

Visibly Hidden:

Rethinking BMSM & **HIV** Prevention

BLACK



C • A • P

BLACK COALITION FOR AIDS PREVENTION

Visibly Hidden:

Rethinking BSM & HIV Prevention

ISBN: 978-0-9784357-0-7

©Black Coalition for AIDS Prevention 2007

ACKNOWLEDGEMENTS

The content of this report is the synthesis of the knowledge and experiences of many community members who enthusiastically shared their time and resources and provided valuable input to the consultation and development of this report. We thank all those involved for their assistance in the development of this report.

David Lewis-Pearl
BMSM HIV Prevention Project Coordinator
June 2007



Visibly Hidden:

Rethinking BSM & HIV Prevention

CONTENTS

1.0	INTRODUCTION	1
1.1	Purpose	1
1.2	Background	1
1.3	Related HIV Prevention Strategies	1
1.4	Definition of Terms	1
1.5	Process Overview	5
1.6	Report Limitations	7
1.7	Local BSM Research	8
1.8	Related Local Services and Programming	8
1.9	Relevant Local Campaigns	11
2.0	EPIDEMIOLOGICAL DATA AND OTHER RELATED FINDINGS	12
2.1.	Epidemiological Data	12
2.2.	Other Related Findings	17
3.0	MULTIPLE BARRIERS	18
3.1.	Dynamic Identities	18
3.2.	The Challenging Concept of a BSM Community	20
3.3.	The Significance of HIV in the Lives of BSM	21
3.4.	The Significance of Gender	23
3.5.	The Impact of Homophobia and Stigma	24
3.6.	Racism and Social Exclusion	26
3.7.	Gaps in Knowledge and Research	28
3.8.	BSM Possess a Number of Protective Attributes	29
4.0	EFFECTIVE PROGRAMMING STRATEGIES	29
5.0	RECOMMENDATIONS	32

6.0 AREAS REQUIRING FUTURE EXPLORATION 35

APPENDICES 35

I)	List of those Interviewed and Affiliated Organizations	35
II)	List of Source Materials	36

1.0 INTRODUCTION

1.1 Purpose

Black men who have sex with men (BMSM) represent an increasing, and significant proportion of HIV cases in Toronto. Despite this trend, related research, education and prevention with this population has been notably inadequate and new prevention responses must be considered. The goal of this report is to provide an overview of the significant needs, barriers and service gaps for Black, gay, bisexual and straight identified African and Caribbean men who have sex with other men in Toronto. It is based upon a consultation process conducted by the Black Coalition for AIDS Prevention's (Black CAP) MSM HIV Prevention Coordinator with a range of service providers, community researchers and others working in Toronto's AIDS service sector and African Caribbean communities. The purpose of this report is to guide the creation and implementation of a targeted, Toronto-based HIV prevention initiative for gay, bisexual, and straight-identified BMSM communities.

The proposed initiative will focus on:

- Determining relevant and effective delivery methods of sexual health and HIV prevention education for BMSM.
- Increasing understandings of the significant risks for HIV and STI (sexually transmitted infections) transmission among BMSM.
- Creating culturally relevant and appropriate prevention interventions.
- Increasing knowledge and awareness of sexual health and HIV-related issues within this community, as well as attempting to reduce HIV/AIDS-related stigma.

1.2. Background

Given increasing rates of HIV infection in specific communities in Ontario, the Ministry of Health and Long-Term Care – AIDS Bureau allocated additional funding in 2005 for a number of new targeted HIV/AIDS strategies throughout the province such as the Gay Men's Prevention Strategy, the Strategy to Address Issues Related to HIV Faced by People from Countries Where HIV is Endemic and the Women's Strategy. Black CAP also has an interest in developing new programming which recognizes the local service context, emerging services and current HIV infection trends. Funded by the AIDS Bureau, guided by the Gay Men's HIV Prevention Strategy and in alignment with the Strategy to Address Issues Related to HIV Faced by People from Countries Where HIV is Endemic (African and Caribbean HIV Prevention or ACCHO Strategy) Black CAP has undertaken the task of creating a prevention campaign/intervention for BMSM living in Toronto.

In addition, Black CAP has entered a period of program expansion in hopes of enhancing its HIV Prevention strategies in Toronto's Black communities (African, Afro-Canadian and Afro-Caribbean) in partnership with ACCHO (African and Caribbean Council on HIV in Ontario). Efforts are being made to ensure that programming is informed by evidence, best-practices and research, and targeted in relation to gender, sexual orientation, religion, culture, class,

age and geographic location. Black CAP also recognizes the importance of developing new service models that acknowledge the dynamic nature of HIV in Toronto's Black communities and the ongoing disproportionate impact that HIV has on BSM. In order to achieve these goals, Black CAP initiated a process to identify the nature of new prevention programming: this process includes community and stakeholder consultations, analysis of research and population trends, and the development of this report.

1.3 Ensuring Links to Related HIV Prevention Strategies

The goal of this project is to make a direct link between this report, future BSM programming and broader HIV Prevention Strategies. The aim of Ontario's African and Caribbean HIV Prevention Strategy is to reduce the incidence of HIV among African and Caribbean people in Ontario and to improve the quality of life for those infected and affected by HIV/AIDS. The Ontario Gay Men's HIV Prevention Strategy envisions - for gay, bisexual and other men who have sex with men - an environment free of new HIV transmissions and supportive of those infected and affected by HIV/AIDS.

The African and Caribbean HIV Prevention Strategy (Strategy to Address Issues Related to HIV Faced by People from Countries Where HIV is Endemic) and the Gay Men's HIV Prevention Strategy have a number of shared objectives. Both recognize the need to address diversity within their respective communities and acknowledge barriers to access that have been identified as social determinants of health. Both strategies also note the effect stigma has in further marginalizing communities at risk, and that addressing both micro and macro level systems are necessary to create significant change in communities. Both Strategies attempt to accomplish these goals by:

- Coordinating the work of agencies, institutions and policy makers related to HIV prevention, education, health promotion, care and support
- Ensuring province-wide access to HIV prevention resources
- Reducing isolation of HIV/AIDS workers, researchers and staff
- Facilitating community development and building of capacity in response to HIV/AIDS challenges
- Identifying research needs, priorities and opportunities, as well as leading new research opportunities
- Supporting evidence-informed program planning

1.4 Definition of Terms

The following is a brief exploration of extremely complex terms frequently used throughout this report.

BMSM

The term ‘men who have sex with men’ (MSM) emerged as an epidemiological term in order to categorize gay, bisexual and straight-identified men who have sex with other men. For the purposes of this report, Black men who have sex with men - whether gay, bisexual, transgender/sexual or heterosexually-identified - will be referred to as BMSM. This term led to significant debate among informants, though in the interest of ease and clarity, the term BMSM will be used in this report.

It is recognized, however, that *“The practice of grouping (straight-identified) MSM, bisexual and gay men together for epidemiological purposes may pose as a problem for HIV prevention because these groups of men differ in sexual identity, behaviour and their perception of risk for HIV. Each group has different perceptions and needs that must be addressed specifically if HIV prevention programs are to be effective.”* (James, 2006)

Furthermore, the labels gay and bisexual may be problematic for many people within Black communities because these terms, as well as general language around sexuality, have emerged from a Eurocentric cultural context. This context has inherent ethnocentric cultural assumptions about sexual language and behaviours that marginalizes and therefore, is not reliably indicative of Black peoples/communities and subsequently, historical and cultural experiences of BMSM. The use of the term BMSM in this report has not been used in place of sexual identity/orientation labels, but is used to reference common sexual behaviours engaged in by gay, bisexual and straight-identified MSM. Wherever possible, the terms gay, bisexual or straight-identified have been used to provide appropriate differentiation between these identities in the report.

Black

When discussing HIV as it affects the Black community, the concept of Black identity that has originated in African-American contexts is often paralleled to African and Caribbean experiences in Canada and co-opted for use within the Canadian context. However, it is important to remember that there are distinct differences between the evolution of the socio-political context of Black peoples/communities in Canada and Blacks in the United States. African-American culture and community is largely based on 300 years of shared history and experience, while more recent immigration of Black peoples from the African diaspora in the mid to late 20th century yields a more heterogeneously defined culture of Black communities in Canada. This is especially true in Toronto.

To view Toronto’s Black population as a homogenous community would limit the success of any strategy targeting this population. It is important that HIV prevention strategies recognize

the multi-national, multi-cultural, multi-lingual nature of Toronto's Black communities. In a Canadian study (Boatswain and Lalonde, 2000) this difference was attributed to three main factors:

- Population size - Black Americans comprise a greater percentage of the general US population.
- Residential/Geographic Segregation - Black Americans experience a more identifiable form of geographical segregation than Blacks in Canada.
- Origins of Black Community – Black Canadians tend to have a more recent connection with other countries of origin compared to Black Americans. Canada's Black communities are more defined by waves of immigration from the African diaspora over the past century, relative to the small numbers taking up residence prior to this time.

These differences may explain why Black Canadians and Black Americans may approach their sense of racial identity somewhat differently, laying claim then to cultural communities rather than racial ones.

'It is possible, therefore, that some Blacks in Canada may refer to former national or regional identities when labeling themselves' (Boatswain and Lalonde, 2000). The distinct differences in the civil rights struggles and related political and legislative interventions have also reinforced particular messages about identity in each country. However, while there are differences between groups, it is important to highlight the shared experience and history of discrimination between African communities and communities of African descent within a North American and Western context.

Social Determinants of Health

The term 'social determinants of health' (SDOH) was developed as a way of identifying factors that influence the health and well-being of individuals and communities. Many of these identifying factors are socially and economically based, and for the BSM population, can be directly linked to race, racism and economic disparity. A number of the themes within this report clearly relate back to the SDOH and are referenced at times within the report. The social determinants of health as compiled by the Public Health Agency of Canada (2003) are as follows: income and social status, social support networks, education and literacy, employment/ working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and culture. While these determinants address a number of factors that impact an individual's health and access to health service, it must be noted that sexual orientation has not been identified as an independent determinant. A number of key informants for this report identified that sexual orientation and identity significantly impact an individual's overall health and wellness, particularly when one's identity is perceived as abnormal. Obstacles experienced by gay, bisexual and other men who have sex with other men may also be compounded by a myriad of other factors outlined by the SDOH such as income, education, social environments and so forth.

1.5. Process Overview

In November 2006, Black CAP determined that an external consultation process was required for the development of a new BSM-focused HIV prevention program. In view of changing funding trends, service responses and increased community mobilization in relation to HIV, Black CAP felt that a review and analysis of current population trends, epidemiological data and existing programming was required.

This report is an analysis and review of the perceptions and experiences of local service providers, community researchers and other community stakeholders in Toronto. Some of the findings are also supported by secondary data gathered through a review of BSM-related literature. There are three main goals for this report:

- To document common themes/trends for the target population in relation to their needs, capacities, and barriers to HIV prevention supports.
- To identify BSM-related health and social services and to assess gaps in service.
- To identify priorities that would aid in the development of prevention and intervention strategies.

Findings in this report are based on a content analysis of field notes and results from the following research methods employed between February and April 2007:

Literature Review: An analysis of a range of sources was conducted to provide context as well as support and verify anecdotal information collected from interviews. This included various research reports, community consultations and community and neighbourhood profiles. Additionally, an online resource search was conducted to locate existing BSM-specific HIV prevention campaigns or interventions. The goal of this search was to identify successes, better practices and challenges, in order to determine the potential for transfer of successful strategy components.

