

The Cycle of Structural Violence in Black Health: Institutional Ethnography of the Social Organization of HIV Healthcare for African, Caribbean, and Black People in Canada

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Research Article

Keywords: Structural violence, Black health inequities, Anti-Black racism, HIV healthcare, Institutional ethnography, Ecological systems framework, African, Caribbean and Black communities, Social determinants of health, Biomedical individualism, Medical carceralism & Conceptual framework

Posted Date: September 25th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-10757823/v1>

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Additional Declarations: No competing interests reported.

Abstract

Background

African, Caribbean, and Black (ACB) communities in Canada experience a disproportionate burden of HIV/AIDS linked to deep-seated socio-political inequities. Traditional health frameworks frequently trivialize these disparities as passive administrative gaps. This paper re-evaluates these dynamics through the lens of structural violence, tracing how institutional systems actively undermine healthcare engagement.

Methods

Drawing from a four-year institutional ethnography, this study maps the systemic organization of HIV healthcare, treatment, and resource allocation for ACB individuals living with HIV in Canada. Data collection and analysis focused on the intersecting operational realities connecting macro-level statutes to meso-level clinical practices.

Results

The study introduces the Cycle of Structural Violence in Black Health as an ecological model structured around four interlocking mechanisms: 1) legalized abandonment and statutory violence, 2) institutional hostility and epistemic violence, 3) socio-economic captivity, and 4) medical carceralism. Rather than serving as isolated barriers, these mechanisms converge to enforce a self-perpetuating feedback loop that continuously reproduces health violence, biological weathering, and rights violations at the core.

Conclusion

Biomedical and behavioral interventions are structurally destined to fail if they treat systemic outcomes as individual non-compliance. Addressing the HIV pandemic within ACB populations requires an abolitionist paradigm shift that prioritizes legislative decolonization, material reparations, and the urgent decarceration of public medicine.

Background

The Epistemological Crisis of HIV Response

Biomedical advances have successfully transformed HIV from a fatal diagnosis into a manageable chronic condition. Timely linkage, engagement, and retention in healthcare, alongside strict adherence to antiretroviral treatment (ART), are established clinical best practices for achieving an undetectable viral load [1, 2]. Reaching and maintaining viral suppression yields profound clinical and epidemiological

outcomes, including enhanced physical functioning, minimized transmission risk, improved quality of life, and dramatically decreased HIV-related mortality [3-6]. Consequently, international bodies and sovereign states have widely endorsed targeted initiatives aimed at optimizing health and ending the global HIV/AIDS pandemic by 2030 [7-11]. Yet, despite these celebrated scientific milestones, there is growing uncertainty regarding whether the institutional commitments oriented toward ending HIV/AIDS are materializing equitably for African, Caribbean, and Black (ACB) communities in Canada.

We argue that the contemporary social organization of HIV healthcare in Canada is structurally inadequate for improving the wellness of ACB populations. By systematically disregarding the historical and material conditions organizing Black life, current health systems routinely individualize systemic health profiles. This reductionist approach pathologizes structural vulnerabilities as isolated personal failures, framing health outcomes as behavioral choices that individuals must autonomously address. Confounded by this biomedical individualism, standard HIV interventions remain confined within a narrow, behaviorally driven framework that leaves the systemic foundations of disease transmission entirely unexamined, ultimately masking state-sanctioned medical neglect as personal non-compliance.

This pervasive model obscures structural forces and systematically directs researchers, practitioners, and policymakers to focus primarily on individual-level factors, to the severe detriment of broader HIV response efforts [12-14]. Clear empirical evidence demonstrates that biomedical individualism renders invisible the deep social and structural inequities that erect hostile barriers to HIV healthcare and treatment for Black people living with HIV [15-17]. By obscuring these barriers, current frameworks produce an incomplete, skewed, and fundamentally flawed understanding of how systemic inequities shape HIV vulnerability and subsequent health outcomes. In objectifying, pathologizing, and individualizing HIV risks and responses, biomedical individualism functions as an active channel of structural violence, causing further direct harm and physical suffering for Black people.

In this paper, we counter this reductionism by explicitly recognizing HIV/AIDS as a biosocial phenomenon shaped and perpetuated by nested, mutually constituting biological, societal, and structural forces that disproportionately affect structurally disadvantaged and marginalized populations. Embracing a biosocial approach makes visible the explicit causal processes and institutional pathways driving health inequities, illuminating far more effective, structural ways to prevent and manage HIV/AIDS [18, 19].

The Social Context of Black Life in Canada

To situate the mechanisms shaping ACB health in Canada, it is essential to interrogate the historical and socio-political context in which these communities are embedded. Globally and domestically, Canada is discursively constructed as a benevolent mosaic of multiculturalism and racial harmony, boasting systems ostensibly committed to diversity, equity, inclusion, and mutual respect [20]. Under this progressive framing, the state maintains immigration, humanitarian, and integration laws designed to welcome global migrants, including refugees, temporary foreign workers, and international students [21].

Currently, approximately 1.2 million individuals in Canada self-identify as Black, representing 3.5% of the total population, with Statistics Canada projecting a significant demographic expansion to 5.6% by 2036 [22].

The Black population is profoundly heterogeneous; some communities possess generational roots in Canada spanning centuries, while others comprise recent immigrants from various African and Caribbean nations. Yet, despite this internal diversity, Black Canadians are structurally unified by the ordering principle of race, a shared historical legacy of transatlantic slavery and colonialism, and collective contemporary experiences of socio-political exclusion, institutional violence, and systemic marginalization. In sharp contrast to Canada's stated egalitarian commitments, persistent structural racism continues to disproportionately deplete the health and biological weathering profiles of Black people [23, 24].

The Measured Realities of HIV in Black Communities in Canada

The devastating material consequences of this structural racism are explicitly captured by contemporary epidemiological tracking, which exposes the severe and disproportionate physical toll of the epidemic within ACB communities across Canada. Black people living with HIV continue to be systematically left behind and disproportionately impacted by the state's public health response. Although Black populations make up less than 5% of the general Canadian population, recent national data reveal a staggering biopolitical disparity. Black individuals account for 27.6% of first-time HIV diagnoses in 2023 among cases where race and ethnicity data were explicitly reported [25]. In contrast, white individuals comprise 70% of Canada's overall population but accounted for only 25.1% of those identical first-time diagnoses in 2023. This physical stratification is further compounded along mortality lines, with Black Canadians experiencing significantly higher HIV-related mortality rates when compared directly to all other racialized groups [26].

This geographic and epidemiological concentration of structural harm becomes even more acute when localized within provincial borders. In Ontario, Black individuals make up only 4.5% of the total provincial population, yet according to 2022 data compiled by the Ontario HIV Epidemiology and Surveillance Initiative (OHESI), ACB people accounted for a critical 29.8% of all first-time provincial HIV diagnoses [27]. Furthermore, empirical data from the community-based A/C study, which examined self-identified Black adults across Toronto and Ottawa between 2018 and 2019 estimated an overwhelming HIV prevalence within the ACB population at 7.5% (95% CI 7.1–8.0%) [28]. This disparities and inequities operates through highly gendered pathways of vulnerability. Black women comprised 59% of the 86 new first-time diagnoses among women in 2019 and 44.4% of the 54 new diagnoses among women in 2020, while Black men comprised 18% of the 365 new diagnoses among men in 2019 and 19.6% of the 271 new diagnoses among men in 2020. Emergent morbidity data further unmask the deep physiological damage inflicted by this cycle. A 2025 Statistics Canada analysis revealed that Black adults experience

drastically higher rates of HIV-related hospitalizations compared directly to white adults. Specifically, Black males faced approximately twice the risk, whereas Black females endured a staggering, more than twelvefold higher risk of acute HIV-related hospitalization compared to their white counterparts [29]. These metrics do not represent accidental statistical anomalies; they serve as definitive, quantified indices of persistent structural violence operating through the social determinants of health, systematically compromising equal access to healthcare, treatment, and basic bodily survival.

Applying Structural Violence to Black Health Realities

These deadly health trajectories do not materialize in a vacuum; they are actively manufactured by the invisible, normalized machinery of structural violence. Coined by Johan Galtung and introduced into global health discourse by Paul Farmer, structural violence is conceptualized as the harm and suffering that materializes from the development, institutionalization, and normalization of political, economic, environmental, cultural, and social structures that are inherently unjust and oppressive [30-32]. Galtung illustrated this link between social structures and human suffering by defining structural violence as the avoidable difference between what is potential and what is actual [33]. Like physical violence, structural violence "inflict[s] damage to body and mind by creating conditions that subject individuals to suffering through seemingly avoidable circumstances including illness, disability, and death" [34, 35].

Crucially, structural violence is often "invisible, static, insidious, silent, taken-for-granted, and hidden" [36-39], causing profound social inequities to be perceived and normalized as ordinary features of everyday life. Scheper-Hughes describes this phenomenon as "the invisible social machinery of inequality that reproduces social relations of exclusion and marginalization via ideologies, stigmas, and dangerous discourses attendant to race, class, sex, and other invidious distinctions." This structural invisibility is highly problematic because, as Ho notes, "there is no easy pointing of fingers" to an isolated, malicious actor [39]. Furthermore, Farmer argues that the intense priority placed on the molecular and biological dimensions of disease in clinical medicine has produced an "increasing desocialization of scientific inquiry: a tendency to ask only biological questions about what are in fact biosocial phenomena" [36, 40]. This institutional desocialization actively shields the state from accountability, concealing systemic violence beneath clinical vocabulary.

The empirical reality of this invisible social machinery becomes evident when examining the everyday navigation of health systems by marginalized populations. Extensive public health literature demonstrates that Black people living with HIV face persistent, deeply entrenched inequities within the structural and social determinants of health, directly compromising their access to life-sustaining healthcare and clinical treatment [41-45]. Black immigrants in particular experience severe, multi-layered barriers to accessing HIV healthcare, treatment, and vital intersecting support services across Canada [46-51]. Critical health scholars and community activists explicitly attribute these clinical tensions and systemic disruptions to the situatedness of Black bodies within a socio-political context engineered by discriminatory, exclusionary, and unjust state laws, immigration policies, institutional practices, and hostile social relationships [52, 53].

Far from operating as an equitable or neutral landscape, the broader HIV research community and frontline healthcare practitioners openly acknowledge that Black people living with HIV face immense structural opposition when navigating the fragmented Canadian healthcare system to access care, improve their quality of life, and achieve optimal health [29, 54, 55]. Specific structural mechanisms, including a total lack of affordable healthcare coverage, the prohibitive costs of specialized HIV medications, the chronic, paralyzing fear of immigration enforcement, and the bureaucratic complexity of system navigation function as direct vectors of state violence. These forces actively coerce Black immigrants to avoid, delay, or completely interrupt life-saving HIV care, accelerating premature biological weathering [56, 57]. Finally, the global civil rights movement following the murder of George Floyd, the sweeping Black Lives Matter protests against anti-Black racism and systemic police brutality, and the devastating biological convergence of the COVID-19 and HIV syndemics have collectively unmasked and magnified these deeply embedded structural inequities within Canada's public health infrastructure, exposing how the state actively manufactures vulnerability and controls Black biological survival.

While emerging critical public health literature increasingly recognizes structural violence, conventional equity frameworks remain largely descriptive. They frequently document statistical disparities without explicating the precise institutional pathways through which structural oppression is translated into bodily harm and premature biological weathering. Consequently, there remains a critical gap in our understanding of how macro-structural policies, clinical gatekeeping, material deprivation, and carceral public health mandates interact dynamically to organize the health outcomes of Black populations.

This paper addresses this gap by presenting findings from a four-year institutional ethnography that investigated the social organization of HIV healthcare, treatment, and resource allocation for ACB individuals living with HIV across Ontario, Canada. The primary theoretical contribution of this work is the formulation of a novel conceptual ecological framework: the ***Cycle of Structural Violence in Black Health***. Moving decisively past passive frameworks of "health equity," this model centers the reality of ***Black Health Violence*** at its core. We map how structural violence is systematically inflicted and reproduced through four interlocking, nested mechanisms: (1) legalized abandonment and statutory violence, (2) institutional hostility and epistemic violence, (3) socio-economic captivity, and (4) medical carceralism and biopolitical warfare. Ultimately, this framework illuminates how these mechanisms operate concurrently to enforce a self-perpetuating feedback loop, demonstrating that true structural transformation requires an explicit shift from managerial health reforms toward an abolitionist, human rights paradigm.

Methodology

Model Development and Institutional Ethnographic Foundations

The multi-axial model presented in this paper was conceptualized using findings from a four-year institutional ethnography that investigated the interplay between structural factors, political dynamics,

and health inequities in the social organization of HIV healthcare and treatment for ACB people living with HIV in Canada, conducted in collaboration with health system practitioners and people with lived experience of HIV/AIDS. The study drew on the methodological techniques and analytic concepts of institutional ethnography (IE), an alternative sociology developed by Canadian sociologist Dorothy Smith that functions simultaneously as a critical method of inquiry [58].

IE provided a particularly suitable methodology for this study because it deliberately centers the everyday experiences of participants as the primary entry point for analysis, rather than imposing external, pre-determined theoretical categories onto their lives. Central to IE is Smith's concept of social relations, which refers to the translocal processes through which people's daily lives, including their practices, activities, and work, are systematically coordinated to conform to dominant ideologies and institutional orders [58]

IE understands everyday experiences in the social world as explicitly organized, ruled, coordinated, and shaped by complex power dynamics and institutional forces that ultimately constrain people's lives, yet often remain completely invisible to those who are locally positioned within them [58].

Although an IE inquiry begins from where people are situated in their everyday lives, its principal aim is to explore the *social relations* and organizational processes in which everyday doings participate but which are not fully visible to those living them [58]. It seeks to make visible the ways in which institutional orders and practices create the conditions of individual experience [59]. The fundamental ontological commitment of an IE inquiry is discovering "how things are actually put together," or "how things work" [60]. This commitment renders IE an exceptionally powerful empirical tool for unmasking the hidden administrative and legislative machinery that drives the *Cycle of Structural Violence in Black Health*, revealing how routine bureaucratic practices are operationalized to execute active harm against Black bodies.

Data Collection

To explore the institutional coordination of care, this study was conducted with three distinct participant groups: ACB people living with HIV, healthcare providers, and policy makers. We applied varied purposive sampling techniques to systematically recruit Black people living with HIV, healthcare workers, and policy makers [61]. The first author relied on deep engagement with community organizations that serve Black populations, specialized HIV clinics, and clinical providers for recruitment support. Participants were also recruited via word-of-mouth networks through other clients or healthcare providers during routine clinic visits.

Black people who self-identify as immigrants including newcomers, refugees, protected persons, undocumented, or international students and those experiencing precarity were prioritized to participate in the study. Recruited healthcare workers included clinical physicians, nurses, social workers, pharmacists, and frontline workers, alongside key policymakers, who were interviewed regarding their

daily work in providing HIV healthcare and treatment. Given the intersecting nature of the field, some participants self-identified both as Black persons living with HIV and as healthcare workers.

