

Review and Commentary

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Commentary: Healthcare Lived Experiences of African, Caribbean, and Black Individuals in Alberta living with HIV/AIDS

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Abstract

Despite biomedical advances that have made HIV a manageable chronic illness and the outcry over increasing access to care for marginalized groups, African, Caribbean, and Black (ACB) communities in Canada still experience disproportionate HIV rates and worse health outcomes related to HIV. A recent phenomenological study by Osuji, Domingo, and Olokude (2025) examines the lived experiences of ACB individuals in Alberta as they navigate HIV care.

Objective: This commentary critically analyses the findings of this study through the lenses of Critical Race Theory, intersectionality, public health policy, and health equity.

Discussion: This study's themes—health literacy and empowerment, non-belonging and invisibility, barriers to adherence, and psychosocial life impact—highlight how structural racism, stigma, and systemic neglect influence HIV care for ACB populations in Alberta. This commentary asserts that these inequities are not incidental but are deeply embedded in healthcare systems and broader societal structures. The invisibility of ACB people within HIV policy and data exemplifies structural racism, leading to poorer health outcomes and wider failures in public health.

Implications: Public health policies and practices must prioritize culturally responsive care, community-based interventions, disaggregated data collection, psychosocial support, and reforms to address the social determinants of health. Without intentional action, Canada will not achieve its HIV elimination targets or uphold its commitment to equity.

Conclusion: Ending HIV requires more than biomedical solutions. It involves dismantling systemic racism, fostering a sense of belonging, and creating inclusive systems where Black lives are visible, valued, and supported.

Despite medical advances that have transformed HIV from a fatal disease into a manageable chronic condition, the epidemic still disproportionately impacts ACB communities in Canada and around the world^{1,2}. Osuji et al.'s (2025) phenomenological study provides a vital perspective on the lived experiences of ACB individuals in Alberta navigating HIV care. Their findings—organized around themes of health literacy and empowerment, non-belonging and invisibility, barriers to adherence, and psychosocial health impact—highlight a troubling reality: stigma, discrimination, and systemic anti-Black racism remain significant barriers to equitable care. This reveals that anti-Black racism in HIV care persists, underscoring an ongoing public health crisis of belonging.

This commentary critically evaluates their findings through the lenses of public health, Critical Race Theory (CRT)³, and intersectionality⁴. The main argument is that the invisibility of ACB people within Canadian HIV policy and practice exemplifies

structural racism, which creates barriers not only to care but also to belonging. Moreover, these inequities are not solely issues for ACB communities but for the entire population because they resonate throughout society, undermine public health objectives, perpetuate health disparities, and weaken collective resilience.

Canada's HIV response has made significant progress towards the UNAIDS 90-90-90 targets, with viral suppression rates surpassing global averages⁵. However, these achievements conceal profound inequalities upon closer examination. National surveillance data reveal the disproportionate impact of HIV on ACB Canadians. Although Black people constitute about 5% of the population, they account for 25% of new HIV infections nationwide¹, and nearly half of all new cases in 2017 involved ACB individuals². This unequal burden is rooted not in biological vulnerability but in structural disparities driven by the cumulative effects of racism, migration stress, poverty, and stigma^{6,7}. The study based in Alberta underscores how systemic racism manifests at both micro-level—during patient-provider interactions—and macro-level—through access to health services.

Participants reported delays in treatment, long wait times, insensitive communication, and experiences of exclusion⁸. These are not isolated stories and reflect structural realities consistent with other Canadian research on medical mistrust among ACB communities in Canada^{9,10}. Such mistrust is not unfounded; it results from a healthcare system that has historically and persistently marginalized Black lives¹¹.

Critical Race Theory (CRT) provides a robust framework for understanding these findings. It explains that racism is not just individual bias but is embedded in laws, institutions, and discourses^{12,13}. The invisibility experienced by participants reflects structural and systemic processes that render Black suffering unseen within Canadian healthcare narratives. Intersectionality further clarifies how racial inequalities become more severe when they intersect with gender, sexuality, class, and immigration status^{14,15}. For example, Black women living with HIV often face not only racial discrimination but also misogyny, a form of racism and sexism that targets Black women explicitly^{6,15}. This intensifies stigma, hinders disclosure, and worsens vulnerabilities at the intersection of racialization¹⁶. Therefore, HIV care for Black individuals must be viewed within the broader systems of oppression.

Another notable contribution of Osuji et al.'s⁸ study is the introduction of the concepts of "non-belonging and invisibility." Belonging is not a privilege but a crucial element in health¹⁷. When individuals feel they do not belong in healthcare settings or within their communities, they often disengage, miss appointments, and delay

starting treatment. Conversely, when patients feel seen, valued, and included, their adherence to care improves, and psychosocial outcomes are significantly enhanced¹⁸.

The feelings of exclusion and othering within the ACB community in HIV care reflect wider racialized barriers to participation in Canadian public life. ACB Canadians have historically been invisible in national health data, policies, and interventions^{19,20}. Without disaggregating HIV-related data by ethnicity and race, disparities remain hidden, perpetuating structural neglect²¹. This results not only in poorer health outcomes for Black individuals but also in a weakened public health system that fails to uphold its commitment to equity.

Participants in the Alberta study described how an HIV diagnosis motivated their pursuit of knowledge, leading to increased health literacy and a sense of empowerment⁸. This aligns with research showing that knowledge is a protective factor that enhances adherence and reduces stigma^{22,23}. However, literacy alone cannot eliminate systemic barriers. For instance, a Black patient might fully understand the importance of adhering to antiretroviral therapy but lack transportation to clinics, face discrimination from healthcare providers, or fear disclosing their status within their community²⁴. Therefore, empowerment through literacy must be combined with structural reforms, because without them a paradox arises: individuals become empowered with knowledge but remain powerless within systems that continue to exclude and oppress them.

The concept of stigma appears across all study themes, influencing disclosure, adherence, and psychosocial well-being. Stigma operates at multiple levels: individual (internalized shame and fear of rejection), interpersonal (discrimination by family, peers, and healthcare providers), and structural (policies and norms that reinforce exclusion). Earnshaw et al.'s²⁵ stigma framework demonstrates how these levels intersect and weaken health outcomes. For ACB communities, stigma is intensified by racialisation, as HIV intersects with anti-Black racism, creating "intersectional stigma"¹⁶. The outcome is a cycle of secrecy, delayed testing, and poor adherence, which perpetuates transmission and worsens health outcomes.

The barriers faced by ACB individuals in HIV care go beyond personal tragedy; they reveal systemic failures that threaten public health. First, unequal access hampers the collective effort to end HIV as a public health threat by 2030²⁶. Canada cannot achieve sustained viral suppression nationwide if key subpopulations are excluded. Second, inequities worsen health disparities, opposing Sustainable Development Goal²⁷. Third, ongoing racism in healthcare damages trust not only among ACB communities but across all marginalized groups, undermining the legitimacy of public health institutions.

The lived experiences of ACB individuals in Alberta demonstrate that HIV care inequalities are driven by structures rooted in racism, stigma, and systemic neglect rather than by chance. While biomedical advancements aim to eliminate HIV/AIDS as a public health threat, this can only be achieved if equity remains at the centre of policy and practice. Addressing the invisibility and lack of belonging of Black people in HIV care is not only a moral obligation but also a crucial public health issue. Ending HIV requires more than just medications and targets; it involves dismantling racism, fostering a sense of belonging, and building systems where all lives matter, are visible, valued, and supported. Anti-Black racism in HIV care must be eliminated; this is the only way to effectively address the ongoing public health crisis related to belonging.

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