Interviews: Semi-structured interviews were conducted with twenty key informants to obtain information on the need for a BSM-specific initiative, to identify priority issues for the target population, determine trends and common themes and to gather suggestions for prevention and intervention initiatives. (See Appendix I for the list of informants).

Key informants represent a wide range of organizations: community health centres, universities, local hospitals, funders, AIDS service organizations (ASOs), community social service agencies serving African and Caribbean populations and individuals doing related community development work. All interviews were audio-recorded and transcribed notes were used to summarize key points and identify common themes. Direct quotes from interviews are found throughout this report.

Interviews with key informants included the following questions:

1. What groups have significant need or risk within the BSM community?
2. What are access barriers to services for this community?
3. What strategies are currently in use for this community and how have they been successful?
4. What methods of evaluation might be considered for this program?
5. What existing research should be considered?

Following key informant interviews, themes were identified, analyzed and compiled into a report with accompanying recommendations. The credibility of the findings was enhanced through supervisory and peer debriefings, as well as ongoing consultation with agency partners.

This report is the first stage of a three-stage process to design Black CAP's new BSM HIV prevention program. The second stage of the process includes a review of the report by a Community Advisory Committee and the third stage will include a program design exercise, determined in stage two.

Community Advisory Committee: A review committee was struck to offer feedback on the content of the report, recommendations and to affirm the project's direction. This advisory body is comprised of six community members representing a range of organizations and agencies working in the Black and/or AIDS service sectors. A substantial portion of the community advisory committee will be comprised of target populations (BSM, youth and people living with HIV/AIDS). Its' main purpose will be to:

- Offer feedback on, and identify any gaps within the report
- Provide recommendations on possible program development and implementation
- Ensure that the direction of the program is aligned with the Gay Men's HIV Prevention and ACCHO strategies
- Ensure that any programming developed is relevant, targeted and innovative

To meet these objectives, the Committee will meet a maximum of three times over a period of one month.

Program Design and Implementation: Following a review of the report by the Committee, a program design process will be undertaken, with a launch of a new BSM prevention program in mid-2007. The design of programming will also be informed by the following principles:

- Program design, delivery and evaluation will reflect the needs of the target population (BSM, youth and people living with HIV/AIDS)
- Program design will incorporate the SDOH into prevention messages
- Partnerships will be made with similar services

1.6. Report Limitations

A number of limitations have been identified regarding the content and findings of this report. These limitations are primarily related to gaps in Toronto-specific and BSM-specific data and include the following:

Dependence on anecdotal information: The consultation and analysis stages of this project lasted three months. Given time constraints, the scope of this study is limited to capturing general trends based on anecdotal data and utilizing resources identified during that time. While this report verifies some of these anecdotal trends with secondary data, it is important that these trends be verified and confirmed with additional data attained from future research studies, epidemiological surveys and census findings. Additionally, it is critical that community trends be verified with the target population and broader community members affected by these issues.

Dependence on external (non-Toronto) sources of information: Numerous documents and resources, including one key informant interview, were used from outside the geographical boundaries of Toronto for this report. Some of the information provided in this report is also drawn from American health journals and data from these sources should be interpreted as approximations for the city of Toronto.

Approximations of data: The population information used in the report is largely based on the most current data from the Ontario HIV/AIDS Epidemiological Monitoring Unit (OHEMU), University of Toronto, and the United Way of Greater Toronto Research Unit. OHEMU data captures information up to and including 2004. It is important that future efforts be made to verify these trends with more recent census data and other statistics from current research projects as they become available.

Limitations in research, resources and formal networks: The BSM population in Toronto is a group about which little is known. There are also significant gaps in BSM-related research and subsequently, a lack of community-specific data and resources. This challenge may be related to difficulty in accessing members of, and networks within, communities outside of mainstream, or “out” gay and bisexual networks. Black CAP is cognizant of these gaps and understands that innovative approaches are required to access existing informal networks. Possibly, community development is required to facilitate more formal networks, or access existing informal networks, in order to support more effective health and wellness interventions and prevention.

1.7. Local BSM Research

There is limited Ontario specific BSM-related research. That said, there are two research studies currently underway: the MaBwana Research Project and the Lambda (M-Track) Study through the Gay Men's Strategy.

- The MaBwana (Getting to Know You) Black Men's Study is a mixed method study of Black MSM sexual behaviour and social networking in Toronto funded through the Canadian Institute of Health Research. This study is part of the ACCHO Strategy and is specific to Toronto BSM.
- The Lambda Study is a study of the sexual behaviors and HIV among gay, bi, straight-identified MSM and trans men in Toronto. Lambda is a Toronto branch of a national surveillance study by the Public Health Agency of Canada.
- The Ethno-racial Research Working Group has, as a part of the Gay Men's HIV Provincial Advisory Committee, led a number of research reports on ethnic Gay/Bi/MSM such as the Ethno-racial MSM Literature Review and the Principles on CBR (Community Based Research) with Ethno-racial Communities (Van der Meulen et al., 2006). Most recently the research group has developed a capacity building grant proposal for a research project working with ethno-racial communities.

In December 2006, Black CAP completed a survey of 35 Black males who have sex in bathhouses. The short survey assessed the appropriateness of bathhouse and other community outreach, familiarity with Black CAP, perceived levels of risk for HIV, age etc. Findings indicated the following:

- 61% of respondents identified as gay, 30% identify as bisexual and the remaining 9% do not identify as gay, straight or bisexual.
- One in four Black males surveyed in the bathhouse setting had not heard of Black CAP.
- Of those surveyed, 61% indicate being 'somewhat at risk for HIV' and 18% indicated they were 'very at risk for HIV infection.' Only 21% felt they were not at risk.
- 60% of males indicated that they require more information about HIV.
- 44% indicated that Black CAP should provide web-based outreach (chat room and website) and 29% indicated that outreach should be conducted in bars and clubs.
- Those surveyed were between the ages of 20-59 with highest representation from 30-39 year olds.

1.8. Related Local Programming and Services

Of the AIDS service organizations (ASOs) working in Ontario, only three provide exclusive services to Black, African and Caribbean communities. They are: Africans in Partnership Against AIDS (APAA), African Community Health Services and Black CAP. Of these, only Black CAP offers BSM-specific programming with the Men2Gether Project (M2G) and other MSM related programming. The African Caribbean Council on HIV in Ontario (ACCHO)

does however deliver Province wide prevention and research programming focused on the black community, and has made significant effort to be inclusive of gay and bisexual BSM in it's agenda.

Described below are additional programs and services offered in the Toronto-area pertaining to BSM. This review indicates significant gaps in services and programming in relation to mutual aid, support, education, testing and prevention for BSM. They are:

Black Queer Youth Group (BQY) – The BQY group is a youth worker facilitated weekly social space housed through the Supporting Our Youth program for Black, multiracial, African/ Caribbean youth under 29 who identify as lesbian, gay, bisexual, transgendered, transsexual and questioning. This is an open format, drop-in group for gay and lesbian youth and does not offer specific services or support for BSM youth.

Gays and Lesbians of African Descent (GLAD) – A greater Toronto area (GTA) organization dedicated to providing support through education, outreach and advocacy around African Canadian LGBTQ issues. GLAD works to challenge homophobia within African communities through educational outreach at Black community events and spaces. GLAD has also headlined community forums on such topics as 'Homosexuality in the African Community,' homophobia and religion. GLAD does not however provide any BSM-specific services or support as part of its' mandate.

Black CAP - Men2Gether Project – This project targets straight men who have sex with men, bisexual and gay-identified men through outreach and prevention initiatives in bars, bathhouses and parks where BSM meet other men. This program focuses upon providing prevention education in these spaces and provides both the practical tools to reduce risk (e.g. condoms, lube) and information related to risk reduction. The Men2Gether Project also refers a large number of clients for HIV and STI testing available at Hassle Free Clinic and other sexual health clinics in Toronto.

Griffin Centre - The Griffin Centre is a counseling and support agency serving youth aged 12 to 18 with mental, emotional or intellectually disability issues in the former city of North York. The Griffin Centre runs ReachOUT, a youth worker facilitated drop-in. This lesbian, gay, bisexual, transgender, transsexual, two-spirit, intersex, queer and questioning (LGBT2IQQ) support and social group is for youth of all abilities in north Toronto. The program also offers one-on-one counseling for youth experiencing sexual identity issues and/or related family or school issues. Services are geared primarily towards youth with existing mental, emotional or intellectual challenges. The Griffin Centre also runs a similar LGBT2IQQ group called Compass for youth with mild developmental delays. At present, the Griffin Centre also offers a peer support group called Not Pink, a group specifically for gay, bi and queer men/ transmen of colour under 30 which has been successful in accessing queer and questioning youth in the Jane/Finch area. An HIV prevention project is also currently under development at the Griffin Centre to provide sexual health and HIV education to youth in and around North York area.

Gay Black Men's Group - This informal Black gay and bisexual men's social group is currently housed at the AIDS Committee of Toronto (ACT). This project runs bi-weekly and is provided in an open format for any members of the BSM community to meet, socialize and discuss current issues. The Gay Black Men's Group is in the development stage and has not, as yet, created a specific project mandate or objective.

Alliance for South Asian AIDS Prevention (ASAAP) – A Toronto-based HIV/AIDS organization providing health promotion, support, education and advocacy to the South Asian community and those living with or affected by HIV, ASAAP's services are inclusive of all South Asian communities (including the Indo-Caribbean community) and incorporates programming specifically targeting MSM. ASAAP also organizes the monthly Dosti (friendship) support group for South Asian MSM. ASAAP also offers the Dosti website which provides sexual health information and resources and a space for queer/gay/bisexual and South Asian MSM to meet, network and chat.

AIDS Committee of Toronto (ACT) - ACT is an organization that runs community-based HIV support services and education, prevention, outreach and fundraising programs that promote the health, well-being, worth and rights of individuals and communities living with, affected by and at risk for HIV/AIDS in addition to generally raising awareness of HIV/AIDS. ACT services include active outreach to gay venues, providing education around prevention that is inclusive of prevention education for HIV positive individuals, as well as online sexual health counseling on major gay cruising sites such as Manhunt.com. ACT also runs programs through their Youth Community education department: Positive Youth Outreach and the Peer Outreach Project (currently under development). Both programs provide peer outreach around sexual health and HIV and safer sex negotiation for young MSM. The Peer Outreach Program is also developing a website which would be informational and youth specific. ACT does not currently offer however BSM specific programs or services to either youth or adults.

Pride and Prejudice Program (Central Toronto Youth Services) – The Pride and Prejudice (P&P) program is a unique counseling and support service offered to all queer and questioning youth under 25. Services are offered to residents of the GTA as part of Central Toronto Youth Services, a registered youth mental health agency in downtown Toronto. P&P offers both individual and group counseling by a clinical team of therapists from the LGBTQ community. Participation in the program takes place through referrals, and group counseling is offered for 12 sessions depending on the needs of the clients.

David Kelley Services (DKS) – This program is delivered by Family Services Association of Toronto and provides individual, couple and family counselling to people who identify as lesbian, gay, bisexual, trans or queer and to persons infected or affected by HIV/AIDS. Though this program works from an anti-oppressive framework and professional counseling services are offered to individuals and families from diverse communities, DKS does not provide ethno-specific services to the African and Caribbean communities.