This project was conducted using qualitative methods, including in-depth semi-structured interviews with 20 ACB people living with HIV and 15 healthcare providers and policymakers engaged in HIV healthcare delivery. Interview guide development was informed by the principles of institutional ethnography, which directs inquiry from the standpoint of people whose experiences are the object of study toward the social relations and institutional processes that organize those experiences [58, 61].

The semi-structured interview guide for ACB people living with HIV included questions relating to their everyday experiences accessing HIV healthcare and treatment across the care cascade. Participants were asked to describe how HIV healthcare and treatment is organized for people living with HIV in Canada; what work they do to access HIV care and treatment and work toward undetectability; how they go about doing this work; what barriers they encounter as they seek HIV healthcare, treatment, and related social services; and how they navigate these barriers to access the care necessary for achieving undetectability and optimal health. These questions were designed to map the work processes of ACB people living with HIV, following the IE principle that inquiry begins from the actualities of people's everyday lives and traces outward to the institutional and textual relations that organize them [58, 62]. The full interview guide is provided as *Additional file 1*.

The semi-structured interview guide for healthcare providers and policymakers was designed to illuminate the institutional side of the same work processes, consistent with the IE approach of examining how ruling relations coordinate the work of service delivery [58, 63]. Participants were asked about the work of providing HIV healthcare to ACB communities; the policies and institutional practices that organize their daily work of healthcare provision; the challenges and barriers ACB people encounter in accessing care from their perspective as providers; and what they do to support ACB people in navigating those barriers. In addition, the study included textual analysis of biomedical HIV discourses, evidence-based guidelines, institutional and professional policies, and extra-local texts including provincial and federal legislative frameworks and human rights discourses. The full interview guide for healthcare providers and policymakers is provided as *Additional file 2*.

Ethics and consent

The study received ethics approval from the University of Toronto Research Ethics Board. Informed consent was obtained from all participants prior to data collection. The consent process included detailed information about the study purpose, the voluntary nature of participation, the types of data being collected, and the use of anonymized data in publications and other knowledge mobilization activities. Participants were informed that they could decline to answer any questions at any time and could withdraw from the study at any point in accordance with the procedures approved by the research ethics board.

Particular attention was paid to ensuring that participation was genuinely voluntary and that all participants fully understood the consent process, including the opportunity to ask questions if anything was unclear. Given that the study included African, Caribbean and Black people living with HIV, a population that may experience heightened vulnerability related to HIV stigma, immigration status, and fear of legal or institutional repercussions, the consent process was designed to be transparent, unhurried, and sensitive to these concerns. Participants were explicitly informed that their identities would be protected through anonymization and that no individually identifying information would appear in any publication or knowledge mobilization product arising from the study.

All participants who completed face-to-face interviews provided written informed consent at enrolment. Towards the end of data collection, ethics approval was obtained to conduct the remaining interviews by telephone or through Zoom in accordance with COVID-19 pandemic public health guidelines. Participants who engaged virtually provided written consent via email or verbally through telephone or Zoom. All verbal consents were audio-recorded, dated, and signed by the principal investigator. All interviews were audio-recorded and transcribed based on participant consent.

Data Analysis and Analytic Strategy

Using Institutional Ethnography analytics, this study systematically explored and mapped the translocal social organization of HIV healthcare and treatment for Black people living with HIV. The analytic strategy was explicitly aligned with the critical inflection points across the standard HIV care cascade that are considered clinically consequential for achieving and sustaining viral suppression, optimal health outcomes, and long-term quality of life: specifically, *linkage, engagement, and retention in HIV healthcare, alongside consistent adherence to ART*.

Our analysis traced the specific, physical "health work" that Black people living with HIV engage in to navigate the system. We conducted a rigorous thematic analysis of this labor, documenting who provides care and support, the systemic problems encountered, the informal strategies deployed to access treatment, and the precise institutional pathways through which participants are constrained and disempowered. We actively coded for replicating themes across participants' narratives that were relevant to their HIV healthcare experiences, subsequently mapping the relationships between codes (e.g., identifying similarities, differences, synergies, and contradictions) to refine the core research problematic.

The interview transcripts were then deductively analyzed, drawing directly on the structural violence framework to illuminate how broader social structures, legislative mandates, and macro-political contexts organize individual experiences within HIV clinical spaces. These descriptive codes and emergent patterns were sequentially synthesized into broader themes aligned with our central research question regarding the systemic harm and suffering experienced by Black populations. Crucially, the utilization of visual mapping tools helped uncover the broader ruling relations, the administrative and ideological regimes of power that operated beneath and beyond the direct codes emerging from the interview transcripts.

Ultimately, this study illuminated critical points of disjuncture and institutional fissures between standardized, individualistic biomedical discourses of HIV healthcare and the actual, everyday material conditions of ACB people living with HIV, particularly those navigating precarious immigration status and deep socioeconomic precarity. This comprehensive, multi-layered analytic strategy provides a contextually grounded, structurally diagnostic understanding of the social organization of HIV healthcare in Canada, revealing remarkable, systemic similarities in the everyday accounts of our participants.

This comprehensive analytical approach provided a deeply contextualized, structurally diagnostic understanding of the social organization of HIV healthcare in Canada, revealing remarkable, systemic similarities in the everyday accounts of our participants seeking healthcare and treatment. By applying IE analytics, we successfully unearthed the hidden and intangible conduits connecting the daily, localized work of accessing care to its broader, translocal social organization. In mapping the specific terrains of the care cascade, our analysis unmasked the explicit structural forces that constrained Black people's ability to gain initial entry into the healthcare system, access specialized HIV care, consistently adhere to ART, reach viral undetectability, and achieve optimal health and quality of life [15-17]. These findings explicate the precise causal pathways through which social structures produce and reproduce severe health disparities, shaping the Black healthcare experience and transforming routine clinical trajectories into active expressions of structural violence and physical suffering.

Crucially, this analysis revealed that HIV healthcare delivery for ACB populations in Canada is textually mediated by an interlocking network of laws, policies, and institutional practices that organize healthcare, immigration, public health, and welfare systems. We demonstrate how these unjust social structures, institutional practices, and racialized ideologies systematically produce and perpetuate active health violence through state-sanctioned social injustices. These acute forms of structural violence routinely go unnoticed because they are actively obscured by dominant, standardized biomedical discourses and clinical practices. These discourses individualize systemic failures through the logics of personal responsibility and neoliberal ideologies that inform modern health policy standards and institutional prioritization. Finally, this analysis uncovered the profound, invisible emotional and material work that both ACB individuals and their healthcare providers must continuously perform to avoid, mitigate, and navigate the hostile policies, exclusionary legislations, and punitive institutional practices that actively restrict and compromise access to life-sustaining HIV care and treatment.

Results and Framework Presentation

Overview of the Multi-Axial Model of Structural Violence in the Social Organization and Delivery of HIV Healthcare in Canada

The multi-axial model presented in this paper synthesizes the rich empirical insights generated across our four-year research program, integrating findings previously reported across three distinct dimensions of this ethnographic study. Rather than evaluating healthcare barriers in isolation, this comprehensive framework unifies the interlocking dynamics of our published findings: namely, the legislative restriction

of healthcare access via exclusionary immigration laws [15]; the perverse, punitive economic constraints embedded within provincial social welfare and housing systems [17] ; and the biopolitical policing of Black bodies via carceral HIV disclosure mandates and invasive public health surveillance across the care cascade [16]. Together, these cumulative empirical findings are woven into a unified ecological framework: the Cycle of Structural Violence in Black Health. Moving past descriptive health equity paradigms, this integrated model maps how these forces converge through a self-perpetuating loop to execute Black Health Violence at its core, organized across the four interlocking, nested mechanisms detailed below.

Locating The Disjuncture: The Social Organization of HIV Healthcare and Treatment

The HIV care cascade, describing the stepwise engagement of people living with HIV from diagnosis through linkage to care, ART initiation, adherence, and viral suppression has become the standardized, universally accepted framework for understanding and scaling up HIV response efforts [64, 65]. When ART is timely initiated and taken strictly as prescribed, it successfully suppresses viral load, facilitates immune reconstitution, optimizes long-term physical functioning, and effectively eliminates the risk of onward HIV transmission [7–9]. Conversely, the systemically forced interruption of treatment can cause severe clinical consequences, including accelerated drug resistance, truncated future medication options, elevated viral loads, and a heightened vulnerability to acute opportunistic infections, advanced morbidity, and premature mortality [66, 67].

As Fig. 1 illustrates, however, the cascade as standardized and organized in Canada does not operate equitably for ACB people living with HIV. Exploring and mapping the lived experiences of ACB people living with HIV and seeking life-sustaining care reveals persistent, profound points of institutional disjuncture across each stage of the cascade.

These fractures represent violent contradictions between what the biomedical framework promises and what Black bodies actually endure under the current healthcare regime. Study participants consistently reported that immigration controls, clinical healthcare spaces, social welfare apparatuses, and other state-enforced administrative systems converge to produce overlapping mechanisms of health violence. These forces actively complicate and hinder their ability to safely access HIV healthcare, disrupt consistent engagement in clinical care, and compromise basic bodily survival. The findings presented below explicate these institutional disjunctures in detail, organized sequentially across the four key nested mechanisms through which ACB populations must perform exhausting survival work to navigate the structural conditions of their HIV care.

Mechanism 1: Legalized Abandonment and Statutory Violence

While Canada is routinely praised for its stated commitment to a universal healthcare system designed to provide equitable access to medically necessary services for all residents, this progressive framing

masks a hostile legislative architecture. In practice, the division of legislative authority between federal and provincial and territorial governments over healthcare delivery actively creates conditions that lead to the systemic exclusion and state-sanctioned denial of healthcare access for specific marginalized groups. Federal and provincial laws and policies intersect directly to establish highly restrictive legal eligibility criteria, configuring uneven rights to healthcare that categorize individuals as either deserving or undeserving of the right to health. Consequently, entitlement to healthcare and life-sustaining services is punitively contingent on meeting the administrative conditions set out in federal and provincial legislative frameworks.

The *Immigration and Refugee Protection Act* establishes the primary legal framework for the categorization of immigrants and the aggressive enforcement of immigration laws and practices [68]. Under subsection 20.1(2) of the IRPA, a foreign national is explicitly defined as *"a person who is not a Canadian citizen or permanent resident and includes a stateless person."* This legal and textual definition of a "foreign national" does not operate as a neutral taxonomy; rather, it actively produces powerful discursive ideologies of foreignness, otherness, illegality, and being structurally undeserving of access to fundamental social and legal protections, including the basic right to health [69].

Precarious status immigrants who are subjected to this statutory vulnerability include temporary visitors, international students, temporary foreign workers, sponsored family members, refugee claimants, protected persons, undocumented individuals, and those held in immigration detention [70]. This state-manufactured precariousness functions as an immediate vector of health violence, erecting severe structural barriers that compromise access to life-sustaining healthcare, accelerate biological weathering, and violently threaten the physical survival of Black immigrants in Canada.

At the same time, the primary federal legislation governing Canada's healthcare insurance system is the Canada Health Act [71]. Under the CHA, the right to health and access to healthcare is punitively contingent on legal immigration and residence status. Section 2 of the CHA defines those eligible for public health insurance as a 'resident' of a province who is *"lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province but does not include a tourist, a transient or a visitor to the province."*

Together, the IRPA and the CHA produce a hostile legislative architecture that systemically enforces the medical abandonment of precarious status immigrants by completely severing their healthcare access. The textual classification of immigration categories and the establishment of eligibility criteria entrench violent ideologies of 'foreignness', 'otherness', and 'illegality', leading to the state-sanctioned legislative exclusion of precarious status immigrants from publicly funded healthcare. The application of the CHA creates a fundamental, structurally engineered paradox that directly undermines its own core pillars of universality and accessibility. While the principle of universality mandates that 100% of "insured persons" must be covered under uniform terms (s. 10), the restrictive definition of a "resident" in Section 2 effectively functions as an aggressive gatekeeping mechanism.

By explicitly excluding "tourists, transients, or visitors," the legislative architecture of the CHA, when intersected with the IRPA, denies coverage to individuals with precarious status, such as temporary foreign workers and international students. This exclusion directly contradicts the accessibility principle, which is legally intended to ensure "*reasonable access*" to services without "*financial or other barriers*" (s. 12). For Black immigrants and other marginalized groups with precarious status, these statutory barriers do not merely impede access; they systematically execute active health violence by legalizing the denial of life-saving HIV healthcare based purely on arbitrary immigration classification [15, 16].

Furthermore, this legislative exclusion exacerbates economic precarity and institutionalizes systemic exclusion. One ACB participant illustrated the compounding, destructive effects of these policies, describing a situation where the lack of insured coverage created an insurmountable financial and administrative barrier:

We had to pay 1990 dollars... the family doctor took all the blood tests to send to the immigration clinic. But I found out they didn't [send it] ... and my medical report was not completed. Because of that, they can't process my work permit.

This firsthand account demonstrates a clear violation of the accessibility principle of the CHA, which is legally intended to protect individuals from "financial or other barriers" that impede medical care under section 12. In this case, the \$1,990 fee directly resulting from the participant's statutory exclusion as a "resident" under Section 2 acts as a coercive financial barrier that not only denies basic healthcare but also jeopardizes their legal right to work. Additionally, institutionalized administrative neglect characterized by severe delays in vital record transfers and persistent, rigid bureaucratic demands jeopardizes work permit approvals, actively restricting access to employment and economic security. These policies function as aggressive gatekeeping mechanisms that exacerbate the racialized marginalization of Black people, executing a form of structural violence that actively compromises the survival of Black migrants living with HIV.

This intersection of legal exclusion and severe financial extortion is not an isolated incident but a permanent structural reality for those categorized as non-residents. Those legislatively excluded from healthcare coverage are expected to acquire private health insurance, pay for specialized services out of pocket, or seek compassionate care through alternative, fragmented channels [51, 72]. However, experiences of severe poverty and income instability stemming from unemployment and precarious employment, compounded by strict insurance eligibility criteria that explicitly exclude pre-existing conditions such as HIV/AIDS make out-of-pocket healthcare expenditure impossible for most ACB people living with HIV.

Consequently, Emergency Departments (EDs) serve as the primary entry point to healthcare for individuals with undocumented status who cannot otherwise access services. However, a well-founded fear of carceral surveillance and discovery due to precarious immigration status, alongside the acute fear of being invoiced for expensive ED services, lead many to delay or avoid accessing care through this route entirely. Participants reported that Black immigrants with precarious status routinely waited until

they were severely ill and in urgent need of care before presenting at EDs. This forced delay represents an aggressive operationalization of biological weathering, where systemic structures actively compel the physical deterioration of the body as a prerequisite for clinical visibility.

