIBUcommunication@gmail.com**

**Tell us you saw this ad.
www.taibuchc.ca**



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