The Philip Aziz Center – This organization provides home hospice care and support for persons living with life threatening illnesses such as HIV/AIDS. As part of its support program,

spirituality support and group counseling are offered to clients. This spiritual support and mutual aid program works with many MSM of colour, but does not provide support services solely to the MSM or BSM community.

The Substance Abuse Program for African Canadian and Caribbean Youth (SAPACCY) – This Center for Addictions and Mental Health (CAMH) program provides a range of culturally appropriate harm reduction treatments, early intervention and prevention services for African and Caribbean identified youth up to 24 years old. Program staff use an approach that involves meeting clients on their terms at a location of their choice, treating each individual youth as an extension of their geographic community and their cultural/racial community. SAPACCY has made great attempts to outreach to, and be inclusive of the lesbian and gay community, and individuals who may be dealing with addictions and mental health concerns. In addition SAPACCY has committed time and funding for a clinical staff member whose role it would be to attend to the needs of lesbian and gay, black youth. The intention will be to develop and define the context and format of services this clinician will provide based on information acquired through consultation with clients.

1.9. Relevant Local Campaigns

In 2006, two Ontario-based campaigns were launched to address the issue of HIV/AIDS in priority communities.

- The Be Real campaign was the first initiative of the Gay Men's Strategy. The strategy attempts to address the issues of social location and increased risk for HIV transmission within diverse MSM communities. The campaign delivered print advertisements, television and radio advertisements and web resources (www.ru4real.ca). Media depicted a range of ethno-cultural backgrounds and also included the female to male transsexual (FTM) community in prevention messaging. Some informants noted that although Be Real attempted to address a number of social issues and target ethno-racial communities, this broad approach may have compromised its ability to reach high priority groups such as the BSM community.
- Keep It Alive – ACCHO launched this HIV prevention campaign for the African and Caribbean HIV Prevention Strategy (Strategy to Address Issues Related to HIV Faced by People from Countries Where HIV is Endemic), targeting diverse Black, African and Caribbean communities in Ontario. This campaign was the first stage of the ACCHO's prevention strategy and the first campaign of its kind to include a range of images representing this diversity of the community in its media. Informants identified that although there was an attempt at the inclusion of various communities in the prevention messages, this campaign did not represent the full range of BSM identities.

2.0 EPIDEMIOLOGICAL DATA AND OTHER FINDINGS

2.1. Epidemiological Data

As identified earlier, there are significant gaps in knowledge about BSM in Toronto. Analysis and review of the data provided basic information related to the rates of infection in the Black community in Toronto and MSM rates of infection.

Black CAP notes that the following data is not available at this time:

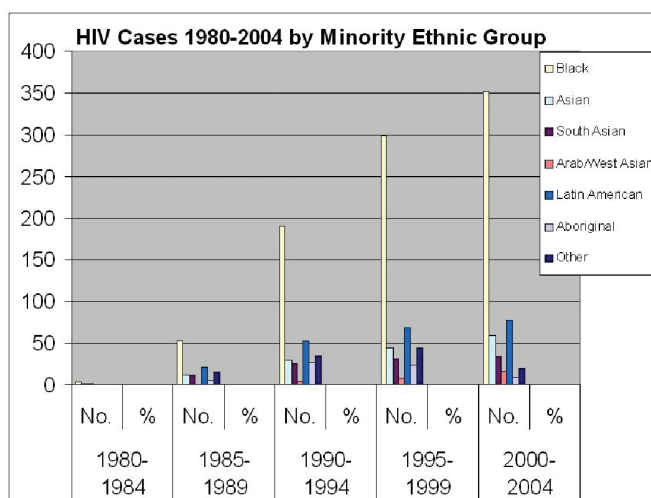
- Data related to geographic concentrations of HIV infection in BSM
- Data related to the age of first testing for BSM in Toronto
- Data related to average age of HIV positive tests for BSM
- Data related to STI and HIV co-infection for BSM

In the analysis of non-BSM related data, we recognize the dynamic nature of HIV infection, incidence, prevalence and so on. This is supported by findings from the Public Health Agency of Canada's 2004 Report on HIV/AIDS in Ontario which state that 'although the proportion of HIV diagnoses comprised by men who have sex with men (MSM) gradually decreased over a 20 year period, from 90% when testing began to about 45-50% in recent years, HIV diagnoses among MSM increased by 38% in 2004 compared to 2000' (Remis et al., 2006). The proportion comprised by persons from HIV endemic countries¹ also continues to increase and new HIV diagnoses in this group were 52 % greater in 2004 than in 2000.

Black CAP also notes discrepancies between heterosexual rates of infection in endemic versus non-endemic communities. Given the difficulty in assigning appropriate exposure categorization of BSM who may not self-identify or who may engage in heterosexual relationships, there is a likelihood that some BSMs may have been accounted for within the HIV endemic exposure category.

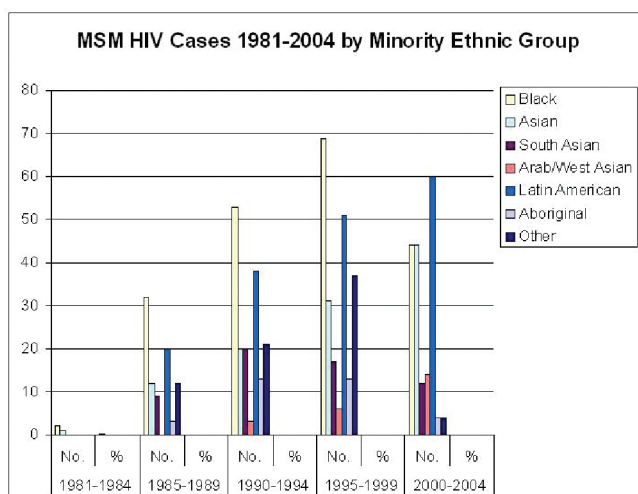
Existing data from OHEMU and Toronto Public Health indicate that BSM account for a significant number of those already living with HIV/AIDS and represent a growing number of new HIV infections.

¹ Definition of HIV endemic: High prevalence of HIV infection in the general population (greater than 0.8%, but may attain 20% or higher); and Heterosexual contact the most important mode of transmission (Remis, 2001).



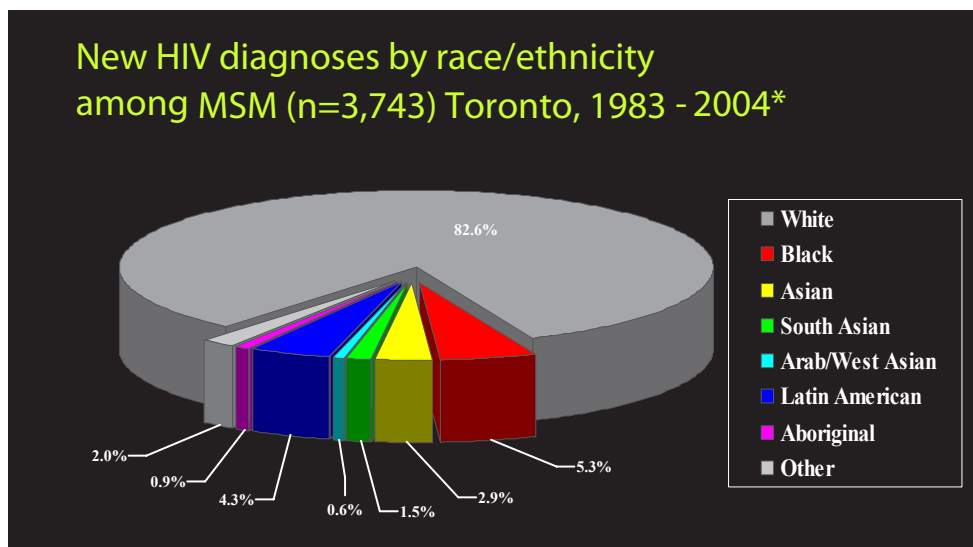
Graph 1: HIV Cases for all minority ethnic groups for the period 1980-2004²
(Remis & Liu, 2007)

- Among Toronto's Black population, overall rates of HIV incidence have been on the rise.
- Out of the 7 identified ethnic minority groups, Blacks account for the highest percentage - 17.2% - of total HIV cases reported in Toronto between 1985 and 2004.



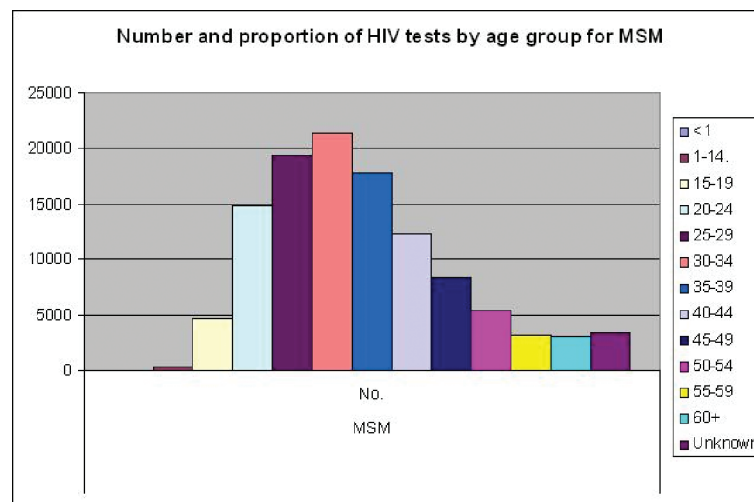
Graph 2: HIV Cases accounted for by MSM within minority ethnic groups for the period 1981-2004 (Remis & Liu, 2007)

- In Toronto, between 1981 and 2004, Black MSM account for the majority of reported HIV cases within the seven identified ethnic minority groups.



Graph 3: New HIV Diagnoses among MSM by Ethnicity in Toronto (Remis & Liu, 2007)

- BSM represent 21.4% of reported HIV cases among Black peoples in Toronto between 1980 and 2004, and 5.3% amongst all MSM (all ethnicities) in that same time period (Remis & Liu, 2007).



Graph 4: MSM Positive HIV Test Results by Age Group (Remis et al., 2006)

- According to the Report on HIV/AIDS in Ontario, since 2001 the incidence of HIV has steadily increased among MSM repeat testers. The top four age groups for MSM HIV positive tests for Ontario in order by number and proportion were: 30 – 34, 25 – 29, 35 – 39, 20 – 24³

³ In the examination of the age groupings of MSM repeat testers in Ontario, it is important to recognize that age of diagnoses does not necessarily correspond to age of infection. With the segregation of categories by five year intervals, some cases of HIV transmission may in fact have fallen into older age groups.