The profound structural uncertainty produced by the violent intersection of precarious immigration status and restricted access to timely HIV healthcare directly exacerbated mental health challenges among ACB people living with HIV, adding a further psychological and physiological dimension to the acute harm generated by legislative abandonment [15]. By forcing individuals to navigate chronic fear, systemic isolation, and advanced physical illness simultaneously, the legislative architecture of the state functions as an active agent of bodily erosion, turning what should be routine clinical management into a traumatic crisis of survival.

Mechanism 2: Institutional Hostility and Epistemic Violence

Canada possesses a patchwork of inequitable public health insurance and delivery plans that disproportionately impact Black people living with HIV [17]. While Canada promotes a dominant narrative of a universal health system rooted in equity, inclusion, and social justice, the violent intersection of federal and provincial legislation, policies, and institutional practices actively manufactures hostile conditions. These structural barriers strictly limit the provision of comprehensive healthcare even for those officially deemed "medically insured" under public Medicare plans. Public healthcare delivery is legally restricted to "medically necessary" hospital and physician services; consequently, it systematically enforces the medical neglect and abandonment of extended essential services, such as outpatient prescription drugs, dental care, long-term care, and vital mental health supports.

In Ontario, life-sustaining drug coverage is managed through a similarly fragmented system of inequitable plans. While the province provides targeted coverage for specific demographics such as individuals over 65, youth under 25, or those receiving social assistance, many working-age ACB people remain structurally trapped within a deadly 'coverage gap.' These legislative exclusions function as institutional gatekeeping practices, denying Black people living with HIV timely, stable access to life-saving ART and the wraparound essential services necessary for protecting their basic health and biological survival [17].

Beyond the restricted scope of coverage, the social organization of healthcare delivery further entrenches this violence through the systemic implementation of the fee-for-service (FFS) physician billing model. As an institutional payment system where medical providers are financially compensated based strictly on the volume and discrete complexity of services delivered, the FFS model functions as a sophisticated administrative gatekeeper of anti-Black harm. By aggressively prioritizing rapid patient turnover and high billing volume over longitudinal, comprehensive, and holistic care, the FFS architecture actively marginalizes ACB patients managing complex, multi-layered clinical realities [16, 17].

The 'rushed' nature of this model is not merely an administrative inconvenience; it functions as an active vector of medical neglect and systemic alienation, erecting a profound structural barrier to clinical engagement. One participant captured the destructive consequences of this fragmented, volume-driven care design, detailing the severe structural friction of managing complex co-morbidities under the current system:

I miss my medical appointments because sometimes I have medical appointment with two doctors. Maybe I have diabetes appointment, and I have HIV appointments. I cannot make both because sometimes they came at the same time. So, I have missed and canceled several appointments.

This lack of clinical coordination highlights how structural health violence materializes directly through the exclusionary gatekeeping practices embedded within institutional healthcare delivery systems. Our findings show that while healthcare providers occupy well-defined medical practice roles, they also frequently function as "legal custodians" of the state's exclusionary mandates and gatekeepers of a highly restricted healthcare network. This oppressive double bind prevents well-meaning practitioners from providing adequate referrals and effectively linking ACB immigrants who test HIV-positive to necessary, life-sustaining care [15].

In Canada, a key determinant of healthcare engagement for individuals who possess public health coverage is the ability to securely access primary care practitioners. People seeking healthcare are required to individually navigate a fragmented market to find a primary care physician or specialist and autonomously book an appointment to access care. However, Black people living with HIV face systemic opposition across this landscape, enduring long wait times, pervasive anti-Black systemic racism, and a critical deficiency of medical providers possessing adequate HIV specialization and cultural humility [17]. Additionally, newly arrived Black individuals face a structural information deficit regarding the complex social organization of Canada's healthcare system. Our findings further expose an absolute systemic failure within public health infrastructure. There are severely limited healthcare providers equipped with adequate HIV knowledge and specialized competence to provide safe, dignified, and quality healthcare to Black people.

Ultimately, the differential access to treatment and provider bias within the HIV healthcare system demonstrates a form of heightened surveillance and bureaucratic gatekeeping that disproportionately affects racialized individuals. Beyond the structural hurdles of volume-driven billing and fragmented scheduling, participants in this study described traumatic experiences of heightened surveillance and hyper-racial scrutiny within clinical encounters, reflecting deeply entrenched systemic hostility. One participant highlighted how provider bias manifests as an active, direct challenge to their health literacy, somatic knowledge, and personal autonomy:

When I go to the clinic, I feel like I'm being scrutinized, like they assume I don't know how to take care of myself. They ask me questions that they wouldn't ask a white person, like if I really understand how to take my medication properly.

These narratives underscore how systemic racism, anti-Black racism, HIV-related stigma, and the pathologization of Black behaviors perpetuate active structural violence within HIV healthcare delivery. This aggressive surveillance is a contemporary extension of the historical legacy of anti-Black racism in healthcare, which continues to dominate clinical interactions, strip patients of bodily sovereignty, and actively manufacture significant disparities in access and health outcomes. The cumulative effect of this provider bias is the cultivation of a widespread, well-founded mistrust of the state's healthcare system, which inherently fractures the patient-provider relationship and forces survival-driven, defensive avoidance behaviors.

For ACB people living with HIV, this systematic erosion of trust manifests in delayed care, clinic avoidance, and reduced adherence to treatment regimens, ultimately accelerating biological weathering and heightening vulnerability to comorbidities and severe mental health conditions. Consequently, the clinical encounter is transformed into a site of active harm where racialized scrutiny reinforces cycles of health violence rather than providing a space for healing. This structural violence is not only produced at the individual clinical level but is actively perpetuated by the broader environmental enclosures and material constraints that surround the clinical space.

Historically, coercive and restrictive surveillance practices such as mandatory screening, confinement through quarantine, and the targeted exclusion of people with infectious diseases or from countries designated as endemic have systematically framed public health threats through a distinct lens of punishment rather than care. This state-enforced alienation aggressively marginalizes those already structurally targeted by the system [73]. This carceral history has directly informed the modern institutionalization and operationalization of standardized, pathologizing models and clinical practices that remain deeply discriminatory, coercive, and punitive across both the immigration and public health systems.

These punitive ideologies regarding public health safety become deeply imbued into intersecting immigration, public health, and criminal justice legislative frameworks, actively dictating how HIV is conceptualized and operationalized, while structuring the hostile interaction between state agents and Black people living with HIV. Within the meso-structural layers of healthcare delivery, this structural violence is explicitly codified through mandatory Immigration Medical Examinations (IMEs), public health contact tracing pipelines, and the aggressive application of criminal law on HIV non-disclosure, all of which serve as administrative tools to facilitate the surveillance, containment, and biopolitical regulation of people living with HIV perceived as posing a public health risk.

This punitive approach is rooted in an enduring state preference for exclusion and containment over bodily sovereignty. In 2000, Health Canada explicitly advised Immigration, Refugees and Citizenship Canada (then CIC) that mandatory testing for all prospective immigrants for HIV, and the total exclusion of those testing positive, represented the *"lowest health risk course of action [and therefore] the preferred option"* [74]. This exclusionary legacy continues to inform current federal IME policies, which are discursively rationalized as benign strategies to *"protect the health and safety of Canadians"* and prevent

an "excessive demand" on the state-funded healthcare system. Under this neoliberal ideology of "excessive demand," HIV is explicitly grouped with syphilis and tuberculosis as a clinical condition that renders foreign nationals potentially inadmissible on health grounds [75]. Consequently, this legislative exclusion activates aggressive public health discourses of pathologization, hyper-surveillance, and the forced racialization of Black people living with HIV.

While these laws are ostensibly applied equally, there is racialized enforcement in their execution, aggressively targeting racialized bodies [76]. By characterizing Black people as "diseased," "pathological," or a threat to the general population, the state legitimizes mandatory testing and the criminalization of non-disclosure. These practices mask structural violence behind the language of "security" and "national prosperity" while actively undermining HIV response efforts by fostering deep-seated fear and alienation [76–78].

According to IME policy, HIV screening must occur in sanctioned Canadian and foreign medical offices under the supervision of a responsible panel of physicians [63]. This federal policy structures the process of mandatory HIV testing and instructs a responsible panel of physicians to provide pre and post-test counselling to HIV positive applicants as per the "handbook for designated medical practitioners" and must have the clients sign the Acknowledgement of HIV post-test counselling form (IMM 5728 form) and report HIV definite diagnosis to immigration and public health officers [79]. Ultimately, when the CIC contracts panel physicians to carry out these tests, the medical encounter ceases to be a space of care and instead becomes a tool of state-sanctioned gatekeeping, reinforcing the "resident" exclusions of the Canada Health Act and ensuring that for many ACB immigrants, the healthcare system operates as a site of hostile surveillance rather than support.

These punitive and gatekeeping practices produce a profound institutional disjuncture between the state's rationale for conducting mandatory HIV screening and mainstream biomedical discourses, HIV healthcare practices, clinical guidelines, and ethical protocols on HIV testing, and the actual lived experiences of Black people undergoing an IME. While ethical protocols mandate informed consent and comprehensive counseling, study findings reveal that Black immigrants undergoing IMEs are frequently tested without genuine bodily sovereignty, transforming a routine clinical evaluation into a mechanism of state violence that initiates the cycle of biological weathering [17].

Furthermore, panel physicians often fail to provide referrals or link newly diagnosed Black immigrants to care, reflecting an IME policy that gives primacy to public health surveillance over individual health outcomes.

In this legislative approach, the state functions to protect those whose lives are deemed 'worthy' of protection, while structurally disadvantaged and racialized individuals are pathologized and classified as public health risks. These individuals are then subjected to control through restrictive surveillance policies and the criminal law on HIV non-disclosure. These violent encounters with state agents and immigration practices produce severe breaches of privacy and a systematic erasure of medical confidentiality. The resulting climate of fear and suspicion actively fractures the patient-provider

relationship, directly forcing defensive avoidance behaviors regarding whether Black people choose to access HIV healthcare.

Ultimately, the intersection of the Canada Health Act's restrictive residency definitions and the state's punitive immigration surveillance ensures that for ACB people living with HIV, the healthcare system functions not as a provider of universal care, but as a mechanism of legal and clinical gatekeeping that sacrifices human rights for the sake of exclusionary national security. This systematic weaponization of clinical tracking marks the absolute boundary of Mechanism 2, where meso-structural hospitality consolidates the macro-exclusions of Mechanism 1, directly driving the severe material deprivation and environmental containment that follow.

Mechanism 3: Socio-Economic Captivity and Material Weathering

Structural violence manifests within the social organization of HIV healthcare and treatment in Canada through systemic mechanisms of harm embedded deep within the structural and social determinants of health (SDOH) that shape the daily lives of African, Caribbean, and Black (ACB) people living with HIV. These destructive conditions are neither incidental nor accidental; rather, they are systematically produced and actively perpetuated by the hostile intersection of racialized economic precarity, restrictive federal policy frameworks, and institutional barriers to healthcare access. This structural configuration effectively places Black populations at the absolute bottom of Canada's social hierarchy, severely compressing their structural capacity to engage consistently in HIV longitudinal care and achieve basic biological survival [15–17].

Consequently, ACB people living with HIV experience a web of compounding, overlapping vectors of structural violence across multiple social and economic axes. These include chronic food insecurity, structural unemployment, homelessness, acute housing instability, deep-seated poverty, anti-Black racism, medical comorbidities, and pervasive HIV-related stigma and discrimination. Precarious and exploitative employment, which serves as the predominant and often exclusive labor market entry point for many ACB individuals, frequently subjects participants to unsafe working conditions and severely limits or entirely denies access to employer-sponsored drug insurance plans. This absence of supplementary private coverage directly undermines ART adherence and clinical health outcomes, reinforcing the public coverage gaps built into provincial systems.

Furthermore, patients are forced to navigate competing survival conflicts, where the immediate, desperate demands of childcare, low-wage work, educational requirements, housing instability, and a total lack of reliable transportation collide. Operating within a broader systemic architecture that actively fosters social injustice and exclusion, these survival conflicts further constrain retention in clinical care and adherence to strict medication regimens. Collectively, these structural and social vectors of violence assemble an insurmountable systemic ceiling to consistent, long-term engagement in HIV healthcare. By actively restricting access to and adherence to medication, these determinants directly impede the

achievement and maintenance of undetectable viral loads, ultimately degrading the overall health-related quality of life and biological survival for ACB communities [15–17].

Economic Precarity, Drug Coverage, and the ODSP Entrapment

One of the most critical structural barriers faced by ACB people living with HIV is the acute tension between economic precarity and access to life-sustaining HIV medication. The pervasive inability to secure stable employment that offers comprehensive healthcare benefits particularly robust prescription drug coverage or to purchase expensive HIV medication entirely out of pocket forces many ACB people to rely on state welfare dependency. Most notably, individuals must rely on the Ontario Disability Support Program (ODSP) as their sole institutional mechanism for accessing antiretroviral therapy. As one participant noted:

"If you're sure of getting the drug every month from ODSP, your health is guaranteed. You're sure you will live well. That is part of it. You're getting the drug; you're not paying for it."

While ODSP undoubtedly provides a critical clinical lifeline, its restrictive, hyper-conditional eligibility frameworks simultaneously engineer a cycle of systemic entrapment that severely penalizes upward mobility, transforming a program of social relief into an active instrument of socio-economic captivity.

Because eligibility for subsidized provincial medication is strictly tied to a recipient's income level, ODSP recipients who actively seek gainful employment face the immediate risk of clawbacks or a total loss of health benefits, effectively severing them from their life-sustaining medication. Consequently, the punitive financial conditions imposed by the ODSP asset and income thresholds erect a violent structural ceiling to pursuing long-term educational and employment opportunities. This administrative architecture reinforces involuntary dependence on state programming and generates a persistent, debilitating fear of financial instability and rapid health deterioration. Participants poignantly described the impossible, dehumanizing choice manufactured by this policy framework:

If I start making more money, I lose my medication coverage. So, what am I supposed to do? Stay poor just to stay alive?

What if, for instance, God forbid, one month I was unable to work, what happens? Will I be able to pay my medication? That is why I said if the medication remains fixed, that I'll be getting my medication, yeah, every month, there's no problem.

If I'm working, and I'm not able to go to work for a few months, ODSP will not pay you. You're not getting money from your work. How're you going to pay your rent? How're you going to feel?

These accounts reveal how welfare policies and institutional practices actively trap ACB people living with HIV within an impossible survival paradox between financial independence and their basic physical

survival. This mechanism enforces biological erosion and socio-economic captivity as a direct consequence of structural design rather than personal choice or individual capability.

The rigid incompatibility of ODSP eligibility criteria with fluctuating employment patterns systemically locks ACB people into deep poverty, preventing full participation in the labor market without risking both their financial survival and health security. As one participant stated: *"I want to work, I want to contribute, but every time I try, I hit this wall where my healthcare becomes unaffordable."* These findings underscore the urgent, mandatory need for a universal pharmacare program that completely decouples access to life-saving HIV medication from income and employment status, permanently breaking the cycle of state-enforced captivity and structural entrapment. This structural transformation was articulated directly by a participant: *"The medication should be 100% sure that every month you are getting your medication, even when I'm working."* This visceral dilemma exposes how provincial social assistance frameworks actively weaponize health coverage to enforce biopolitical containment and material weathering. For ACB people living with HIV, navigating the ODSP system becomes an acute exercise in structural violence, where the state explicitly conditions biomedical survival on the deliberate maintenance of poverty and the forced renunciation of socioeconomic advancement.

The COVID-19 Syndemic and Compounding Structural Vulnerabilities

The COVID-19 pandemic further exposed and deepened the structural violence embedded within Canada's state-sanctioned healthcare infrastructure and social systems, radically amplifying the pre-existing vectors of violence within the structural and social determinants of health that already constrained retention in HIV care, ART adherence, and community-led efforts to achieve undetectable viral loads among ACB populations. The pandemic did not create these vulnerabilities in a vacuum; rather, it magnified and made hyper-visible the pre-existing, deeply entrenched structural conditions and historical exclusions that have long positioned ACB people outside the social parameters required for equitable HIV healthcare. Government responses to COVID-19, including stringent physical distancing measures and nationwide shutdowns, severely disrupted HIV healthcare services across the entire care cascade for Black communities [80]. This near-total institutional disruption and mass cancellation of in-person clinical services produced a devastating collateral effect that compounded existing institutional barriers and medical neglect. Community-based organizations and frontline healthcare providers faced significant operational constraints in linking ACB individuals to HIV healthcare, facilitating necessary medical referrals, and delivering face-to-face social welfare or harm reduction supports

Consequently, ACB people reported profound difficulties accessing HIV healthcare remotely via telehealth models, alongside compromised ART adherence. These structural breakdowns were heavily driven by acute economic constraints, a total lack of reliable access to technology (the digital divide), and the intersectional crises associated with homelessness and acute housing instability. Furthermore, managing HIV within shared, highly crowded, or unstable living environments generated a heightened, paralyzing fear of accidental status disclosure, stigma, and systemic discrimination. The COVID-19

pandemic therefore functioned as a powerful syndemic accelerator, adding a distinct and acute layer of structural violence and physical suffering to ACB people living with HIV who were already navigating an oppressive social order explicitly organized to compromise their biological survival

Mechanism 4: Medical Carceralism and Biopolitical Warfare

HIV Criminalization as an Instrument of Black Health Violence

Structural violence within the social organization of HIV healthcare and treatment further materializes through Canada's carceral apparatus, which legitimizes and enforces the criminalization of HIV non-disclosure. In Canada, people living with HIV are legally obligated to disclose their HIV status to sexual partners before engaging in activities that pose a "realistic possibility" of HIV transmission. Failure to disclose, even in the absolute absence of actual viral transmission, can result in state prosecution under the severe charge of aggravated sexual assault, carrying a maximum penalty of life imprisonment and mandatory federal sex offender registration. This carceral infrastructure is fundamentally detached from contemporary public health or harm reduction principles, operating as an active mechanism of state violence that targetedly criminalizes marginalized populations, most notably Black people and other racialized groups living with HIV.

The legitimacy of HIV non-disclosure prosecutions is heavily shaped by dominant biomedical discourses that equate an undetectable viral load with responsible HIV management. Extensive advances in ART have produced the widely accepted biomedical principle of Undetectable Equals Untransmittable (U = U), establishing that individuals with an undetectable viral load cannot sexually transmit the virus. Canadian courts have directly integrated this biomedical knowledge into legal decision-making, utilizing an individual's ability to achieve and maintain an undetectable viral load as the primary determinant of criminal liability. However, weaponizing this biological standard within criminal law, without accounting for the macro-structural laws and material captivity that systematically constrain access to treatment, produces a lethal iteration of structural violence. One participants provide a comprehensive understanding of the racial and gendered effect of the law:

I wish I had the literature so that I could point into the facts but that is what I think is what is affecting black people or people of colour and then when you look at 25 or 30 criminal cases, there is only one white person that was convicted of sexual criminal action. The rest were people from minority background; Africans, Caribbean as well as the native Indians and those minority groups which are in the society. So although a lot of the people who came here healthy contracted HIV because ofcircumstances. Some come as refugees and had to live under very difficult circumstance whether they were brought out of the shelter. I am speaking for women, if a boyfriend offered to take the out of the shelter they won't stop and think twice about what they are really getting themselves into with respect to their health.

This judicial reliance on viral load undetectability as the sole measure of legal compliance completely divorced from the complex socio-political realities that shape HIV treatment access inflicts severe legal, psychological, and physical consequences on Black people living with HIV. Because systemic forces block individuals from accessing consistent, life-sustaining treatment, using a biological biomarker as the sole determinant of criminal liability aggressively punishes Black individuals for the very structural barriers the state has manufactured. This carceral surveillance produces profound psychological trauma and constant anxiety, actively fracturing any possibility of holistic wellness. One participant vividly described the paralyzing, everyday terror engineered by this legal landscape.

This visceral account exposes the profound epistemic and physical violence embedded within Canada's judicial response to HIV. By legally defining the absence of status disclosure as an act of sexual violence, even when transmission is biologically impossible, the state effectively transforms the human body into a permanent site of criminal liability. For Black immigrants who already navigate the hostile borders of Mechanism 1 and the material captivity of Mechanism 3, this carceral threat forces a state of complete social isolation. Fear of state surveillance and criminal prosecution actively deters individuals from seeking care or engaging openly with clinical systems, as the medical encounter becomes intimately entangled with the policing apparatus of the state. Consequently, the reliance on viral suppression as a measure of legal innocence directly exacerbates the biological weathering of Black bodies, weaponizing medicine to enforce a cruel cycle of containment and physical suffering.

Workaround Practices and Survival Work in HIV Healthcare Access

Structural violence also materializes through the workaround practices and survival work that ACB people living with HIV and frontline healthcare workers engage in to resist and navigate the systemic mechanisms of harm and state-sanctioned social injustices produced by oppressive social structures. Workaround practices refer to informal, nonstandard, and subversion-driven strategies employed by healthcare workers, community organizations, and patients to deliberately bypass systemic constraints and institutional barriers that restrict healthcare access [81, 82]. These practices highlight the administrative subversion and moral resistance required by frontline actors when formal policy mechanisms fail to provide equitable care, forcing practitioners to bend or break institutional rules to preserve human life

Parallel to these institutional workarounds is the concept of survival work, which refers to the persistent, creative, and often invisible labor that individuals perform to navigate, resist, and endure hostile architectures and punitive institutional practices. Within healthcare, survival work is particularly salient for patients who lack state-sanctioned healthcare legitimacy, specifically those excluded by systemic violence, precarious legal status, stigma, or aggressive clinical gatekeeping. It encompasses the adaptive strategies and resourceful actions individuals undertake to access necessary care, frequently relying on informal networks, personal resilience, and grassroots community support. Crucially, survival work is not mere coping; it is an active expression of agency shaped by the sharp intersection of oppressive structures and the determination of those resisting medical abandonment. Ultimately, it

imposes a disproportionate and exhausting physical, emotional, and cognitive weathering toll on the very people those structures have already marginalized and physically depleted.

By centering survival work and workaround practices in this analysis, we make visible the extraordinary, uncompensated labor ACB people living with HIV are compelled to perform simply to access basic healthcare. This is a form of labor that is rendered mandatory by structural violence but systematically hidden by the reductionist, desocialized lens of biomedical individualism. These dual practices unmask the violent gaps in the state's healthcare safety net, transforming what public health data packages as "treatment compliance" into a profound narrative of everyday resistance and survival against state-sanctioned neglect.

Workaround Practices in Community and Institutional Settings

In Ontario, the provincial government established Community Health Centres (CHCs) as an alternative healthcare pathway intentionally designed for individuals facing systemic mechanisms of harm and exclusion within mainstream healthcare due to precarious immigration status and harsh economic conditions [15]. Parallel to these institutional clinics, pharmaceutical companies offer compassionate treatment programs administered directly through specialized healthcare providers. While CHCs represent formalized, state-sanctioned strategies meant to address critical points of statutory exclusion for individuals violently barred from mainstream publicly funded Medicare, they function in practice as components of a broader, fragmented workaround ecosystem. This precarious ecosystem places an overwhelming reliance on the labor of healthcare workers, community organizations, and frontline social workers to bridge the massive structural chasms that formal public policy has failed to close.

Crucially, findings reveal that significant institutional barriers persist even within these specialized alternative pathways. Many ACB immigrants lack vital knowledge regarding the availability of CHCs and compassionate pharmaceutical treatment programs. Consequently, they must remain dependent on healthcare professionals, community networks, and frontline social workers to facilitate a linkage to these services. Healthcare workers within CHCs must also engage in administrative workaround practices of their own, including relentless grassroots advocacy work, intense navigation support, and strategic collaboration with community-based and AIDS service organizations just to connect patients with essential medications and bridge manifestations of institutional neglect. For ACB people, navigating these spaces involves leveraging informal social networks and relying heavily on the goodwill of healthcare workers and community organizations, reinforcing that their biological survival remains structurally precarious and dependent on informal subversion rather than an enforceable human right.

Ultimately, the systemic violence of executing these complex workarounds falls disproportionately on marginalized patients who are least positionally equipped to bear its structural weight. A particularly harmful and deeply hidden dimension of this systemic burden is the involuntary disclosure it routinely mandates. The rigid and bureaucratic institutional arrangements governing access to alternative care force Black immigrants to repeatedly disclose their HIV status and precarious immigration status to

multiple disconnected actors differentially positioned within the healthcare ecosystem before they can access any care at all. Legislative exclusion, fear of acute social stigma, the very real risk of jeopardizing an ongoing refugee claim, and the pervasive, paralyzing fear of state detention or deportation heavily compound this administrative burden. Together, these intersecting structural terrors act as secondary gatekeeping barriers, causing many Black immigrants to actively avoid or drastically delay accessing life-sustaining HIV healthcare altogether. One participant poignantly described the grueling, multi-layered experience of navigating this fragmented ecosystem as a medically uninsured person with precarious immigration status:

"I came to [organization A]. It was my worker in the shelter who sent me... I was not supposed to disclose my identity. I did not have a choice but to tell her what I was going through. So, she could not help me. She told me, 'There's a place you could go.' I came here [organization B]. I saw a lady here who referred me to the Women's Centre [organization C]. It was hard for me to disclose my identity."

This raw account vividly illuminates the exhausting, multi-site navigation that ACB people with precarious status are compelled to perform simply to secure basic physical survival. It maps a bureaucratic maze that demands repeated psychological exposure through forced status disclosure, continuous and exhausting self-advocacy, and constant physical movement across a carousel of separate organizations. Rather than offering a dignified sanctuary from structural violence, these alternative frameworks inadvertently perpetuate a system of distributed surveillance, forcing vulnerable individuals to continuously trade their privacy and risk legal exposure across multiple sites in an agonizing barter for basic survival. Each setting operates under structural constraints that render it unable to fully or holistically meet the person's clinical and human needs, transforming an intended safety net into a site of compounding biological weathering and institutional harm.

Survival Work and Its Costs

Black individuals in Ontario who lack both public and private drug coverage are forced to rely heavily on provincial social assistance or compassionate drug programs just to access life-sustaining HIV treatment [17]. Participants described the intricate process of applying for these stop-gap programs as exceptionally strenuous, adversarial, and time-consuming. This manifestation of survival work requires navigating rigid, highly bureaucratic institutional processes, such as coordinating multiple appointments across separate systems with physicians and social assistance workers, completing extensive and repetitive paperwork, and repeatedly disclosing private HIV status and family income to numerous gatekeeping individuals. While survival work inherently reflects profound acts of resistance and individual resilience, it simultaneously exposes how systemic mechanisms of harm and active health violence are targetedly executed against marginalized populations. The state essentially compels racialized bodies to perform exhausting, labor-intensive strategies simply to access the foundational healthcare they are legally being denied.

Crucially, the costs of executing this survival work extend far beyond the expenditure of time and physical effort. Findings demonstrate that the ongoing burden of survival work directly exacerbates

severe mental health challenges among ACB people living with HIV, adding a further dimension of psychological harm and bodily weathering to an already violently restricted existence. For many ACB individuals, surviving the system also entails enduring inadequate, coercive, and overtly discriminatory healthcare treatment while attempting to navigate these alternative pathways to care. One participant described a deeply traumatizing and painful medical procedure that was performed on them without the administration of proper numbing medication:

The treatment I got from that nurse there... he was so harsh and when he was operating there without anything to just cool myself, make it probably numb... I was just done! It was so painful.

Reflecting on this encounter, the participant explicitly attributed this medical mistreatment and the deliberate withholding of standard clinical comfort directly to anti-Black racism: *"That is when I realized I am a black person, that is why... Everybody there, the white HIV positive, they never got the same treatment I got."* This experience not only reinforced his sense of exclusion and dehumanization but also deterred him from returning to that healthcare facility, demonstrating how discriminatory treatment causes ACB people to disengage from care. As he stated: *"I don't feel like going to XXX any longer, but I know why; because I was black."* This account illustrates how anti-Black racism embedded in clinical encounters operates as an active mechanism of structural violence, producing the very disengagement from care that is then attributed to individual non-compliance within biomedical frameworks.

Together, these findings reveal that workaround practices and survival work are not evidence of individual resourcefulness operating independently of structure; they are evidence of profound structural failure. Black individuals are compelled to perform extra, often exhausting labor to navigate healthcare systems that routinely exclude and harm them. This reliance is not passive; it requires persistent advocacy, repeated bureaucratic negotiation, and sustained resilience in the face of systemic neglect. Centering survival work in the analysis makes visible the overlapping vectors of health violence placed on ACB people living with HIV and underscores the urgent, mandatory need for structural transformation, not temporary workarounds, to ensure equitable HIV healthcare and treatment for ACB communities in Canada.

This searing indictment exposes the ultimate violence of the workaround ecosystem. For the uninsured or precariously documented Black immigrant, the survival work required to access care does not shield them from systemic harm; rather, it funnels them into clinical arenas where their bodily sovereignty is systematically compromised in an agonizing barter for survival.

Discussion

This institutional ethnography demonstrates that the social organization of HIV healthcare and treatment in Canada produces and perpetuates structural violence against ACB populations. The severe, stratified health outcomes documented across the care cascade are not administrative anomalies; they are the predictable outcomes of legislative, institutional, material, and carceral systems organized along racialized lines of inclusion and exclusion. To map this architecture of harm, the multi-axial model

(Fig. 1) identifies the precise sites of institutional disjuncture where structural conditions fracture the clinical cascade. Correspondingly, the Cycle of Structural Violence in Black Health (Fig. 2) names the four interlocking mechanisms through which this violence is produced and reproduced, advancing a transferable diagnostic framework for understanding Black health violence beyond the boundaries of HIV medicine. Together, these contributions establish that the disproportionate health burden borne by ACB Canadians is the predictable outcome of structural design. Consistent with Link and Phelan's fundamental cause theory, this burden persists not because of changing disease landscapes or insufficient biomedical innovation, but because the fundamental conditions that produce it; unequal access to resources distributed along racial lines remain structurally intact [83]. Eliminating this burden requires the simultaneous dismantling of the legislative, institutional, material, and carceral systems that enforce it.