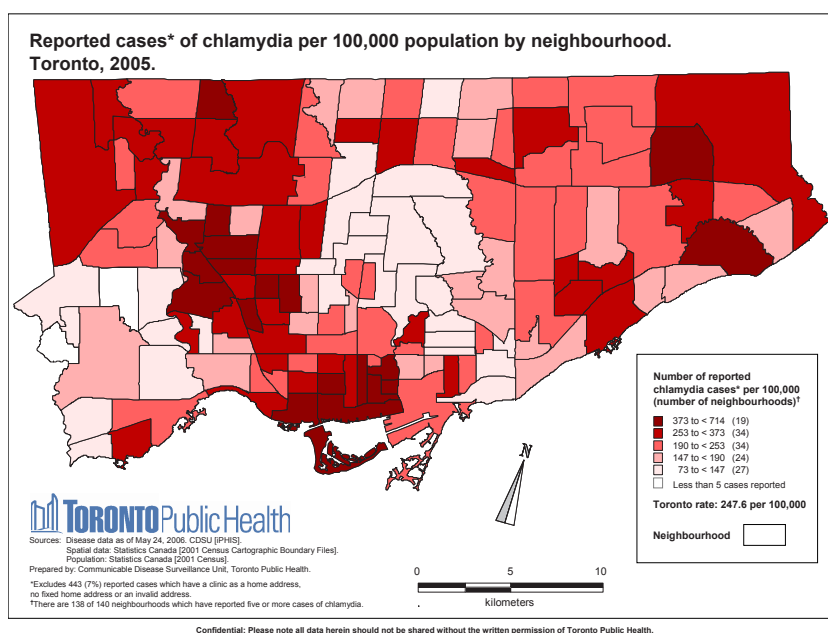
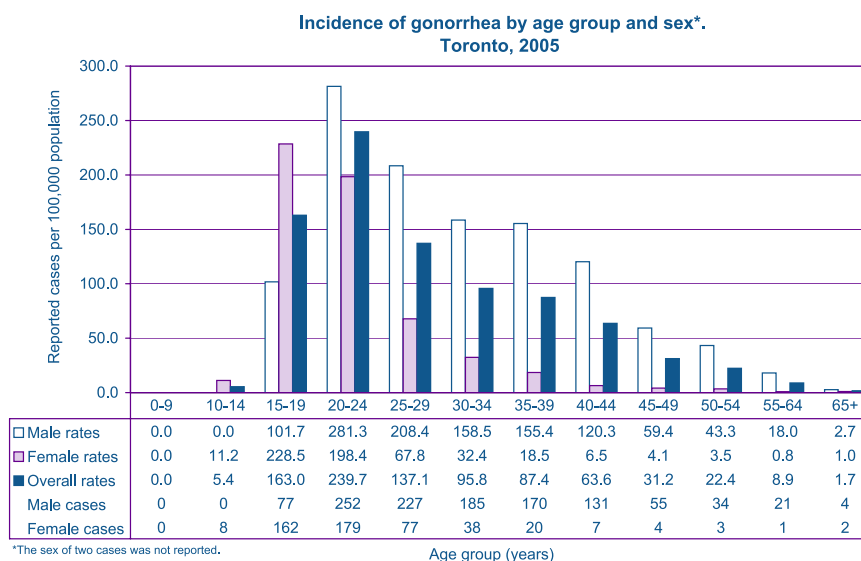


Figure 1: Reported Chlamydia Cases by Geographic Location (Shahin, 2007)

- Most reported cases of chlamydia in Toronto are located in the downtown core and inner-suburban areas (Scarborough, East York, York, North York and Etobicoke).
- According to Ontario Men's Survey, chlamydia is the 3rd most common STI for Toronto amongst MSM.



Graph 5: Incidence of Gonorrhea by Age Group and Sex (Shahin, 2007)

- Incidence of gonorrhea is highest among males aged 20-24 years, followed by 15-19 year olds.

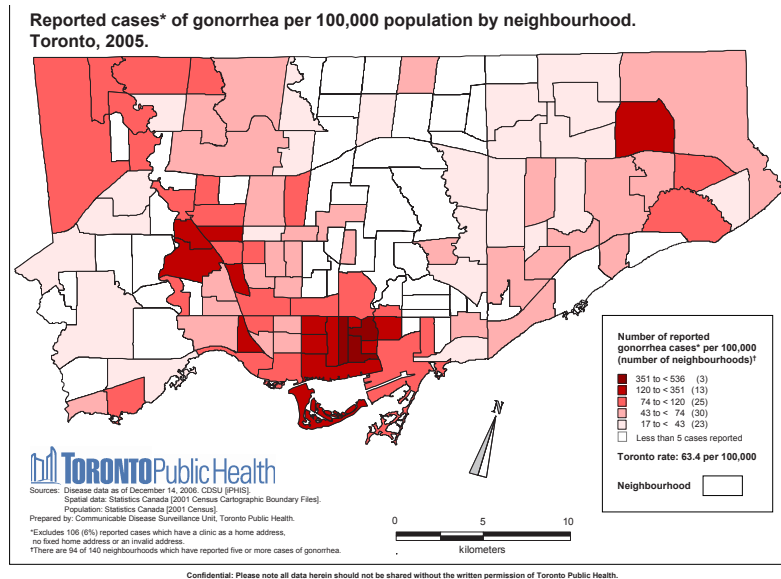
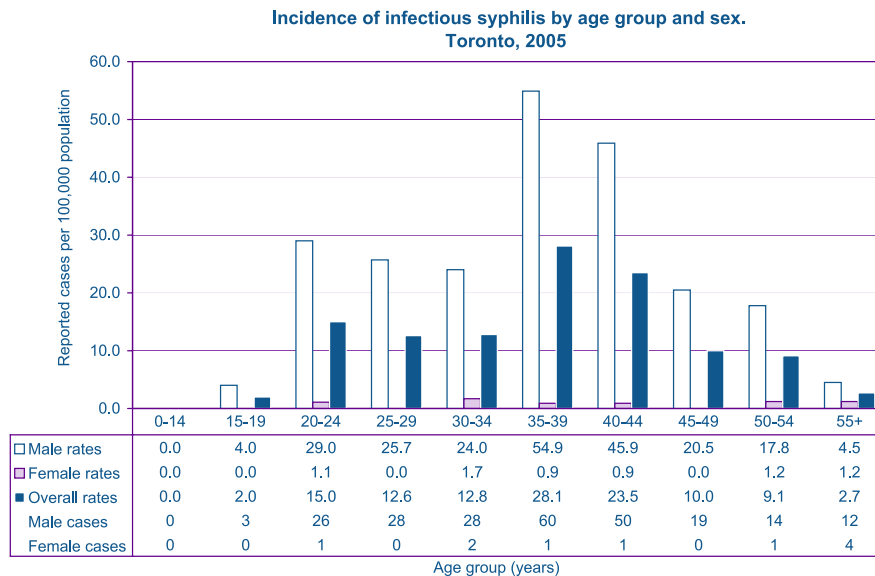


Figure 2: Reported Gonorrhea Cases by Geographic Location (Shahin, 2007)

- Major concentrations of reported cases of gonorrhea are within the downtown core and specific inner-suburban communities.
- Among concurrent STI's which facilitate transmission of HIV, gonorrhea is the leading reported co-infection, followed by chlamydia and syphilis.



Graph 6: Incidence of Syphilis by Age Group and Sex (Shahin, 2007)

- The incidence of infectious syphilis for men is highest in the age groups 30-39 and 40-44.

2.2 Additional Related Findings

Black CAP also considered non-HIV/AIDS and STI-related data that could be instructive in the development of BSM-specific programming. Data was gathered internally and from outside sources including the City of Toronto and the United Way of Greater Toronto.

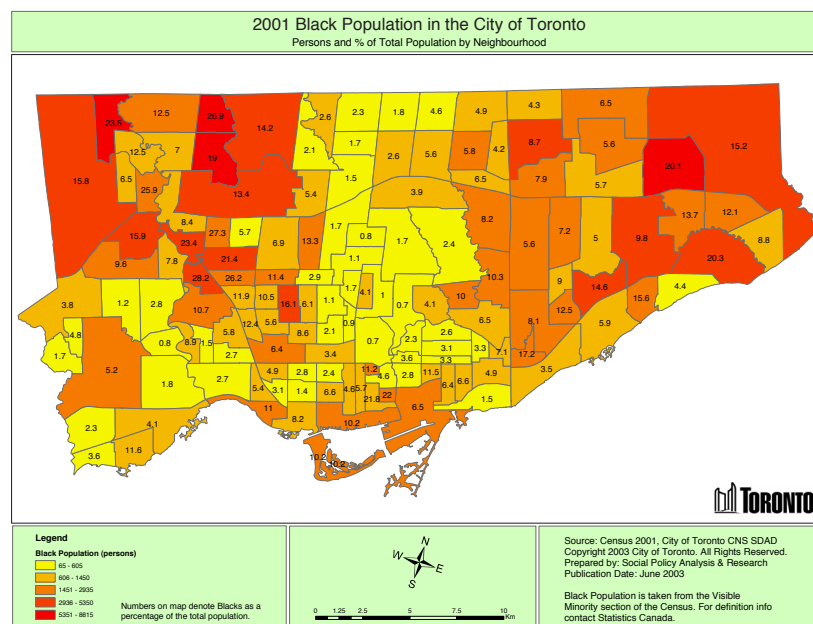


Figure 3: Black Population in City of Toronto (TCHPP, 2004)

- Geographic concentrations of the Black population are both downtown and in several specific inner-suburban communities.

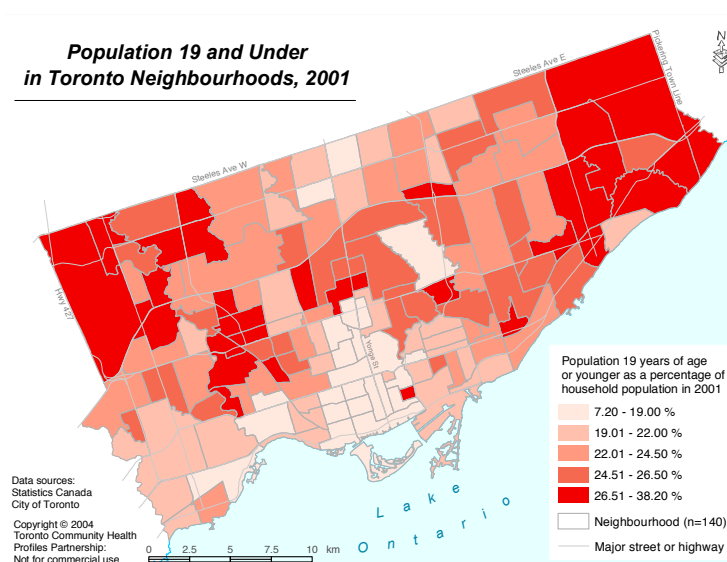


Figure 4: Population 19 and Under in Toronto Neighbourhoods (TCHPP, 2004)

- The areas with a significant concentration of youth aged 19 and under are also the areas with the largest percentage of Black people: mainly inner-suburban neighbourhoods.

3.0 MULTIPLE BARRIERS

Despite the diversity of stakeholders consulted in the development of this report, all participants raised similar observations, namely that gay, bisexual and straight-identified BSM are at heightened risk for HIV infection and should be considered a high priority demographic for HIV prevention work in Toronto. The analysis also identified especially challenging issues faced by BSM related to homophobia, racism, social exclusion and isolation, all of which contribute to increased risk of HIV infection. For the purposes of this report, themes identified from the issues discussed with key informants are as follows:

- Dynamic Identities
- The Challenging Concept of a BSM Community
- The Significance of HIV in the Lives of BSM
- The Significance of Gender
- The Impact of Homophobia and Stigma
- Racism and Social Exclusion
- Gaps in Knowledge and Research
- BSM Possess a Number of Protective Attributes

It is important to note that the themes identified above are inter-linked and no one issue can be appropriately discussed without taking into account others. The order of themes is for the sake of fluidity of thought and is in no way an attempt to assign more or less significance.