Biomedical Individualism and the Limits of the HIV Care Cascade

The social organization of HIV interventions in Canada remains predominantly organized within a framework of biomedical individualism. This paradigm locates both the problem of HIV and its solution at the level of individual risk, personal behaviour, and moral responsibility. Within this individualized architecture, the complex labour of accessing clinical care, consistently adhering to ART, and achieving viral undetectability is constructed as a personal obligation. This framing renders invisible the structural conditions that determine whether fulfilling that obligation is possible for racialized people navigating a system organized to exclude them.

The standardized HIV care cascade exemplifies this epistemological limitation. While the cascade provides a useful sequential roadmap for tracking clinical progression from diagnosis through viral suppression, it is fundamentally incapable of analyzing the broader socio-political and economic conditions that shape an individual's engagement with health services [84]. It charts what should happen in a clinically ideal context; it cannot explain why equitable engagement does not materialize for Black communities, because answering that question requires a structural rather than a biomedical frame of analysis. For ACB people living with HIV in Canada, legislative exclusion, fee-for-service clinical gatekeeping, and state-enforced welfare dependency are not peripheral variables to the clinical cascade. They are the primary determinants of whether equitable engagement in that cascade is possible at all.

The persistence of disproportionate HIV morbidity and mortality among ACB populations, despite the availability of effective antiretroviral treatment, is evidence not of individual non-compliance but of structural conditions that make consistent clinical engagement impossible. Biomedical individualism obscures this reality by attributing structurally produced outcomes to individual behaviour, functioning as an analytical mechanism that masks state-sanctioned institutional neglect behind clinical vocabulary. As Mbembe (2003) argues through the concept of necropolitics, contemporary sovereignty is expressed through the administration of who is permitted to live and who is exposed to conditions of premature death. The institutionalization and normalization of biomedical individualism as the organizing logic of

HIV response in Canada is a political decision that renders invisible the structural conditions that produce Black mortality, thereby absolving the state of accountability for its production.

This logic reaches its most consequential expression within Canada's carceral apparatus, where the legal system weaponizes the care cascade's clinical milestone - viral suppression - as the determinant of criminal liability in HIV non-disclosure cases. By incorporating the Undetectable Equals Untransmittable (U = U) standard into judicial decision-making without accounting for the structural barriers that restrict medication access, the state transforms a biomedical marker into an instrument of biopolitical control, criminalizing a biological outcome engineered by the state's own structural design.

The COVID-19 pandemic exposed and deepened the structural violence embedded within Canada's health systems, functioning as a syndemic accelerator rather than an isolated public health emergency [19]. Pandemic-related clinical disruptions and the rapid shift to digital telehealth did not generate new disparities; they intensified pre-existing material conditions, the digital divide, structural underemployment, and housing instability that already constrained ACB people's engagement in HIV care.

For ACB individuals managing HIV within crowded or precarious living environments, pandemic directives transformed an administrative public health response into an acute vector of physiological and psychological harm. Critically, the pandemic provided empirical demonstration of the weathering hypothesis [85]; the chronic stress of navigating structural racism produces accelerated biological ageing that is compounded rather than created by acute macro-environmental shocks. Biological survival is structurally compromised when the social order producing that vulnerability is left intact.

Nested Structural Forces and the Production of Structural Violence

The multi-axial model demonstrates that the social world of ACB people living with HIV is shaped by structural forces operating far beyond individual agency. Black people in Canada are embedded within complex, intersecting social structures (laws, policies, institutions, labour markets, and cultural and ideological systems) from which conditions emerge to increase HIV vulnerability, restrict access to care, and violate the right to health. These conditions are not incidental features of a healthcare system otherwise committed to equity; they are the predictable and recurring outcomes of a system organized along racialized lines of inclusion and exclusion [33, 37]. As Robinson demonstrates through the concept of racial capitalism, capitalism has never operated independently of racial hierarchy; the differential valuation of racialized life is not a deviation from the economic order but a foundational feature of it [86]. The legislative architecture documented in this study; immigration categories organized by economic utility, welfare structures that enforce dependency, labour markets that require precarious Black labour is not coincidental policy failure but the expression of a racial capitalist order that requires the material containment of Black life to sustain its productive logic.

Canada's immigration, public health, welfare, healthcare, and health-related systems, laws, policies, and institutional practices intersect to restrict access to the social determinants of health for ACB

communities [87]. The hierarchical ordering of immigration classes, the social organization of healthcare delivery, and dominant ideologies of race, nationality, and neoliberalism produce and perpetuate inequities that constrain ACB people's capacity to achieve optimal health.

Consistent with fundamental cause theory, these conditions persist across shifting disease landscapes because they are organized around the unequal distribution of resources, knowledge, money, power, prestige, and beneficial social connections that protect health in any context [83]. The racial organization of resource distribution in Canada ensures that no single biomedical or programmatic intervention can close the gap in HIV outcomes for ACB people; the fundamental cause remains structurally intact.

The Cycle of Structural Violence in Black Health: A Conceptual Ecological Framework

Synthesizing the empirical patterns identified across this programme of institutional ethnographic research, we propose the Cycle of Structural Violence in Black Health as a novel conceptual ecological framework. This framework advances existing health equity literature by identifying and naming the four interlocking mechanisms through which structural violence is systematically inflicted, sustained, and reproduced within the social organization of Black life. Anchored in Bronfenbrenner's (1979) ecological systems theory [88], the framework conceptualizes these mechanisms as nested concentric rings, tracing oppressive power dynamics from the distal macro-structural level inward to the most proximate and acute expressions of violence at the core. Drawing additionally on Farmer's multi-axial model of suffering, Galtung's structural and cultural violence framework, Krieger's ecosocial theory of biological embodiment and Mbembe's necropolitics [33, 34, 37, 89–91], the framework accounts not only for the social organization of structural violence but for the biological pathways through which it enters the body, and the political sovereignty through which it administers premature death.

The model positions the four mechanisms as fundamentally embedded within and fuelled by the enduring historical and ideological contexts of colonialism, slavery, white supremacy, anti-Black racism, and neoliberalism. Critically, biomedical individualism and racial capitalism are named as additional cross-cutting ideological formations within this outer context [86]. Biomedical individualism renders the structural mechanisms invisible by attributing their outcomes to individual behaviour, while racial capitalism explains why the legislative architecture of Mechanism 1 takes the specific form it does, organizing healthcare access through hierarchies of economic productivity and racial belonging that are not incidental to the economic order but foundational to it.

By mapping these pathways, the framework illuminates how macro-structural violence materializes into three distinct, compounding core expressions: systemic health violence and premature weathering, state-sanctioned human rights violations, and the forced reliance on exhausting survival work and informal workaround practices. Premature death, conceptualized through Mbembe's necropolitics as the political administration of whose life the state permits and whose it exposes to conditions of deterioration, is incorporated as a fourth dimension of the core expression, reflecting the ultimate biological consequence of the cycle's operation on Black bodies [86].

The critical analytical utility of this framework lies in its identification of a self-reproducing feedback loop, which channels these compounding expressions of violence directly back into the outermost macro-structural mechanisms, ensuring continuous renewal and historical durability. This systemic reciprocity offers a robust explanation for why conventional, individualized public health interventions consistently fail to disrupt deeply entrenched, state-sanctioned health violence. Consistent with Link and Phelan's fundamental cause theory [83], the cycle persists not because of changing disease landscapes or insufficient biomedical innovation, but because the fundamental conditions that produce it, unequal access to resources distributed along racial lines, remain structurally intact across all iterations of health system reform.

The introduction of the Cycle of Structural Violence in Black Health shifts the analytical focus of social epidemiology and critical public health from standard descriptive models of health inequality to an active, diagnostic critique of state-sanctioned harm. While traditional health equity research relies on the vocabulary of health disparities or health inequities, this model demonstrates that such framing is epistemologically inadequate for capturing the lived experiences of ACB populations navigating healthcare ecosystems organized to exclude them.

By shifting the conceptual core from a passive distributional imbalance to an active force, *Black health violence*, the framework offers a reinterpretation of how macro-structural policies, clinical environments, socio-economic containment, and carceral public health systems converge to erode and destroy Black life. This shift is not rhetorical; it is analytical. Naming the phenomenon as violence rather than disparity holds different actors accountable, demands different responses, and opens different possibilities for structural transformation.

Mechanism 1: Legalized Abandonment and Statutory Violence

Mechanism 1, Legalized Abandonment and Statutory Violence, functions as the primary entry point of the cycle, operating entirely at the macro-structural level. This mechanism operationalizes structural violence through the systematic, categorical denial of foundational healthcare rights and social protections to Black populations. It is codified across a network of intersecting state policies, including the Immigration and Refugee Protection Act (IRPA), the restrictive eligibility criteria of the Canada Health Act, HIV non-disclosure criminalization, mandatory immigration medical examinations (IMEs), and punitive welfare entrapment structures. These statutory frameworks do not merely mirror pre-existing social stratification; they actively generate and enforce it. As Ho posits, legal taxonomies such as 'foreign national' within the IRPA do not just categorize; they produce powerful discursive ideologies of foreignness, otherness, and illegality that determine whose right to health is protected and whose bodily survival is allowed to deteriorate [39].

Understood through Robinson's racial capitalism, the legislative architecture of Mechanism 1 is not incidental policy failure but a structural expression of a racial capitalist order that organizes healthcare

access through hierarchies of economic productivity and racial belonging [86]. Black immigrants with precarious status are legally constituted as economically insufficient and categorically undeserving, a classification that authorizes, sequences, and orchestrates the mechanisms that follow.

Our empirical findings demonstrate that the IRPA and the CHA operate in tandem to erect a punitive legislative architecture that systematically strips Black immigrants with precarious legal status of access to publicly funded, life-sustaining healthcare. Simultaneously, state mechanisms including mandatory IME testing and HIV criminalization transform the clinical encounter into a site of aggressive state surveillance and severe legal jeopardy [15]. This carceral approach to public health is further compounded by welfare entrapment, most acutely visible within the Ontario Disability Support Program (ODSP). By tethering access to life-sustaining ART to restrictive income thresholds, the state enforces a state of biopolitical captivity that actively penalizes employment and forecloses upward economic mobility, institutionalizing state dependency and poverty as absolute prerequisites for basic physical survival [92]. This is the foundational paradox of Mechanism 1's design: the state simultaneously requires economic independence as the condition of healthcare access and enforces a welfare structure that prevents the economic mobility that would enable it. The mechanism performs precisely its designed function, which is the containment of Black life within conditions of managed dependency [86].

Mechanism 2: Institutional Hostility and Epistemic Violence

Mechanism 2, Institutional Hostility and Epistemic Violence, operates at the meso-structural level, directly translating macro-legal exclusions into the mundane, everyday encounters of HIV healthcare delivery through institutional and organizational power. Anti-Black racism within clinical spaces, fee-for-service payment models that artificially restrict comprehensive care to a single issue per visit, provider bias, hyper-racial scrutiny, HIV-related stigma, and fractured care coordination are not accidental aberrations within an otherwise equitable system. Rather, these are the deliberate, racialized logics through which healthcare institutions operationalize and execute the macro-structural violence engineered by Mechanism 1 [24]. The epistemic dimension of this mechanism requires particular theoretical attention. Roberts and Washington document how medical knowledge itself is produced through racial hierarchy, how Black bodies have been historically constituted as objects of experimentation, pathologization, and surveillance rather than as subjects of care [86, 93]. Metzl and Hansen's concept of structural competency extends this analysis to the contemporary clinical encounter, arguing that what appears as individual provider bias is in fact the expression of structural forces embedded in medical training, clinical guidelines, and institutional resource allocation [94]. The healthcare provider who functions as a gatekeeper does not act alone; they act through the organizational culture, professional norms, and payment structures that constitute medicine as an institution committed to racial hierarchy as much as to healing.

Empirical findings demonstrate that these institutional practices severely obstructed adequate linkage to care for Black immigrants who tested HIV-positive, transforming the clinical space into an environment

of active hostility. Furthermore, intense racial scrutiny within clinical encounters functioned as a powerful deterrent to sustained patient engagement, while the arbitrary one-issue-per-visit constraint routinely resulted in misdiagnosed or entirely unaddressed comorbidities, a systemic form of medical neglect. These institutional assaults directly compromised the structural parameters required for consistent ART adherence [15–17].

The systemic convergence of the clinician's medical authority and state-enforced legal gatekeeper role, most acute in the IME physician who conducts HIV testing without informed consent and refers HIV-positive immigrants to immigration enforcement rather than to clinical care, effectively turns healthcare providers into clinical executors of state violence. Ultimately, the analytical significance of Mechanism 2 extends far beyond the boundaries of HIV healthcare; wherever institutional demands for efficiency, bureaucratic survival, and racialized suspicion dictate clinical priorities, medicine functions not as a site of healing but as a vector of structural harm.

Mechanism 3: Socio-Economic Captivity and Material Weathering

Mechanism 3, Socio-Economic Captivity and Material Weathering, is produced by the violent intersection of Mechanisms 1 and 2, shifting the cycle's focus directly onto the level of lived material conditions through biopolitical power. Categorically excluded from universal healthcare coverage by macro-legal mandates and systematically denied equitable institutional care by meso-level clinical hostility, ACB individuals are functionally coerced into state welfare dependency. This dependency does not serve as a genuine safety net; instead, it operates as a mechanism of economic captivity and social control. The ODSP entrapment documented in this study represents an HIV-specific manifestation of a broader structural logic in which access to life-sustaining health resources is punitively tethered to rigid income thresholds, forcing individuals into an impossible, state-enforced biopolitical paradox: they must choose between economic independence and basic health security.

This captivity operates through what Geronimus identifies as the weathering process: the chronic physiological stress of navigating structural racism produces accelerated biological ageing in Black people relative to white people of equivalent chronological age [85]. The syndemic convergence of housing instability, acute food insecurity, precarious employment, and deep-seated poverty documented in this study does not produce weathering additively but synergistically, with each material deprivation amplifying the biological impact of the others [19]. This is the critical pathway connecting Mechanism 3's structural conditions to the biological outcomes at the cycle's core: structural entrapment enters the body through the weathering process, rendering consistent, sustained engagement in the HIV care cascade structurally impossible not because of individual compliance failure but because the body is biologically depleted by the conditions the state has engineered.

These compounding crises must not be misconstrued as the consequences of individual failures regarding motivation, compliance, or personal responsibility. Rather, they are the predictable, structurally

engineered conditions of individuals trapped within a social order explicitly organized to suppress their economic and social mobility.