3.1 Dynamic Identities

Successful HIV prevention is often focused on specific groups of people who share similar attributes. The epidemiological term MSM, which is so often used to group together gay, bisexual and straight-identified but same sex engaging men, has been the chosen term to frame the range of same-sex sexual relationships entered into by Black men. Several informants indicated that this is a challenging conceptual framework to apply to BSM however. As one key informant noted, “It is important to clearly identify priority populations and identify groups clearly, as the needs, barriers, service gaps and subsequent risks likely differ for these groups.” This raises a significant point – namely that the risk factors for a gay-identified BSM may be different than the risk factors for a straight-identified BSM in terms of how they access services and their exposure to safer sex messaging. As such, identity should be considered in the development of future BSM programming.

Informants commonly highlighted the risk for those men who engage in same-sex relationships but do not define themselves as gay or bisexual. As one informant put it “if a supposedly straight Black man leaves his home to go to pick up a man with a condom in his pocket then he is now gay, because there was some intention there, some forethought. A man who believes himself to be straight does not think about navigating the risks of gay sex. Having sex with a man is something that just happened along his day.” A U.S. report (Peterson et al., 2003) found that among African-American MSM, ‘spur of the moment thinking’ was

identified as a barrier some BSM face when negotiating safer sex choices. Men, who may not identify as gay and who may not actively engage in venues such as bars and clubs where same-sex courting occurs, might be more resigned to spontaneous encounters where there is inadequate preparation and negotiation for use of condoms.

Conversely, there is research that may suggest there is also an increase in risk for those BSM who have chosen to self-identify as gay. Although it is thought that straight-identified MSM may experience lower self-esteem, depression and loss of peer support, it may in fact not always be the case. Straight-identified BSM's ability to "pass" may, in fact, be a protective and preventative factor from social and emotional trauma that some gay-identified BSM may be forced to experience and navigate daily. This particularly may be the case for those who appear to display behaviour that may be coded as effeminate or "gay". The psychological impact that personally identifying or being identified by others as gay on these individuals may also impact their ability to make informed choices around their sexual health.

Prevention methods aimed at MSM must also recognize that language choice can limit the ability of those messages to reach the intended audience. This is in many ways due to the associated stigma and homophobia surrounding words that can identify the recipient as gay or queer. Methods that signal the risk of HIV transmission to gay men are ultimately unsuccessful for these men because the information is thought not to be relevant to the MSM who self-identify as heterosexual men (Parker & Aggleton, 2002).

Though stigma and homophobia do in part inform BSM's formulation of identity, Black men's overall inability to link sexual behaviours with sexual identity cannot be seen solely as a by-product of internalized homophobia and fear of stigma. For some Black men adopting a gay identity is not congruent with the ways in which they view themselves based on culture, race and even orientation. Gay identity, then, just does not fit their perception of who they are culturally and what they do sexually. A Canadian report identified the need for a distinction between internalized homophobia for some MSM and a resistance to adopting a gay identity (NRG, 2001). Gay identity as seen in the media depicts a predominantly white, middle class experience and lifestyle that may not personally resonate for BSM and, in many cases may be unattainable to them. For a number of BSM, gay identity may then be seen as being connected to a particular lifestyle or politic. Recognizing this, prevention messaging must acknowledge that a significant number of BSM may never make the decision to identify as gay or bisexual.

We also recognize that many BSM will also have situational identities. By this we mean that in some settings BSM may identify as straight and in others, may identify as gay or bisexual. For these men, there may also then be negotiation of other identities such as that of father, husband and so forth which may take precedence over what they believe to be only peripheral and less significant relationships. In a qualitative report (Chrichlow, 2003) one respondent spoke to this: "As for married men who have sex with other men I just see it as something they try with no commitment to it. I do not see myself living my life around this gay identity and gay politics."

A recent American study indicated that 20% of the Black men surveyed in gay venues reported having sex with men and women as compared to 12% of Latinos and 4% of Whites (CDC, 2001). Similarly, a study conducted in Michigan found that of the 1,001 HIV positive Black MSM surveyed, 36% reported having sex with women (Wright, 1999). A number of studies also indicate that BSM are more likely than MSM of other races and ethnicities to identify themselves as bisexual and to be bisexually active (Millet et al, 2005). It is important to recognize gaps in knowledge in relation to this question however. The recent Ontario Men's Survey (OMS) indicated that "research conducted to identify and track the behaviours of men who have sex with men then often lack reliability in the examination of Black homosexual behaviours because a significant number of Black men choose to identify as straight, despite engaging in same sex sexual relationships" (Myers et al., 2004). Key informants noted that although there was an overall successful recruitment of Black men, the Ontario Men's Survey was primarily a study of self-identified gay and bisexual men and did not necessarily account for the behaviours of those who lay outside those definitions.

While a number of BSM may not identify as gay or bisexual while still engaging in same sex behaviour, a number of BSM do choose to carry these specific identities and only be involved in same-sex relationships. None of the data indicated that the majority of BSM do not identify as gay or bisexual. Programming cannot lose site of this distinction.

3.2 The Challenging Concept of a BSM Community

Related to the concept of identity is community. Individuals with shared identities make up a community. A key issue identified in many of the interviews is that the "BSM community" exists academically or theoretically and hence, the recognition that there may not be a defined community as such. Similarly to the larger Black communities, BSM are a disparate group in their multi-national, cultural, lingual and nature of social, sexual and gender identification. Along with their counterparts, BWSW (Black women who have sex with women), BSM are at the intersection of race, ethnicity, sexual orientation and gender identification among other varying identities. They have to negotiate the collective challenges of the socio-political issues related to race and culture as with the wider Black communities in addition to navigating heterosexism, homophobia and transphobia inherent in those communities and in the larger society. This complicates the experiences and nature of identification of these men and efforts to form social networks. There is a particular challenge in understanding and accessing non-gay or bisexual-identified BSM. Informants recognized that many currently existing networks are informal and undefined. It was suggested that this may likely be the result of the fragmentation caused by HIV/AIDS in the Black gay community during the 1980's and 1990's. BSM involved in creating formal networks during that period were subsumed by wider community efforts that left little space to nurture fledgling BSM community building efforts. Moreover, HIV/AIDS was responsible for taking the lives of many men involved in community efforts, creating a significant gap in leadership.

Stakeholders consistently recommended that in order to be successful, HIV prevention activities for BSM should attempt to reach all levels of the community. They also identified the importance of connecting to and understanding the range of social networks BSM

access for sex, friendships and relationships including web-based networks. It must also be noted that while social networks for Canadian BMSM have always extended outside of Canada and into the U.S., social networks for Canadian BMSM increasingly extend into the United States in part due to the greater accessibility of the Internet. This phenomenon may also be related to the contrasts between the more visible and vibrant BMSM communities in the U.S. and the local BMSM community. Easy accessibility to these communities may pose a unique risk for Canadian BMSM as their social and sexual networks increasingly include American BMSM for whom rates of HIV prevalence may be significantly higher. That being said, programming needs to recognize the importance that these social networks have in the lives and health of BMSM. Strong social support networks are known to act as buffers against poor emotional, mental and physical health according to the SDOH outline by the Public Health Agency of Canada (2003).

Several key informants also commented that many BMSM may not have an interest in, or feel particularly welcome, in the dominantly white or European defined and influenced mainstream gay and bisexual community. A number of key informants highlighted the issue of racism within the mainstream queer community whether in the form of overt acts of exclusion and discrimination or through sexual objectification.

Without ongoing support in the queer Black community due to lack of any community structure and in addition the experience of racism within the dominantly white queer community, little room is left for BMSM to develop a healthy and integrated sense of self that unites their Black and MSM identities. It was suggested that many BMSM may then default to their community of origin which often rejects same-sex relationships and may be homophobic, thus causing a prioritization of oppressions leading many BMSM to reject, repress or compartmentalize their sexual identities. This default may also take place for BMSM who choose to self-identify as gay or bisexual. Pressure to assimilate into the “mainstream” queer community may cause these BMSM to reject, repress or compartmentalize their racial identities. Either process has the potential to further restrict the development of identity for BMSM, who must often balance a number of conflicting roles and identities.

3.3 The Significance of HIV in the Lives of BMSM

Given the scarcity of BMSM-specific programming one can question the availability and accessibility of HIV related information and supports. Informants indicated that:

- Testing has not been significantly promoted among BMSM in Toronto and no HIV testing campaigns have specifically focused or targeted BMSM.
- There are limited BMSM specific HIV prevention education activities in Toronto.

This speaks to the importance of the developing new, responsive and innovative programming and also speaks to the depth of the challenge faced by organizations developing BMSM prevention programming. In addition, little is known about the contributing factors which place BMSM in Toronto at heightened risk for HIV infection.

An American study examined the nature of the relationships of African-American MSM to try to explain higher rates of infection despite lower rates of risk behaviors compared to other gay men. They examined partner characteristics using the Los Angeles County Young MSM Survey (YMS) and concluded that young African-American MSM were more likely to have older and predominantly African-American partners. The study also suggested that being the older partner, for example, may confer greater perceived power in a relationship, resulting perhaps in a greater likelihood of these young men acquiescing to requests for unprotected sex. Older men are also more likely to be HIV infected given their longer histories of risk exposure (Mays, Cochran & Zamudio, 2004). Conversely, a Canadian report made note that older HIV negative MSM may also be at risk of HIV transmission as they may be more likely to trade negotiating safer sex for opportunities to be with younger partners (Adams, 2006). Either way, prevention programming would benefit from research that tries to understand how relationships of BSM either put them at risk for HIV infection or can be used as a protective force in maintaining a HIV-negative sero-status.

The YMS Survey also noted that 32% of non-identified BSM youth reported having had unprotected intercourse with male sexual partners in the past six months, compared to 41% of gay identified youth. Of the straight-identified young BSM, 23% reported having had unprotected sex with a female partner in the last six months and identified that their primary sexual partners were female. Of Blacks, 27% of straight-identified youth had had a previous sexually transmitted infection versus 21% of gay-identified youth. In addition, 29% of straight-identified BSM had had an HIV test versus 24% of gay-identified BSM.

This report also indicated that to reduce HIV/STD transmission among young MSM and their female sex partners, comprehensive HIV/STD testing and prevention programs for young Black non-disclosers should be developed or expanded. Another study indicated that rates of risky sexual behavior by African-American MSM compared to their white counterparts were not higher despite the higher rates of seroprevalence (Mays, Cochran & Zamudio, 2004).

The data identified in this section highlights the importance of understanding the social conditions of BSM, where they find relationships and the specific choices they make within those relationships. As was mentioned earlier it may also be important to examine the relationship between BSM, unsafe sexual health choices and few defined social networks for BSM to access.

We also recognize that the Ontario Gay Men's Prevention Strategy has highlighted the importance of positive prevention and has identified the inclusion of HIV positive males in prevention activities as an important approach in reducing HIV infections for sero-negative men and cross infections for sero-positive men in the MSM community. The Poz Prevention working group is a sub-Committee of the Gay Men's Strategy Committee whose role is to ensure that future approaches to prevention strategies acknowledge the importance of including HIV positive men. Recognizing this, prevention campaigns must ensure that health promotion messages be relevant to sero-positive individuals as well as include information on specific risks for sero-positive BSM.