Krieger's ecosocial theory provides the theoretical architecture for understanding how these conditions become biologically embodied: people incorporate their social experiences into their biology through exposure pathways shaped by their position within systems of power [90, 95]. The ODSP entrapment, housing instability, food insecurity, and precarious employment documented in this study are not incidental stressors; they are the material pathways through which structural violence is biologically incorporated. The profound systemic violence of this mechanism lies in its foundational design: the state actively blocks the very economic mobility it simultaneously requires as a prerequisite for healthcare access, using poverty as a regulatory instrument for the biopolitical administration of Black life.

Mechanism 4: Medical Carceralism and Biopolitical Warfare

Mechanism 4, Medical Carceralism and Biopolitical Warfare, forms the innermost ring of the ecological cycle, representing its most acute, intimate, and physically invasive expression. This mechanism aggressively weaponizes biomedical metrics as punitive legal instruments, directly criminalizing the very biological outcomes that Mechanisms 1, 2, and 3 have collectively manufactured. The application of viral undetectability as the baseline standard for criminal liability in HIV non-disclosure cases captures this carceral logic precisely. While the structural assaults engineered by the outer rings render viral suppression profoundly difficult or impossible for many ACB individuals, the criminal justice system isolates these individuals from their socio-structural context and holds them exclusively and individually accountable for a biological failure engineered by the state. As human rights advocates and legal scholars argue, standardized biomedical discourses reproduce deeply racialized virological classifications that relegate Black people to a highly stigmatized viral underclass, positioning them as perpetual subjects of criminalization, surveillance, policing, and state control rather than as rights-bearing individuals entitled to structural support [96].

Mbembe's concept of necropolitics is precisely operative here. While HIV criminalization operates as a broad statutory framework across Canada, its disproportionate enforcement against Black populations who are simultaneously denied the structural conditions required to achieve viral undetectability functions as a distinct necropolitical mechanism [91]. This penal approach administers the conditions of biological survival and legal personhood differentially along racial lines, transforming what is written as a universal law into a targeted regime of surveillance and criminal sanction for Black individuals living with HIV, rather than an infrastructure of structural care. Gilmore's concept of carceral geography extends this analysis by demonstrating that carceral logics are not contained within prisons but extend into healthcare, welfare, immigration, and public health systems, exactly the institutional landscape Mechanism 4 maps.

Mandatory IMEs executed without genuine informed consent or ethical post-test counselling, alongside public health contact tracing practices that prioritize policing and containment over holistic care, further illustrate the deployment of state power within Mechanism 4. These state actions do not respond to public health risks in a racially neutral manner. Instead, they operate as an epidemiological surveillance pipeline to selectively surveil, pathologize, and criminalize populations already rendered structurally vulnerable by the outer rings of the cycle.

The result is a structurally violent architecture. The state engineers the material and institutional conditions that render viral suppression impossible for many ACB populations, and then deploys the criminal law to punish those exact populations for their system-induced inability to achieve it. This represents the ultimate expression of the cycle's self-reproducing logic, the failure of the state is made invisible by its conversion into the criminality of the individual, and in that conversion, Mechanism 1 is renewed. Understanding Mechanism 4 as the expression of both necropolitical sovereignty [91] and carceral geography [97] names both the political rationality of the mechanism and the spatial and institutional architecture through which it is enforced.

Structural Violence Across the Care Cascade

The four interlocking mechanisms do not merely intersect with the HIV care cascade; they systematically dictate it, operating at every stage to restrict and disrupt equitable healthcare engagement. Within this structural architecture, failure to engage with, deliberate avoidance of, or forced interruption of HIV healthcare must not be pathologized as individual non-compliance. Rather, these are systemically engineered manifestations of clinical abandonment that produce missed opportunities for timely ART initiation, undermine effective prevention strategies, and artificially drive transmission dynamics at both individual and population levels. The resulting clinical trajectories, including accelerated drug resistance, truncated future treatment regimens, elevated viral loads, and a heightened vulnerability to opportunistic infections, morbidity, and premature death are well-documented by conventional epidemiological surveillance [66, 67].

However, while the clinical cascade meticulously quantifies these structural casualties, *the Cycle of Structural Violence in Black Health* unmask why they stubbornly persist despite the widespread availability of highly effective biomedical treatments. Our framework addresses what recent public health appeals describe as a critical "paradigm shift" in behavioral science, proving that individual-level health campaigns will continuously stall if they fail to remove macro-level policy barriers [98]. The self-reproducing feedback loop operates as an engine of systemic continuity. The profound health violence generated by the cycle does not disrupt the hostile conditions that produce them; instead, they legitimize and reinforce them. This cyclical reciprocity ensures that successive generations of ACB individuals at risk and living with HIV inevitably inherit the exact same structural barriers weathered by their predecessors.

This violence is further compounded when macro-structural forces converge with dominant biomedical HIV discourses, producing a distinct form of biopolitical harm. The rigid standardized virological

classification of bodies as either "detectable" or "undetectable" functions as a mechanism of racialized stratification. It codifies a stigmatized viral underclass, pathologizing Black individuals whose structurally engineered material realities render viral undetectability an impossibility. Crucially, the system cloaks this pathologization in the objective, neutral language of clinical judgment, systematically obscuring its deeply political and ideological origins [96]. This insidious dynamic is perfectly illustrated by the contemporary instrumentalization of the U = U principle. While U = U represents an undeniable scientific milestone and a monumental triumph for HIV advocacy, its state-sanctioned weaponization as a legal standard for criminal liability divorced from any recognition of the structural inequalities that govern its attainment deviants a public health breakthrough into a carceral mechanism of prosecution.

This localized reality directly aligns with macro-level epidemiological data proving that dismantling structural racism, housing instability, and legal exclusion is an absolute prerequisite to achieving equity across public health metrics [99]. Such systemic alignment underscores the critical operations of Mechanism 4 within the HIV context, exposing a cruel and cynical state architecture. Specifically, the state actively engineers the hostile social, economic, and institutional conditions that prevent ACB populations from achieving viral suppression and subsequently weaponizes the criminal justice apparatus to prosecute these same individuals for failing to reach that unachievable standard.

The four mechanisms operate at every stage of the HIV care cascade to restrict equitable engagement in care. Failure to engage with, avoidance of, or interruption of HIV healthcare produces missed opportunities for timely ART initiation, undermines effective prevention, and increases transmission risk at both individual and population levels. Treatment interruption generates drug resistance, limits future medication options, elevates viral load, and heightens the likelihood of opportunistic infections, morbidity, and premature death [66, 67]. These are the clinical outcomes the cascade documents. On the other hand, the Cycle of Structural Violence in Black Health explains why they persist despite the availability of effective treatment. The feedback loop illustrated in Fig. 2 demonstrates how the health inequities produced by the cycle do not interrupt the structural conditions that generate them but reproduce them, ensuring that the next generation of ACB people living with HIV encounters the same barriers their predecessors faced.

The intersection of structural violence with biomedical HIV discourse creates a further and distinctive form of harm. Standardized virological classification of people with detectable or undetectable viral loads reproduces a racialized viral underclass, pathologizing Black people whose structural conditions make undetectability unachievable while presenting that pathologization as a clinical rather than a political judgment [96]. The U = U principle represents a genuine scientific advance and a significant achievement of HIV advocacy; yet its instrumentalization as a legal standard for criminal liability, without accounting for the structural inequities that constrain its attainment, transforms a public health breakthrough into a mechanism of prosecution. It is the most explicit expression of Mechanism 4 in the HIV context: the system first creates the conditions that make undetectability impossible for many ACB people, then criminalizes the resulting detectable viral load as evidence of irresponsible behaviour.

Structural violence, in this instance, is not merely latent in unjust policy; it is actively enforced through criminal law.

Theoretical Significance: Shifting from "Inequities" to "Violence"

The principal theoretical contribution of this framework lies in its rejection of standard public health terminology that sanitizes the physiological realities of structural racism. Standard discourses around "health inequities" or "gaps" often frame deadly clinical outcomes as passive imbalances, statistical anomalies, or administrative failures that can be resolved through gradual policy adjustments. In contrast, centering the model on Black Health Violence explicitly names a perpetrator: the state and its interlocking institutional apparatuses.

This conceptualization positions premature mortality, medical neglect, and biological erosion not as tragic, unforeseen side effects of an otherwise neutral system, but as the direct, predictable results of state-sanctioned neglect and carceral surveillance. "Inequities" implies that the underlying institutional architecture is fundamentally sound but requires better resource distribution. "Violence," however, identifies the system itself as an active vector of physical harm. This framework makes it clear that the physical destruction of Black bodies, manifested through accelerated cellular deterioration and systemic abandonment, is an operational objective of a racialized social order, demanding an abolitionist response rather than institutional reform.

Methodological Innovation: The Power of the Ecological Feedback Loop

Methodologically, this framework advances traditional applications of Bronfenbrenner's (1979) ecological systems theory. Conventional public health adaptations of ecological models are frequently static, presenting nested layers, such as the macro, meso, and micro environments as distinct, isolated containers of experience. This linear approach fails to explain how structural oppression maintains its historical durability despite decades of targeted public health interventions. This framework resolves this limitation by introducing a dynamic, self-reproducing feedback loop that models systemic reciprocity.

When Mechanism 4 (Medical Carceralism and Biopolitical Warfare) weaponizes clinical data to pathologize and criminalize Black bodies, it does not simply produce an isolated outcome at the core. Instead, this state-sanctioned criminalization generates fresh empirical data, public stigmas, and institutional precedents. These outputs are subsequently channeled back outward to reinforce and legitimize the outermost layer: the Historical and Ideological Context (e.g., reinforcing anti-Black myths that Black populations are inherently diseased, dangerous, or non-compliant). This continuous loop explains why conventional, individualized public health interventions such as health literacy campaigns or localized clinic expansions consistently fail. They attempt to modify the behavior of the individual at the core while leaving the self-sustaining, cyclical engine of structural violence completely intact.

Ultimately, the multi-axial ecological model of structural violence (Fig. 1) and the Cycle of Structural Violence in Black Health (Fig. 2) developed across this research program provide a rigorous, evidence-

based foundation upon which future researchers, practitioners, policymakers, and community advocates can build. While Fig. 1 maps the interlocking, intersecting structural pathways that actively produce inequity for ACB people within HIV healthcare, Fig. 2 conceptualizes and names the foundational mechanisms that generate those pathways, demonstrating their theoretical transferability to other domains of Black health equity. Together, they advance a unified, unyielding toolkit for systemic disruption, proving that racial health equity is not achieved by clinical infrastructure tweaks, but through the deliberate deconstruction of structural violence.

Toward a Structural Violence, Equity, and Human Rights Response

The central, unassailable implication of the *Cycle of Structural Violence in Black Health* framework is that isolated biomedical responses are fundamentally insufficient to dismantle the HIV epidemic among ACB populations in Canada. For decades, the systemic subordination of macro-structural analysis to individualized biomedical reductionism and behavioral modification has done more than just fail to close racially stratified profiles of medical violence. This narrow framing has actively protected and sustained the very conditions that drive these inequities by mischaracterizing the predictable consequences of deliberate structural design as isolated personal or cultural failures [100]. Black communities will continue to bear a disproportionate burden of HIV transmission, morbidity, and premature mortality until this interlocking cycle of mechanisms is intentionally disrupted at every ecological tier simultaneously.

The analytical precision of this framework makes the intervention imperative clear: targeting a single mechanism while leaving the surrounding structural rings intact merely shifts the manifestation of violence, ensuring the cycle's overall durability. Superficial policy adjustments without deep institutional dismantling leave anti-Black racism unaddressed within clinical spaces. Conversely, institutional modification without sweeping legislative change leaves macro-structural exclusion codified in state law [24]. Finally, mitigating socio-economic captivity without completely abolishing the punitive carceral surveillance mechanisms that criminalize its clinical consequences leaves ACB people exposed to the most acute, intimate expressions of state-sanctioned violence.

This systemic failure is starkly exposed by the social organization of workaround practices and survival work documented across Ontario's healthcare landscape. While the state presents alternative pathways such as Community Health Centres and compassionate pharmaceutical programs as evidence of an inclusive safety net, this ethnography reveals that these parallel networks function as a system of distributed surveillance and violence. To secure basic physical survival, medically uninsured Black immigrants are structurally forced into an agonizing barter, repeatedly disclosing their HIV and legal status across disconnected institutional nodes. This continuous psychological exposure and administrative exhaustion operates as a direct physical tax extorted from Black bodies. By leaving alternative care networks chronically underfunded, the state effectively outsources its statutory and moral accountability to the uncompensated goodwill of frontline healthcare workers and community organizations. Survival work and workaround strategies are therefore not indicators of commendable

client resourcefulness; they are diagnostic symptoms of a profoundly broken system that legalizes medical abandonment.

Drawing on the four mechanisms of the cycle as definitive intervention targets, achieving true structural transformation demands coordinated, simultaneous disruptive actions across all systemic levels:

- *Legislative abolition and decolonization (Disrupting Mechanism 1)*: Disrupting this layer requires moving past simple changes to immigration point systems or temporary health coverage extensions, to comprehensive legal and policy overhaul. It demands the complete repeal of the "medical inadmissibility" clause (Section 38(1)(c) of the Immigration and Refugee Protection Act) and an expansion of the Canada Health Act to provide unconditional, universal care to all individuals upon arrival, completely decoupling healthcare from migration status. It also calls for implementation of a universal pharmacare program that successfully provides access to life-saving HIV medications and allows for economic freedom not limited to income brackets and employment status.
- *Institutional reforms and epistemic restitution (Disrupting Mechanism 2)*: Dismantling this layer requires mandating anti-Black racism, cultural safety, and structural anti-oppression training across all healthcare institutions [24]. This framework also calls for the complete elimination of fee-for-service billing structures that penalize comprehensive care, the removal of healthcare providers from state-enforced immigration gatekeeping roles, and the direct funding of Black-led, community-governed health infrastructures.
- *Structural Emancipation and Material Reparations (Disrupting Mechanism 3)*: Overcoming material captivity requires shifting away from temporary social assistance programs that enforce dependency. It mandates universal basic income, guaranteed dignified housing, and environmental remediation to halt the physical weathering caused by enforced spatial segregation.
- *Decarceration of medicine and restorative care (Disrupting Mechanism 4)*: Disrupting the innermost ring requires the absolute separation of public health data from state policing, the abolition of mandatory surveillance pipelines (such as automatic reporting to child welfare or law enforcement within clinical spaces), and the complete decriminalization of HIV non-disclosure. This carceral apparatus must be actively replaced with models rooted in trauma informed, harm reduction, structural advocacy, and holistic care.

This urgent need for an epistemic shift is underscored by a profound historical convergence. The civil rights uprisings following the murder of George Floyd, global Black Lives Matter mobilizations, and the compounding syndemics of COVID-19 and HIV have collectively exposed the violent structural inequities embedded within public health architectures [101]. These social crises and public health emergencies did not uncover novel social dynamics; rather, they rendered politically and socially undeniable what critical race and structural scholars have meticulously documented for generations. These historical flashpoints reinforce the foundational imperative of this research; an effective, equitable HIV response for ACB communities demands a radical rupture in problem-definition. Public health must abandon

individualist paradigms and pivot toward a human rights framework that targets the political, legal, and economic structures manufacturing vulnerability.

Theoretical Transferability and Generalizability Across Black Health Domains

The analytical and theoretical reach of the *Cycle of Structural Violence in Black Health* framework extends far beyond the bounds of HIV healthcare; indeed, its profound generalizability across diverse health domains constitutes its primary scholarly contribution. The framework's core utility lies in its capacity to decode varied health inequities by exposing their shared structural roots.

In maternal health, for instance, Mechanism 2 materializes as pervasive obstetric racism and the systemic dismissal of Black women's physical pain and clinical presentations. This institutionalized epistemic injustice directly drives the disproportionate, preventable maternal mortality and obstetric violence documented across Canada and globally [24].

Similarly, within mental healthcare, Mechanism 4 shifts from virological policing to carceral psychiatry. This manifests as the over-pathologization of Black psychological distress and its immediate criminalization through involuntary psychiatric detentions and state-sanctioned police interventions during acute mental health crises [102].

Further, the systemic devastation of the COVID-19 pandemic offers a stark illustration of how all four mechanisms converge synergistically. This convergence manufactured an unequal distribution of environmental risk, social protection, and vaccine access, radically amplifying racially stratified mortality profiles through a distinctly structured syndemic [92, 103, 104]. Finally, in the management of chronic disease, Mechanisms 2 and 3 operate in tandem to institutionalize delayed diagnoses and highly fragmented care, cementing these barriers as permanent structural features of the Black healthcare experience rather than accidental aberrations within an ostensibly equitable system[105].

Ultimately, while the specific institutional expressions and clinical vocabularies vary across medical disciplines, the underlying architecture of the cycle remains immutable, offering a robust tool for future research aiming to dismantle state-sanctioned health violence. The disproportionate burden of severe illness, medical neglect, and premature death concentrated within Black communities across multiple health domains is not a statistical coincidence of individual risk factors; it is the predictable, mathematical output of a singular, interlocking structural logic.

Study Limitations and Methodological Boundaries

The analysis presented in this paper does not claim to offer a totalizing, exhaustive mapping of the vast web of structural and biological violence shaping the HIV response among ACB populations in Canada. Rather, in alignment with principles of epistemic humility and situated standpoint epistemologies, this study provides a contextually grounded, deep-bore understanding of how specific macro-structural forces organize the day-to-day social worlds of ACB individuals living with HIV and constrain their navigation of the care cascade. Furthermore, ACB populations constitute a deeply heterogeneous

collective whose multiple, intersecting social identities, including gender, sexual orientation, ethnicity, nationality, socioeconomic status, and disability shape their interactions with social structures in highly differentiated way [106].

The manifestations of health violence experienced by ACB individuals navigating the HIV healthcare continuum are not uniform; the structural forces that severely constrain one group may operate with fluctuating intensity or manifest through entirely distinct institutional expressions for another. This complex internal variation represents a nuance that the present analysis does not fully capture. Additionally, because the *Cycle of Structural Violence in Black Health* framework is derived from a specific Canadian institutional ethnographic context, its immediate, unadapted transferability to divergent national settings or alternative healthcare jurisdictions remains a question for future empirical inquiry. The unique configuration of Canada's social welfare systems and immigration infrastructure dictates that applying this framework elsewhere requires careful contextual adaptation and empirical verification [58].

Future scholarship must advance this work by investigating how these four mechanisms manifest across varying socio-political and legislative landscapes, identifying whether additional mechanisms emerge in different settings, and measuring how their relative force and systemic interactions fluctuate. Ultimately, we call for a more granular, intersectional analysis that centers the highly specific experiences of ACB women, gender-diverse people, individuals with intersectional disability challenges, and precarious temporary workers.

Conclusion

This paper introduces the Cycle of Structural Violence in Black Health as a critical intervention in public health and social epidemiology, fundamentally reframing the persistent healthcare challenges observed among Black populations. By centering Black Health Violence rather than passive "inequities" at the core of an ecological model, we reveal how legal architectures, institutional gatekeeping, socio-economic captivity, and medical carceralism operate concurrently as an integrated engine of physical harm. The identified self-reproducing feedback loop demonstrates that conventional, individual-level behavioral interventions are structurally destined to stall because they leave the broader macro-structural machinery of oppression entirely intact. Ultimately, achieving true health equity for African, Caribbean, and Black communities requires moving decisively past incremental administrative reforms. Public health scholarship and practice must pivot toward an abolitionist, human rights framework centered on systemic decolonization, material reparations, and the urgent decarceration of medicine to permanently dismantle the structures that compromise Black biological survival.

Declarations

Conflict of interest

The author declares no competing interests, financial or otherwise, in relation to this manuscript.

Ethics Approval

Approval was obtained from the ethics committee of University of Toronto. The procedures used in this study adhere to the tenets of the Declaration of Helsinki.

Informed Consent

Participants provided informed consent to participate and for anonymized data to be used in publications.

Prior publication

The manuscript has not been published and is not under consideration for publication at any other journal. Three related prior publications from the same research programme are cited in the manuscript (Odhiambo et al. 2022a, 2022b, 2023) and are disclosed above. The present manuscript constitutes a substantively original contribution that has not been previously published in whole or in part.

Consent for publication:

Not applicable.

Funding

The research leading to these results received funding support from the Canadian Institutes of Health Research (CIHR) and the Ontario HIV Treatment Network (OHTN).

Author Contribution

All authors contributed to the study conception and design. Material preparation, data collection and curation, and formal analysis were performed by [AJO]. She conceptualized and developed the multi-axial model (Figure 1) and the Cycle of Structural Violence in Black Health framework (Figure 2), and drafted and revised the manuscript in its entirety. All authors read and approved the final manuscript. Funding acquisition and resources, project administration was by [AJO]. Project supervision was by [DG].

Acknowledgement

We would like to thank all the African, Caribbean, and Black people living with HIV that in the study, and without whom this work would not be possible. We would also like to acknowledge all healthcare

workers who participated and supported the study. We are also grateful to the research committee and the funders who supported the study.

Data Availability

The dataset(s) supporting the conclusions of this article is (are) included within the article.

Code availability

Not applicable.

References

1. Patterson SE, et al. The impact of criminalization of HIV non-disclosure on the healthcare engagement of women living with HIV in Canada: a comprehensive review of the evidence. *J Int AIDS Soc.* 2015;18(1):20572.
2. Grace D. Criminalizing HIV transmission using model law: troubling best practice standardizations in the global HIV/AIDS response. *Crit Public Health.* 2015;25(4):441–54.
3. Oguntibeju OO. Quality of life of people living with HIV and AIDS and antiretroviral therapy. *HIV AIDS (Auckl).* 2012;4:117–24.
4. Skarbinski J, et al. Human Immunodeficiency Virus Transmission at Each Step of the Care Continuum in the United States. *JAMA Intern Med.* 2015;175(4):588–96.
5. Fisher SD, Miller TL, Lipshultz SE. Impact of HIV and highly active antiretroviral therapy on leukocyte adhesion molecules, arterial inflammation, dyslipidemia, and atherosclerosis. *Atherosclerosis.* 2006;185(1):1–11.
6. Mitchell MM, et al. Psychosocial and Service Use Correlates of Health-Related Quality of Life Among a Vulnerable Population Living with HIV/AIDS. *AIDS Behav.* 2017;21(6):1580–7.
7. Group ISS. Initiation of antiretroviral therapy in early asymptomatic HIV infection. *N Engl J Med.* 2015;373(9):795–807.
8. Rodger AJ, et al. Sexual activity without condoms and risk of HIV transmission in serodifferent couples when the HIV-positive partner is using suppressive antiretroviral therapy. *JAMA.* 2016;316(2):171–81.
9. Bangsberg DR, et al. Non-adherence to highly active antiretroviral therapy predicts progression to AIDS. *AIDS.* 2001;15(9):1181–3.
10. UNAIDS. *90-90-90 An ambitious treatment target to help end the AIDS epidemic.* 2014.
11. WHO. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, in 2016 Update.* World Health Organization; 2016.

12. Aral SO. Determinants of STD epidemics: implications for phase appropriate intervention strategies. *Sex Transm Infect.* 2002;78(1):i3–13.
13. Miringoff ML. Dissecting people and ignoring social structure: an analysis of individualism, public policy, and genetic labeling. *Behav Sci Law.* 1996;14(4):433–42.
14. Lane SD, et al. Structural violence and racial disparity in HIV transmission. *J Health Care Poor Underserved.* 2004;15(3):319–35.
15. Odhiambo AJ, et al. Legislatively Excluded, Medically Uninsured and Structurally Violated: The Social Organization of HIV Healthcare for African, Caribbean and Black Immigrants with Precarious Immigration Status in Toronto, Canada. *Qual Health Res.* 2022;32(5):847–65.
16. Odhiambo AJ et al. *Structural Violence and the Uncertainty of Viral Undetectability for African, Caribbean and Black People Living with HIV in Canada: An Institutional Ethnography.* 2022.
17. Odhiambo AJ, et al. Unmasking legislative constraints: An institutional ethnography of linkage and engagement in HIV healthcare for African, Caribbean, and Black people in Ontario, Canada. *PLOS Global Public Health.* 2022;2(9):e0000714.
18. Singer M, Clair S. Syndemics and public health: Reconceptualizing disease in bio-social context. *Med Anthropol Q.* 2003;17(4):423–41.
19. Singer M, et al. Syndemics and the biosocial conception of health. *Lancet.* 2017;389(10072):941–50.
20. Maynard R. Policing Black lives: State violence in Canada from slavery to the present. Fernwood Publishing; 2017.
21. Esses V et al. *Supporting Canada's COVID-19 resilience and recovery through robust immigration policy and programs.* 2021.
22. Canada S. Immigration and Diversity: Population Projections for Canada and its Regions, 2011 to 2036, Statistics Canada, Catalogue no. 91-551-X (low immigration and high immigration scenarios). Statistics Canada; 2017.
23. Oppenheimer DB, Prakash S, Burns R. Playing the Trump card: The enduring legacy of racism in immigration law. *Berkeley La Raza LJ.* 2016;26:1.
24. Dryden O, Nnorom O. Time to dismantle systemic anti-Black racism in medicine in Canada. *CMAJ.* 2021;193(2):E55–7.
25. PHAC. *HIV in Canada, Surveillance Report to December 31, 2023.* Ottawa, ON: Public Health Agency of Canada = Agence de la santé publique du Canada, 2023-, 2023(2023).
26. Tjepkema M, et al. Mortality inequalities of Black adults in Canada. *Health Rep.* 2023;34(2):3–16.
27. PHAC. HIV among African, Caribbean and Black people in Ontario. *CCDR;* 2024.
28. Mbuagbaw L, et al. *A cross-sectional investigation of HIV prevalence and risk factors among African, Caribbean and Black people in Ontario: The A/C study.* *Can. Commun Dis Rep.* 2022;48:429–37.
29. Olaniyan T, et al. Understanding mortality differentials of Black adults in Canada. *Health Rep.* 2025;36(4):3–13.

30. Lundy C. Social work, social justice & human rights: A structural approach to practice. University of Toronto; 2011.
31. Mullaly B. *Oppression: an overview*. Challenging oppression and confronting privilege: a critical social work approach, 2010: pp. 34–65.
32. Farmer P. Pathologies of power: Health, human rights, and the new war on the poor. Volume 4. Univ of California; 2004.
33. Galtung J. Violence, Peace, and Peace Research. J Peace Res. 1969;6(3):167–91.
34. Krieger N. Discrimination and health inequities. Int J Health Serv. 2014;44(4):643–710.
35. Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. Public Health Rep. 2014;129(Suppl 2):19–31.
36. Taylor S. Structural violence, oppression, and the place-based marginality of homelessness. Can Social Work Review/Revue canadienne de service social, 2013: pp. 255–73.
37. Farmer P. On suffering and structural violence: A view from below. Daedalus. 1996;125(1):261–83.
38. Galtung J. Peace by peaceful means: Peace and conflict, development and civilization. Volume 14. Sage; 1996.
39. Ho K. Structural violence as a human rights violation. University of Essex Essex; 2007.
40. Farmer PE, et al. Structural violence and clinical medicine. PLoS Med. 2006;3(10):e449.
41. Logie CH, et al. A Structural Equation Model of HIV-Related Stigma, Racial Discrimination, Housing Insecurity and Wellbeing among African and Caribbean Black Women Living with HIV in Ontario, Canada. PLoS ONE. 2016;11(9):e0162826.
42. Magalhaes L, Carrasco C, Gastaldo D. Undocumented migrants in Canada: a scope literature review on health, access to services, and working conditions. J Immigr Minor Health. 2010;12(1):132–51.
43. Young MET. Immigration versus immigrant: The cycle of anti-immigrant policies. Am J Public Health. 2018;108(4):436–7.
44. Mbuagbaw L, et al. A/C study protocol: a cross-sectional study of HIV epidemiology among African, Caribbean and Black people in Ontario. BMJ Open. 2020;10(7):e036259.
45. McClarty LM, Blanchard JF, Becker ML. Leaving no one behind? An equity analysis of the HIV care cascade among a cohort of people living with HIV in Manitoba, Canada. BMC Public Health. 2021;21(1):281.
46. Chen YB, et al. Improving access to mental health services for racialized immigrants, refugees, and non-status people living with HIV/AIDS. J Health Care Poor Underserved. 2015;26(2):505–18.
47. Pui-Hing Wong J, et al. An exploratory study on the mental health of immigrants, refugees and non-status people living with HIV in Toronto. Int J Migration Health Social Care. 2013;9(3):122–34.
48. Ku L, Matani S. Left out: immigrants' access to health care and insurance. Health Aff. 2001;20(1):247–56.
49. Magalhaes L, Carrasco C, Gastaldo D. Undocumented migrants in Canada: a scope literature review on health, access to services, and working conditions. J Immigr Minor Health. 2010;12(1):132.