Future HIV/STI prevention campaigns should also recognize that the promotion of activities, including education and testing, could result in an increase in HIV/STI tests and positive test results. Health services and ASOs must be prepared to respond to the potential increase in demand for services by BMSMs who have tested positive.

3.4 The Significance of Gender

Gender plays an important role in how BMSM choose to define themselves, how they may approach relationships and the significance of gender roles in the broader Black community. We also recognize the links between gender and homophobia, that is, masculine and feminine archetypes inform how communities and individuals view others who do not conform to these archetypes. It is also important to recognize that BMSM will be placed somewhere on the scale between hyper-masculine identities and more feminine ones and that ones position on this scale may bring with it a range of vulnerabilities and risk, or perceived power and privilege.

Men often define themselves through their manhood or masculinity, defining their masculinity through the fulfillment of performative roles such as father, provider and protector. Unfortunately, for many Black men, barriers such as racism and poverty have negatively impacted their ability to fulfill these roles of 'provider' and 'protector' adequately (Husbands, 2006). As a result, many Black men may overcompensate in their roles to deal with feelings of emasculation. For instance, this could result in the adoption of and adherence to hyper-exaggerated sexual role performance. This hyper-masculine, hyper-sexualized behaviour could lead men to engage in casual and/or unprotected intercourse. For many, opting into this hyper-masculine ideal may be a method of survival from emotional, or, in many cases, physical violence.

In Buller Men and Bwatty Bwoys (2003), Wesley Chrichlow identified the adoption of such protective roles. He indicates that for some Black men, coming out is unnecessary. For others, it isn't an option because it would threaten their family, economic, psychological and community ties. Some are breadwinners and coming to terms with a same-sex identity might feminize them, thus distracting or inhibiting them from earning a living. This idea of overcompensation is then even more present in the realities of these BMSM who must take on such hetero-normative behaviours and attitudes in order to remain a part of, and protected by, their cultural communities.

This fear of being feminized or emasculated may also play out in the ways Black men navigate their relationships. For BMSM who do not fit these gender norm expectations, the risk of social exclusion as well physical and emotional safety becomes very real. It was also suggested that there is an acceptance of BMSM who present as fulfilling the prescribed roles and expectations. This dynamic leads to a number of outcomes, including the 'homo-thug' culture, widely examined within U.S. media. This particular sub-culture of BMSM in the United States has built an identity around their involvement in hip hop culture and by adopting hyper-masculine role structures and identities, which may be in opposition to stereotyped notions of effeminate homosexual gender expressions.

The unfortunate result of this subculture has been the transfer of gender role norms to same-sex relationships. For instance, less dominant partners viewed as less than worthy due to an inability to fulfill their gender roles are at risk for abuse. This behaviour among some BSM has not developed in isolation however, and is linked to gender inequality and sexism. Violence within these BSM relationships may parallel abusive relationship dynamics in some male-female partnerships. This transference of oppression also put these men at increased HIV risk due to their inability to negotiate safer sex choices with their same-sex partners for fear of exclusion from the protective factors of being partnered with these “masculine” men who may act as a buffer from the often very real physical and emotional violence experienced from the outside community. A U.S. report (Wilchins & Taylor, 2006) found that youth who were non-gender conforming were at increased risk of physical assault and murder. Of the youth murdered in the last decade, most were gay or trans identified and 85% were African American or Latin American. The report noted that there may in fact be an important connection between race and gender-conformity that leaves these individuals at significant risk of violence.

With this said, it is important to make mention of the virtual invisibility of the transgendered community in our analysis of this issue. While we recognize that gender becomes even more complex in this instance, it is important to recognize that transgendered men should be considered as BSM prevention activities are developed.

3.5 The Impact of Homophobia and Stigma

Homophobia (and heterosexism) in Black communities is pervasive, highly misunderstood and rarely discussed. Homophobia was also identified throughout the key informant interviews as especially significant and an issue to be considered in developing effective HIV prevention programming. For a number of BSM, the decision to remain identified with their communities of origin often also means accepting community restrictions on sexual expression. An exceptional level of homophobia and heterosexism has been identified in a number of African and Caribbean Black communities, notably in a report on HIV and African and Caribbean Women (Tharao, Massaquoi & Teclom, 2004). These views were predominantly based upon religious beliefs which tended to view homosexuality as a moral aberration.

As identified by informants in the study HIV/AIDS Stigma, Denial Fear and Discrimination (Lawson et al., 2006), people in the Black community do not want to be seen with men whom they perceive to be gay and Black gay men are not safe in certain parts of Toronto unless they can “pass as straight.” One participant mentioned that discrimination is more strongly related to being gay than to being HIV positive. Some participants described reduced family support because they are gay. Being gay and HIV positive can result in extreme levels of exclusion or isolation. Another report takes this further:

“African and Caribbean cultures were viewed as inherently homophobic, a situation that was fueled predominantly by religious beliefs and values. Those who found homosexuality taboo, unacceptable and/or termed it a moral aberration based such opinions on what their religious faith said about a gay sexual orientation. Some communities reacted quite violently towards those who were or were suspected to be gay. All research participants indicated that same sex partnerships/ relationships were unacceptable in their communities, a factor that resulted in most gay men choosing to maintain heterosexual relationships as a cover up.”

(Tharao, Massaquoi & Teclom, 2004)

As discussed earlier in the report, for many Black people identity is rooted in cultural affiliation. With any affiliation comes the expectation that there will be an observation of cultural norms and mores. As the definition of community implies, the individual must navigate themselves as part of a larger unit. In order for that unit to maintain its cohesiveness, there may also be a policing of those within to ensure the observance of those cultural expectations. Even with this “policing” of cultural norms, there is a hierarchy of offences. In Black communities, homosexuality may place quite near the top of this list. Stated one key informant, “In the Black community you can more easily be pardoned of murder than you can of being homosexual.”

Reasons for this may be due partially to strong faith-based value systems central to many Black communities or perhaps due to long held survivor instincts of self preservation resting in our communities’ need for procreation. Homosexuality may be more a cultural offence to Blacks than a religious one. Cultural norms, which may be religiously offensive such as premarital sex, may be more likely to be overlooked or accepted when compared to homosexuality. Behaviours, attitudes and belief systems that meet these cultural expectations are then accepted and, in many cases promoted, because they serve this primary purpose. Masculine gender expectations in the Black community may meet this purpose by seeming to protect the Black family unit from perceived deterioration. Those individuals who fail to meet these expectations are not only seen as affecting themselves but then a larger community of individuals who rely on each individual’s maintenance of their assigned roles for the preservation of the overall unit. This failure is often met with judgment, shaming and ostracism from the community, and the labeling of the offender as ‘other.’

It is also important to note the roles religion and faith play in the lives of many Black people including BSM. Many discussions around the construction of identity and values for those in the Black community lead back to the church. Elijah Ward, in his report on Homophobia and the U.S. Black Church (2005), spoke to the spiritual, emotional and social roles Black churches have held and their empowerment of Black peoples during and following the time of slavery. The church’s history as a place of knowledge and community sharing has continued to be relevant for Black peoples across various social and economic strata as a source of reverence. Unfortunately, ‘Traditional religious values reinforce the assertion of negative masculine attitudes and support the marginalization of women from all but their traditional roles. Religious influence also fosters intolerance towards gay and lesbian sexuality in the Black community’ (Achilles Heel, 1992). This intolerance towards gay and lesbian communities in some instances results in the violent expression of these beliefs by

some within Black communities.

Though this cultural atmosphere of homophobia may be due in part to religious intolerance, a number of additional factors have contributed to this environment. As Wesley Chrichlow (2003) emphasizes, the merger of both religious moralizing and a particular Black consciousness rooted in a perceived struggle against white domination and a racial survivalism has also created this divide between same-gender loving men and their Black identity.

When examining risk and possible correlations to self-identification, one must also note the role homophobia plays in both how one chooses to identify oneself and higher risk behaviours. Several informants identified the direct link between HIV infection rates and homophobia. This almost causal relationship requires that any successful HIV prevention intervention programming recognize both the impact and roots of homophobia and the negative outcomes which result. Social service agencies working within Black communities may be unaware or ignoring the realities of gay, bisexual and transgendered BSM. Homophobia within these institutions can create significant barriers for BSM as they attempt to access health and other related services.

3.6 Racism and Social Exclusion

As identified earlier, BSM identity is often multilayered and complex. One cannot examine the concept of multiple identities without taking into account the experiences that inform the construction of identity. Within this report we have focused on a number of factors within the Black community which contribute to the significant challenges faced by BSM. We however also recognize the significant and pervasive structural barriers that BSM face due to racism and social exclusion. BSM must often navigate traumatic socio-emotional experiences created by barriers such as racism, poverty, under-employment, lack of access to formal education, access to health care, trauma and the threat of violent crime. All of these factors may limit the ability of these men to address other less immediate concerns such as HIV infection. Sexual health interventions, then, must address social marginalization based on race, class and other intersections and how their location informs how individuals make choices around safer sex within their lives.

In the Gay, Bi, MSM Situation Report (Adams et al., 2006) coping with racism was identified as a significant social factor and subsequent barrier for Black MSM. Adams writes of the importance of social belonging as a means of navigating the effects of marginalization. Based on their experiences, it is less likely that Black gay, bisexual and other MSM will feel this sense of belonging in either their own communities or in the mainstream gay community. And, as a result of social and economic exclusion, may be more likely to experience substance (ab) use, mental health problems and so forth. In an American journal, Myrick (1999) identified the consequences of racism, that many African-Americans living in urban areas face multiple threats to their survival and these conditions take precedence over issues of sexual identity and HIV prevention. If a person is dealing with locating food and shelter or coping with the crippling effects of substance abuse, the only messages of any importance are those that help solve immediate needs for survival.

The detrimental effects of racism and economic exclusion on the mental well being of individuals have been widely documented. Coping mechanisms such as substance use and misuse may impair negotiating condom use and/ or selecting appropriate partners who will support safer sex options. Furthermore, repeated exposure to homophobia and related forms of social isolation may be triggers for mental health issues such as depression or anxiety. Such conditions as a result of said social isolation may lead some BMSM to substance use as a form of release and self-medication. In the presentation *Oppression, Black Men who Have Sex with Men and HIV*, Malebranche (2003) makes a direct link between poor mental health, personal risk behaviours such as unprotected sex, utilization of health resources and finally a person's ability to seek testing or treatment.

For youth, these barriers are then added to the challenges many already face. According to the SAPACCY program, of clients seen between 2003 and 2007, over 60% reported experiencing Post Traumatic Stress Disorder as a result of an individual loss and community displacement, and 20% of youth accessing this program report experiencing depression. Young MSM in particular are at increased risk for depression and attempts at suicide in comparison to their straight counterparts (Russel & Joyner, 2001). Compared to other age groups, youth of all ethnicities are more prone to experiences of poverty, disenfranchisement, homelessness, inadequate social support, depression, low self-esteem and substance abuse - all factors that increase risk around sexual health choices and the ability to negotiate healthy behaviours with partners.

Of particular concern when examining youth is that sexual health risks are then increased because of their isolation from protective family or community structures. Gay-identified youth who are forced to leave home due to violence or ostracism may be more likely to end up on the street. According to a report by the U.S. based National Gay and Lesbian Task Force and the National Coalition for the Homeless, a large percentage of youth living on the street self-identified as gay or lesbian (Ray, 2006). The report also found that many homeless gay youth are found to resort to "survival sex" in order to take care of basic needs.