50. Rousseau C, et al. Health care access for refugees and immigrants with precarious status. *Can J Public Health*. 2008;99(4):290–2.
51. Simich L, Wu F, Nerad S. Status and health security: an exploratory study of irregular immigrants in Toronto. *Can J Public Health*. 2007;98(5):369–73.
52. Li A. *Immigrants, Refugees and Non-status People with HIV*. 2017.
53. UNAIDS. *Miles to Go Closing Gaps Breaking Barriers Righting Justice*. 2018.
54. Logie C, et al. Associations between HIV-related stigma, racial discrimination, gender discrimination, and depression among HIV-positive African, Caribbean, and Black women in Ontario, Canada. *AIDS Patient Care STDS*. 2013;27(2):114–22.
55. Patterson AC, Veenstra G. Black-White health inequalities in Canada at the intersection of gender and immigration. *Can J Public Health*. 2016;107(3):e278–84.
56. Berinstein C et al. April,, *Access Not Fear: Non-Status Immigrants and City Services*. Retrieved 2006. 19: p. 2006.
57. Centre AAMCH. *Racialised Groups and Health Status: A literature review exploring poverty, housing, race-based discrimination and access to health care as determinants of health for racialised groups*. Access Alliance Multicultural Health and Community Services; 2000.
58. Smith DE. *Institutional ethnography: A sociology for people*. Rowman Altamira; 2005.
59. McCoy. L.J.I.e.a.p. *Working Interview Acc Everyday Experience* 2006: p. 109.
60. Smith DE. *Institutional ethnography as practice*. Rowman & Littlefield; 2006.
61. Campbell M, Gregor F. *Mapping social relations: A primer in doing institutional ethnography*. University of Toronto; 2002.
62. DeVault ML. and L.J.I.e.a.p. McCoy, *Institutional ethnography: Using interviews to investigate ruling relations*. 2006: pp. 15–44.
63. Bisailon LM. Human rights consequences of mandatory HIV screening policy of newcomers to Canada. *Health Hum Rights*. 2010;12(2):119–34.
64. Patterson SE, et al. The impact of criminalization of HIV non-disclosure on the healthcare engagement of women living with HIV in Canada: a comprehensive review of the evidence. *J Int AIDS Soc*. 2015;18:20572.
65. Cohen MS, Gamble T, McCauley M. Prevention of HIV Transmission and the HPTN 052 Study. *Annu Rev Med*. 2020;71:347–60.
66. Cohen MS, et al. Prevention of HIV-1 infection with early antiretroviral therapy. *N Engl J Med*. 2011;365(6):493–505.
67. Rachlis B, et al. Social determinants of health and retention in HIV care in a clinical cohort in Ontario, Canada. *AIDS Care*. 2017;29(7):828–37.
68. IRPA, Immigration and Refugee Protection Act, S.C.. 2001, c. 27, in c. 2001.
69. Goldring L, Landolt P. *Producing and negotiating non-citizenship: Precarious legal status in Canada*. University of Toronto; 2013.

70. Goldring L, Berinstein C, Bernhard JK. Institutionalizing precarious migratory status in Canada. *Citizen Stud.* 2009;13(3):239–65.
71. CHA, *Canada Health Act*, in c. 1985, R.S.C: Canada.
72. Caulford P, D'Andrade J. Health care for Canada's medically uninsured immigrants and refugees: Whose problem is it? *Can Fam Physician.* 2012;58(7):725–7.
73. Somerville MA, Wilson S, McGill LJ. 1997. 43: p. 781.
74. Dodge D. *Deputy Minister, Health Canada. Letter to Janice Cochrane, Deputy Minister, Citizenship and Immigration Canada*, H.o. Commons, Editor. 2000: House of Commons.
75. GoC. Who must submit to an immigration medical examination?. 2018; Available from: <https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/operational-bulletins-manuals/standard-requirements/medical-requirements/exam/who-must-submit-immigration-medical-examination.html>
76. Mykhalovskiy E et al. '*Callous, Cold and Deliberately Duplicious*': *Racialization, Immigration and the Representation of HIV Criminalization in Canadian Mainstream Newspapers.* 2016.
77. ACCHO. *Criminals and Victims? The Impact of the Criminalization of HIV Non-Disclosure on African, Caribbean and Black Communities in Ontario.* 2010.
78. ACCHO, *Our Voices: HIV, Race and the Criminal law an ACCHO Special Report.* 2013.
79. Immigration Refugees and Citizenship Canada. Panel Members' Handbook. 2013; Available from: <https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/panel-members-handbook-2013.html>
80. Melamed OC, et al. COVID-19 and persons with substance use disorders: Inequities and mitigation strategies. *Substance abuse.* 2020;41(3):286–91.
81. Berlinger N. *Are Workarounds ethical? managing moral problems in health care systems.* Oxford University Press; 2016.
82. Fabi RE, Taylor HA. Prenatal Care for Undocumented Immigrants: Professional Norms, Ethical Tensions, and Practical Workarounds. *J Law Med Ethics.* 2019;47(3):398–408.
83. Link BG, Phelan J. Social Conditions As Fundamental Causes of Disease. *J Health Soc Behav*, 1995: pp. 80–94.
84. Seckinelgin H. People don't live on the care cascade: The life of the HIV care cascade as an international AIDS policy and its implications. *Glob Public Health.* 2020;15(3):321–33.
85. Geronimus AT. The weathering hypothesis and the health of African-American women and infants: evidence and speculations. *Ethn Dis.* 1992;2(3):207–21.
86. Robinson CJ. *Black marxism.* London: Zed; 1983.
87. Raphael D. *Immigration, public policy, and health: Newcomer experiences in developed nations.* Canadian Scholars; 2016.
88. Bronfenbrenner U. *The Ecology of Human Development Experiments by Nature and Design.* Harvard University Press; 1979.

89. Farmer P. Pathologies of power: Health, human rights, and the new war on the poor (California Series in Public Anthropology; 4). University of California Press; 2003.
90. Krieger N. Embodiment: a conceptual glossary for epidemiology. *J Epidemiol Commun Health*. 2005;59(5):350–5.
91. Mbembe A. Necropolitics. Duke University Press; 2020.
92. Singer M, Clair S. Syndemics and Public Health: Reconceptualizing Disease in Bio-Social Context. *Med Anthropol Q*. 2003;17(4):423–41.
93. Washington HA. Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present. Doubleday Books; 2006.
94. Metzl JM, Hansen H. Structural competency: Theorizing a new medical engagement with stigma and inequality. *Soc Sci Med*. 2014;103:126–33.
95. Krieger N. Epidemiology and the people's health: theory and context. Oxford University Press; 2024.
96. Edwin Cameron SB, Clayton M. *HIV is a virus, not a crime: ten reasons against criminal statutes and criminal prosecutions*. 2008.
97. Gilmore RW. Golden gulag: Prisons, surplus, crisis, and opposition in globalizing California. Volume 21. Univ of California; 2007.
98. Biglan A, et al. The critical role of nurturing environments for promoting human well-being. *Am Psychol*. 2012;67(4):257.
99. Adkins-Jackson PB, et al. Measuring Structural Racism: A Guide for Epidemiologists and Other Health Researchers. *Am J Epidemiol*. 2022;191(4):539–47.
100. Ford CL, Airhihenbuwa CO. Critical Race Theory, race equity, and public health: toward antiracism praxis. *Am J Public Health*. 2010;100(1):S30–5.
101. Osman S, et al. Dual Pandemics: Intersecting Influences of Anti-Black Racism and the COVID-19 Pandemic on the Mental Health of Black Youth. *Can J Nurs Res*. 2025;57(1):24–32.
102. Craig E, et al. From mental health detention to health systems reform: Co-producing policy and practice recommendations with Black men, their communities, and health and social care professionals. *PLOS Mental Health*. 2025;2(12):e0000457.
103. Sharif MZ, et al. Racism and structural violence: interconnected threats to health equity. *Front public health*. 2022;9:676783.
104. Bowleg L. *We're not all in this together: On COVID-19, intersectionality, and structural inequality*. 2020, American Public Health Association. pp. 917–917.
105. Olanlesi-Aliu A, Alaazi D, Salami B. Black health in Canada: protocol for a scoping review. *JMIR Res Protocols*. 2023;12(1):e42212.
106. Crenshaw KW. *Mapping the margins: Intersectionality, identity politics, and violence against women of color*, in *The public nature of private violence*. Routledge; 2013. pp. 93–118.

Figures

**The Social Organization of HIV Healthcare and Treatment for African, Caribbean and Black (ACB) Living with HIV in Canada:
Multi-Axial Model of Structural Violence, Inequities, Social Injustices and Suffering**

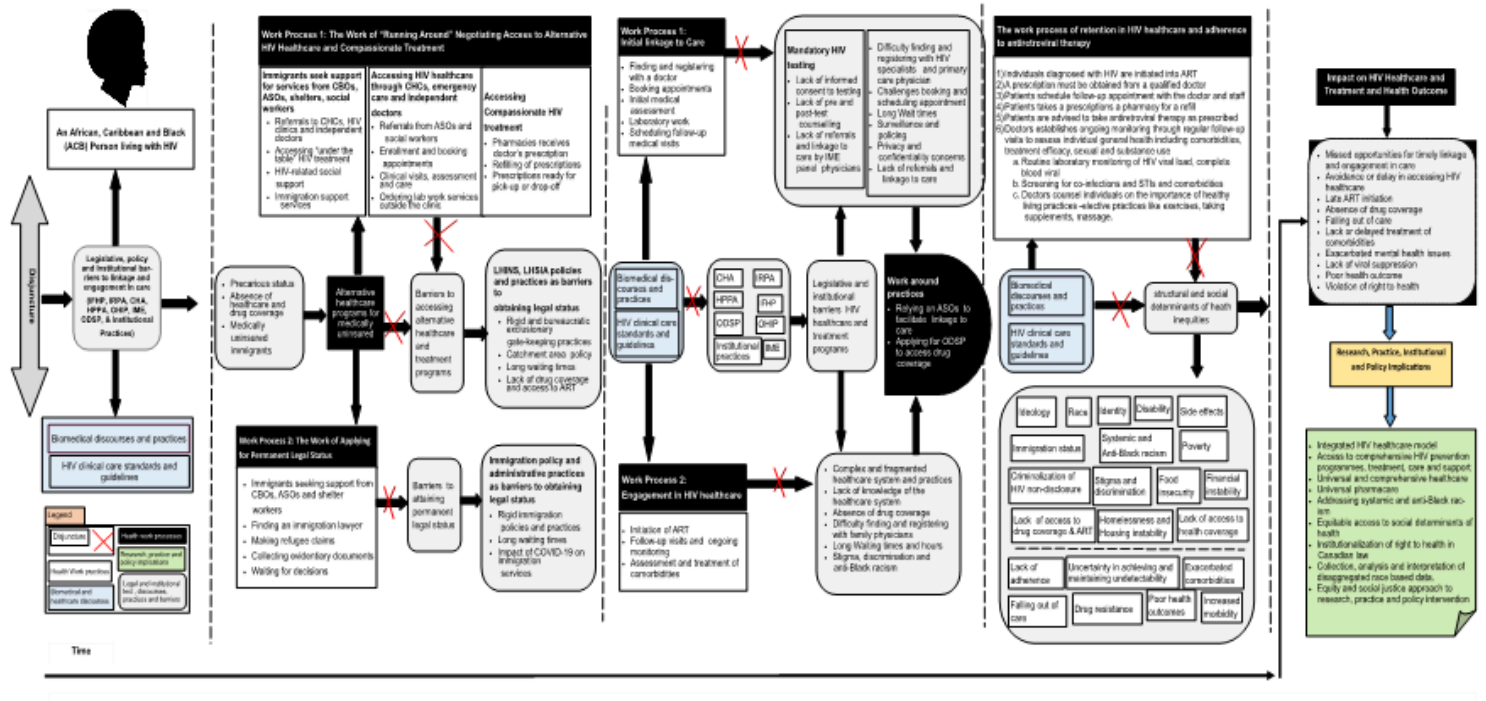


Figure 1

Multi-Axial Model of Structural Violence, Inequities and Social Injustices for ACB People.

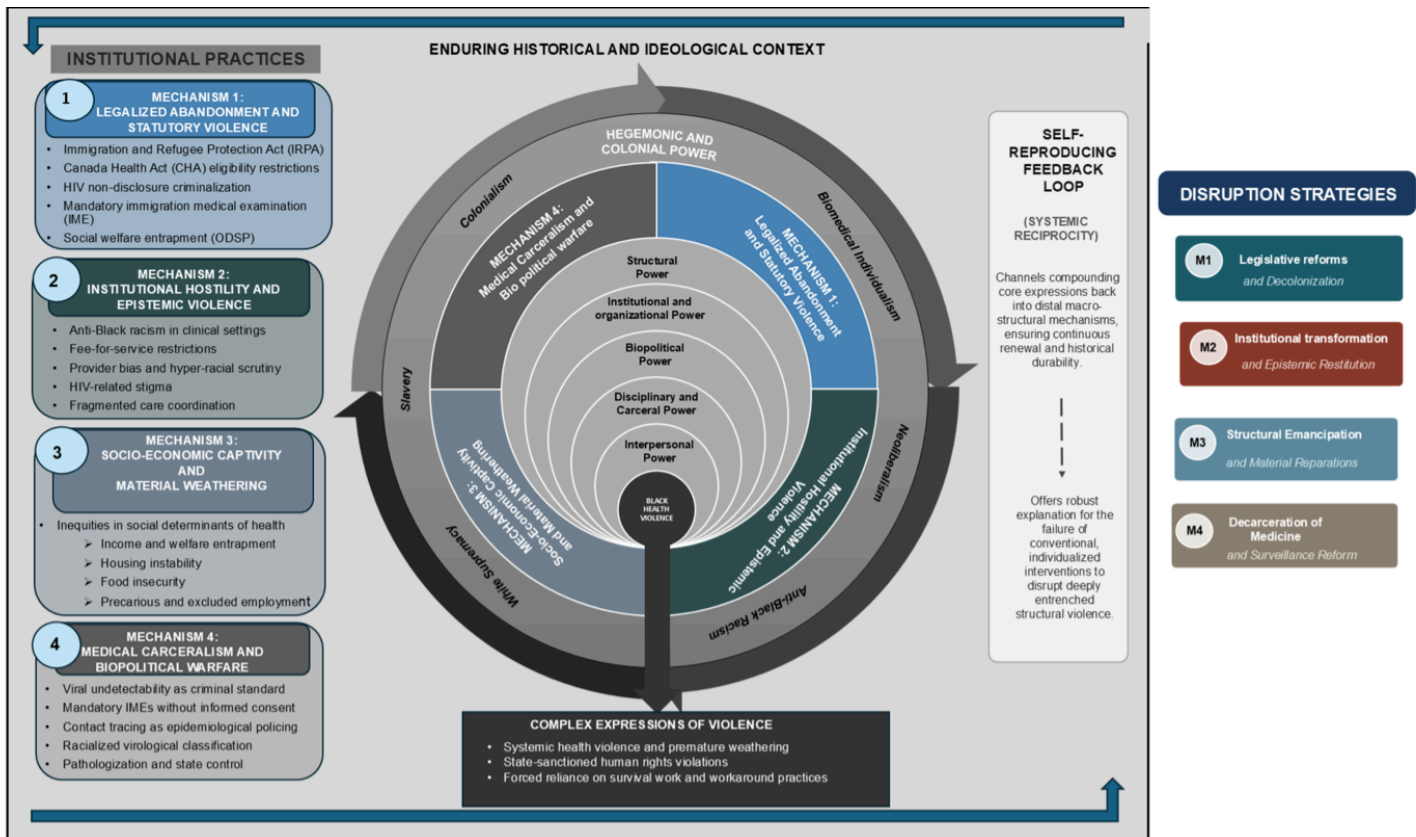


Figure 2

The Cycle of Structural Violence in Black Health.

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