Recent newcomers (immigrants and refugees) experience gaps in access to services caused by linguistic and cultural differences, placing these individuals in vulnerable positions that may lead to higher risk sexual choices. In Planned Parenthood's report *Improving Access for Newcomer Youth* (2005) both youth and service provider key informants noted that sexual health issues are foremost of concern for young newcomers. Services that are offered to newcomers often focus on status and immigration concerns or cultural adjustment and may not take into consideration the difficulties in adjustment related to sexual orientation issues. Some newcomers may not feel comfortable disclosing their orientation as MSM for fear of discrimination. This fear, often tied to a concern for confidentiality, is a common feeling for newcomers who access services offered by members of their communities of origin. For newcomers accessing LGBT-sensitive services outside of their community of origin, language barriers, cultural differences and discrimination are then issues. These BMSM are then forced to choose between services that meet their cultural or linguistic needs and those that address their sexual health and lifestyle concerns.

3.7 Gaps in Knowledge and Research

It is also important to note the significant gaps in knowledge and understandings of BMSM. A report by the Ethno-racial MSM Research Working Group recognized that there was a significant deficit in ethno-specific research surrounding MSM (Meulen et al., 2006). In this document, institutionalized racism was identified as a pervasive and underlying reason for the lack of interest in, or support for, research about people of colour and BMSM. Conversely, a significant amount of research devoted to the experiences of white gay and bisexual communities has been used to create existing models of HIV prevention, models that have been somewhat less successful in reaching those communities outside this reference group.

“Measures, surveys, and instruments may be culturally inappropriate for BMSM; interviewers may not be race and gender concordant with or may not be properly trained to interview BMSM; instruments may use language or terminology that does not resonate with BMSM; research settings may not be comfortable environments for open discussion with and responses by BMSM.”

(Malebranche, 2003)

The report also called for more qualitative research within the BMSM community, taking place in safe spaces in order to openly discuss issues such as sexuality and sexual health. From this research more culturally relevant techniques could be designed.

That being said, the effects of racism on Black communities have also created a sense of unease and mistrust of research and researchers. For communities that have historically faced stigma and marginalization, the collection of data that may cause further discrimination and marginalization is highly scrutinized. For gay Black men whose experience with racism alone is often cause for feelings of stigma and marginalization, the added effects of homophobia and, in the instances of sexual health data collection, HIV and related STI stigmatization may likely come into play. In the study HIV/AIDS Stigma, Denial, Fear and Discrimination (Lawson et al., 2006), many participants identified the issue of African and Caribbean peoples being labeled ‘carriers of disease’ - and HIV in particular - from those outside the community. Conversely, from within the Black community, HIV was identified and stigmatized as a “gay disease.” Clemon George labels this the ‘The Triple Whammy’ in his presentation Advancing a Research Agenda for Effective Work on AIDS (2006). The impact the label “diseased” on individuals within communities can thereby be felt triple fold for BMSMs already navigating popular assumptions based on their communities of origin, their race and finally, their sexual orientation. While we recognize the work of ACCHO in this area and their plans for deeper exploration of these issues, very little instructive data exists to guide an evidence-based approach in the development of Toronto-specific BMSM programming.

3.8 BSM Possess a Number of Protective Attributes

We would also like to highlight that the majority of data and information gathered through interviews focused on deficits related to and challenges faced by BSM. It is clear that BSM experience significant challenges in their lives, must survive in predominantly hostile environments and that these issues have significant negative outcomes. However, it was particularly difficult to locate information which identified the protective factors or assets possessed by BSM, attributes such as the high levels of resiliency BSM must possess as a result of living and surviving in oft hostile environments. It is our assumption that survival in such settings must result in the acquisition of some skills and capacities. For instance is it possible that BSM acquire especially effective negotiation skills, are uniquely sensitive to certain forms of danger and risk and have created ways of navigating them. If Black CAP plans to initiate new HIV prevention programming for BSM, it must consider an approach which recognizes that BSM possess a range of assets, and have developed a unique adaptability and resiliency.

4.0 EFFECTIVE PROGRAMMING STRATEGIES

In order to effectively reach men, BSM HIV prevention messages must go beyond gay-identified spaces to reach men who may not access information or supports in these settings. Forums relating to MSM issues in Toronto are often delivered in gay-identified venues within the downtown core, which by virtue of their location limit attendance to individuals with existing relationships or comfort in the downtown gay community. Such settings may not be particularly welcoming or inclusive of MSM who engage outside of this identified community. One key informant recommended that service providers create inclusive spaces that allow for straight-identified MSM to share their understanding of their needs. The challenge however is to locate this group and make environments where their feedback can be sought.

HIV education strategies must not only disseminate information, but also be proactive in identifying and then dispelling inaccurate beliefs that influence risk-related behaviours. Two evidence-based strategies have been implemented in the United States with these very goals in mind. The first is the Critical Thinking and Cultural Affirmation Model (CTCA) (Amassi, 2006). The CTCA model uses a social cognitive theory-based approach to HIV risk reduction and prevention. This intervention implements a culturally relevant curriculum that addresses the impact of societal challenges on BSM such as racism, peer pressure, disenfranchisement as well as barriers such as substance (ab)use, HIV, mental health and violence. The objective of this model is to reduce and prevent various risk-taking behaviours in the Black community, through education and empowerment. The CTCA model was developed by Cleo Manago at the AMASSI Center (African American Advocacy, Support Services and Survival Institutes) in Los Angeles. Core elements of the model include providing wellness services such as individual counseling, education sessions, wellness workshops, mutual aid support, and healthy living and wellness planning. Services are provided using culturally sensitive and competent staff as well as social network leaders trained to identify and recruit program participants. This model also looks at the total health and wellness

of Black men and acknowledges the unique health issues facing marginalized Black gay and bisexual men. It is also part of a broader mainstream network of health and wellness organizations and initiatives.

The second is the Popular Opinion Leader Model (POL) (CDC, n.d.). The POL model is based on the theory of Social Diffusion and uses opinion leaders within targeted social groups to disseminate risk reduction information around sexual health. This model was initiated at the Center for Disease Control, was developed specifically for at-risk MSM, but has since been implemented with various high risk target groups. A POL modeled program uses identified target community leaders trained to deliver accurate sexual health information to their peers conversationally in informal settings. The idea here is change risky sexual norms and behaviours in their communities by challenging misconceptions and disseminating factual information.

Both models focus not only on the provision of information, but dissemination and skills-building for change. It is extremely important that social marketing prevention campaigns also take into account the limitations of previous behaviour modification campaigns such as the infamous “Just Say No” anti-drug use campaign popular in the 1980’s and 1990’s. Attempts at simply promoting condom use and/ or HIV testing need to be part of a larger message about sexual health and risk location. “Knowledge-attitude-behaviour (KAB) studies are based on an assumption that changes in behaviour result from knowledge and attitudinal changes. The assumption overlooks the unconscious filters which intervene between media AIDS campaign messages and peoples reading of these messages” (Joffe, 1993). This point was further supported by the best practices report from the Two-Spirited Peoples of the First Nations in Ontario, which identified that though the level of sexual health knowledge in the Aboriginal communities was high, this was not an automatic translation into safer sexual behaviours in the community (Thoms, 2007). It is important that interventions not only provide factual health information, but also tools, resources and opportunity for skills practice that take into account the social contexts of the target group.

When examining the lack of success in some social marketing campaign strategies, print material tools that do not represent the group being targeted can often be dismissed as being irrelevant by those for whom the message is intended. This was an issue addressed in the Vancouver-based Assumptions HIV Prevention Campaign for gay men engaging in unprotected anal sex (Trussler & Marchand, 2005). The campaign, which challenged popular assumptions held by men, was successful due in part to its use of practical language, coupled with bold and challenging images. Poor choice of language, context of the scenarios depicted and choice of models or characters in prevention materials can limit the efficacy of those messages, especially amongst youth. The Keep It Alive Campaign also recognized the need to use images that represented the range of communities in Ontario’s Black communities and made significant attempts to recruit models depicting different ethnic groups and lifestyles. The difficulty increases however, when attempting to include images that represent a range of BSM identities. Prevention campaigns must incorporate creative ways of depicting BSM that are bold and engaging. A study through the Center for Interdisciplinary Research on AIDS - Yale University, looked at the development of appropriate prevention messaging for social marketing campaigns for urban at-risk youth in

Connecticut. The study conducted eight focus groups with youth to assess demographic, risk and general HIV knowledge. The youth were then consulted on what types of prevention messages they felt would impact them most. Results from the focus groups indicate that the youth responded best to storytelling and humour accompanied by colourful, graphic images (CIRA, 2007).

As programming for BMSM is being developed, it must ensure that messages are also tied to identities. As a key informant put it, “Prevention strategies must be unique and must be different from gay men. It (BMSM) is not the same demographic, is not the same language, or behaviour.” This is especially significant when dealing with BMSM who do not identify as gay or bisexual because images and language that do not speak to their experience, reflecting instead the community of gay and bisexually identified men, are ineffective. With this in mind, BMSM-focused campaigns should address sexual behaviours that BMSM are engaging in, as well as the accompanying attitudes and beliefs which ultimately influence the choices they make.

Effective campaigns also paired information related to risk reduction with alternatives that are contextually reasonable and identifiable for BMSM. It is also important to recognize that in many instances risk reduction - and not risk prevention - may be a more achievable goal for this group. The Gay/Bi/MSM Situation Report (2006) observes that MSM HIV transmission risks are in large part due to the social systems and networks that have developed over time for MSM, often in defiance of societal judgment, persecution and shame. Without confronting larger macro-level social systems that facilitate HIV transmission, campaigns must attempt more realistic and achievable change expectations. A campaign looking to reduce overall transmission rates within a group might need to look instead to simply increasing testing within its’ target group. The intent then would be increased awareness of HIV status; with this, changes in unprotected sex with uninfected partners may decrease. This, then, is not about prevention of all transmission, which is unrealistic and does not take into account the multiple situational occurrences that facilitate transmission, but instead looks to reduce transmission.

Addressing the needs of gay, bisexual and straight men who have sex with other men is a difficult task given their unique locations and choice of identities. Campaigns must meet these different sub-groupings of men in spaces that are common to all, and where there is opportunity for dissemination of information. A number of key informants identified the Internet as a primary venue for MSM to socialize and/or negotiate sexual relationships with other men. Statistical analysis repeatedly finds a positive association between Internet use and unprotected anal intercourse (UAI). However, further investigation shows that it is not so much that the Internet “causes” UAI but that sexually active men, including those with higher rates of UAI, seek partners through the Internet (Adams, 2006)

Recognizing this, U.S. web-based campaigns have begun to target MSM who use the Internet to meet anonymous sex partners. These Internet sites use a compilation of HIV/AIDS facts and local resources, deliver brief sex health counseling and provide referrals to clinics for MSM. In addition, some such campaigns have offered training opportunities to sexual health counselors on delivering brief interventions via the Internet. Toronto-based ethno-

specific prevention campaigns such as ACAS's I Rice Internet sex counseling program and ASAAP's Dosti online information, counseling and networking site have proven very effective in using this same medium within their respective communities. Campaigns attempting to reach BSM communities must look at the Internet as a possible opportunity to create safe spaces for BSM youth. Currently there are no Canadian web sites for BSM specifically. Popular U.S.-based sites frequented by young BSM are Downelink.com, BlackPlanet.com and Adam 4 Adam. Com. This may be an area of intervention for an HIV prevention campaign following formats such as Facebook.com which both traces and tracks the social networks of individuals and could also be a possible future direction for BSM research and programming.

5.0 RECOMMENDATIONS

Through analysis of key informant feedback, assessment of epidemiological data and review of effective programming, a number of recommendations have been identified. Future programming, initiatives or campaigns for BMSM in Toronto must be integrative and holistic in their approach. Programming must also address the multiple experiences, needs and barriers of the BMSM community, recognizing the dual locale of members in both the Black and MSM community and the difficulties experienced navigating that dichotomy. Recognizing this, it is important that programs or initiatives be created to address the needs of Black, MSM youth who may not have access to relevant and accurate sexual health information that specifically relates to their social location and cultural context.

The following are recommendations for the development of Black CAP's BMSM HIV Prevention Program:

- Prevention programming should recognize the geographic concentration of Black communities and STI infections in Toronto, and focus programming appropriately.
- Prevention messages must be delivered outside of “gay”-identified venues and areas outside the downtown core, as well as within “gay”-identified venues.
- Programming should prioritize targeting BMSM youth between the ages of 16 and 29 years of age who engage in risky behaviours.
- Collaborate with existing agencies, institutions, strategies and campaigns already addressing related issues such as mental health, substance use, anti-violence, anti-homophobia and so forth.
- Consider the use of social marketing campaigns and link with popular media outlets and related service sector agencies working with youth.
- Support the development of social networks of BMSM in Toronto through the creation of safe spaces such as groups, BMSM-focused events and the development of web-based networks.
- Ensure that a range of BMSM (age, orientations, HIV status) are involved in the programs development, implementation, and evaluation process in practical and tangible ways.
- Make visible the varied experiences of BMSM using imagery reflecting a range of masculinities, ethno-cultural backgrounds, sexual orientations, age ranges, and roles/identities within the BMSM community.
- Ensure that messages do not exclusively use the labels gay and/or bisexual in prevention materials.
- Include/ integrate messages focused on reducing homophobia and gender-based discrimination into sexual health and HIV prevention campaigns.
- Ensure health promotion messages include information on specific risks for sero-positive BMSM.
- Focus on identifying risky behaviors, and not risk categories such as Black and gay, in prevention materials.

- Include messages which focus on attitudinal change and skills building, as well as providing basic prevention knowledge from a harm/risk reduction framework.
- Provide basic sexual health knowledge while also attempting to develop the skills base for participants to act upon this knowledge.
- Support or conduct BSM related research and evaluation to add to understandings of BSM in Toronto.

Additionally, other recommendations identified by key informants are beyond the scope of this report. However, the following recommendations should be considered as part of a broader strategies to address the needs of Black gay, bisexual and straight-identified MSM:

Future Programming

- Collaborate with partners such as Toronto Public Health, ACCHO and Hassle Free Clinic to implement a targeted HIV/STI testing campaign for gay, bisexual and straight identified BSM.
- Black CAP should consider a process to prepare for potential increases in demand for services by gay, bisexual and straight-identified BSM who have tested HIV positive.

Research

- Black CAP should support or conduct BSM-related research and evaluation to add to understanding BSM in Toronto.
- Research should be conducted to investigate gender role norms, gender inequality, sexism, homophobia, cultural norms and values and possible links to sexual risk taking behaviours in Black gay and bisexual men.
- Pursue collaborations with funders and research institutions to ensure the needs of gay, bisexual, and straight-identified BSM are included in HIV/AIDS research initiatives.

Advocacy

- Focus on integrating social justice and social marginalization issues (race, class, culture, gender) and other intersections linked to the social determinants of health into HIV/AIDS advocacy, education and support programs.

6.0 AREAS REQUIRING FUTURE EXPLORATION

Through the consultation process Black CAP also identified a number of related issues which require future exploration and response. While these issues may not have been identified in the majority of interviews, or significantly present in the literature, we would like to recommend that Black CAP either support or lead research and/or programming in the following areas:

- Black CAP recognizes that the HIV prevention requirements for the trans community were not significantly discussed in this report. We feel this is an area which requires deeper consultation and further gathering of information and data. Several members of the Advisory Committee recommended that transgender issues be more meaningfully included in this report. However, it was particularly difficult to locate appropriate information relating to trans BSM. It was also noted that transsexual women should be included in this report's discussion given the unique location of pre-operative transsexual women of African and Caribbean descent and the significant vulnerabilities of this community. We believe that the complexity of issues faced by these communities requires a more focused and specific examination through the creation of a targeted report focusing on the Black transsexual and transgendered population.
- As identified earlier in this report, there is little discussion of protective factors that BSM may employ to avoid HIV and STI infection. Black CAP recognizes these protective factors as valuable and important, and urge service providers and researchers to consider approaches that include recognition of these in their work.
- There is very little primary research or data on BSM HIV infection trends in Toronto. There is a significant need for the increased gathering and analysis of this data in the future.

Appendix I: List of those interviewed and affiliated organizations

1. James Murray, Senior Policy Analyst, Ministry of Health and Long Term Care - AIDS Bureau
2. Winston Husbands, Director of Research, AIDS Committee of Toronto and ACCHO Co-Chair
3. Clemon George, Researcher, St. Michael's Hospital
4. Ted Myers, Researcher, University of Toronto, Epidemiological Unit
5. Elmer Bagares, Counsellor, Hassle Free Clinic
6. Nadia Bellows, Program Director, (T.E.A.C.H), Planned Parenthood of Toronto
7. Roseanne Bailey, HIV Educator, Rexdale Community Health Centre
8. LLana James, National Project Coordinator, African Caribbean Council on HIV in Ontario
9. Trevor Gray, Youth Education & Outreach Program Coordinator, PASAN
10. Trevor Hart, Researcher, York University
11. Ishwar Parshad, Equity and Diversity Officer, Centre for Addiction and Mental Health
12. Ben Haughton, Youth Education Coordinator, AIDS Committee of Toronto
13. Junior Prashad, MSM HIV Prevention Coordinator, ASAAP
14. Nkem Anizor, President, Black Youth Taking Action
15. Stephen Martin, Youth Outreach Worker, Toronto Parks and Recreation
16. Daniel Le, MSM HIV Prevention Coordinator, Asian Community AIDS Services (ACAS)
17. Kenneth Jones, Researcher, Atlanta Center for Disease Control
18. Wendy Komiotis, Executive Director, Metropolitan Action Committee on Violence Against Women and Children (METRAC)
19. Tony Caines, Community Projects Officer, Toronto Public Health
20. Rinaldo Walcott, Associate Professor, University of Toronto
21. Douglas Stewart, Organizational Development Consultant, Competence Consultants & Associates
22. Alex Dow, HIV/AIDS Outreach Youth Worker, Griffin Center
23. Shani Robertson, HIV Prevention Coordinator, Black Coalition for AIDS Prevention (Black CAP)
24. Shannon Ryan, Executive Director, Black Coalition for AIDS Prevention (Black CAP)
25. Lew Golding, Program Manager, Substance Abuse Program for African and Caribbean Youth, Program-, Centre for Addiction and Mental Health

Appendix II: List of Source Materials

Adams, B., Bartolin, S., Bereket, T. et al. (2006). Gay, Bi, MSM Situation Report. Toronto, Ontario: AIDS Bureau, Ministry of Health and Long Term Care.

Achilles Heel Online Magazine. (1992) Breaching Barriers, Issue 13. [Online, accessed 20 April, 2007]. URL: http://www.achillesheel.freeuk.com/article13_8.html

Amassi Health and Cultural Centers. (2006). Introduction to Cultural Affirmation and Critical Thinking (CTCA) Mission, Vision, and Strategy (PDF). [Online, accessed 16 April, 2007] URL: www.amassi.com/assets/AmASSI_CTCA.pdf

Boatswain, S.J. & Lalonde, R.N. (2000). Social Identity and Ethnic/Racial Labels for Blacks in Canada. *Journal of Black Psychology*, 26(2), p. 216-234

Center for Disease Control - Morbidity and Mortality Weekly Report. (2001, June 21). HIV Incidence Among Young Men Who Have Sex With Men --- Seven U.S. Cities, 1994—2000. [Online, accessed 15 April, 2007]. URL: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5021a4.htm>

Center for Disease Control and Prevention (n.d.). Popular Opinion Leader (PDF) [Online, accessed 15 April, 2007]. URL: www.cdc.gov/hiv/topics/prev_prog/AHP/resources/guidelines/pro_guidance_pol.pdf

Center for Interdisciplinary Research on AIDS (2007). Developing a Social Marketing Campaign for Urban At-Risk Youth [Online, accessed 19 April, 2007] URL: http://cira.med.yale.edu/research/project_page.asp?projID=249

Chrichlow, W. (2003). *Bullermen and Batty Bwoys: The Hidden Men in Toronto and Halifax Black Communities*. Toronto, Ontario: University of Toronto Press.

George, C. (2006, August). The Need to Know: Advancing a Research Agenda for Effective Work on AIDS The case of African and Caribbean peoples in Canada. Presentation. St. Michaels Hospital, Toronto, Ontario.

Husbands, Winston. (2006, November). Living, Learning, and Serving: Responding to HIV/AIDS in Racialized Communities . Presentation – OHTN Research Conference. Toronto, Ontario

James, L. (2006). HIV Prevention Guidelines and Manual: A Tool for Service Providers Serving African Caribbean Communities Living in Canada, 1st Edition, Toronto: Women's Health in Women's Hands Community Health Centre.

Joffe, H. (1993, June 6-11). Beyond the knowledge-attitude-behaviour paradigm of AIDS research. Abstract, International AIDS Conference. [Online, accessed 12 April, 2007]. URL: <http://www.aegis.org/conferences/iac/1993/POD384423.html>

Lawson, E., Gardezi, F., Calzavara, L., Husbands, W., Myers, T., Tharao, W.E. (2006). HIV/AIDS Stigma, Denial, Fear, and Discrimination. Toronto, Ontario: The African and Caribbean Council on HIV/AIDS in Ontario (ACCHO).

Malebranche, D. (2003, June). Oppression, Black Men who Have Sex with Men (BMSM) and HIV. Presentation – Stigma, Discrimination, Racism, Homophobia Conference. Los Angeles, CA.

Mays, V. M., Cochran, S.D. & Zamudio, A. (2004). HIV Prevention Research: Are We Meeting the Needs of African American Men Who Have Sex With Men? *Journal of Black Psychology*, 30(1),p. 78-105

Millet, G., Malebranche, D., Mason, B. & Spikes, P. (2005). Focusing “Down Low”: Bisexual Black Men, HIV Risk and Heterosexual Transmission. *Journal of the National Medical Association*, 97(7),p. 52-59S

Myers, T., Allman, D., Calzavara, L., Maxwell, J., Remis, R., Swantee, C., Travers, R. (2004). Ontario Men’s Survey. Toronto, Ontario: AIDS Bureau, Ministry of Health and Long Term Care.

Myrick, R. (1999, May). In the Life; Culture Specific HIV communication programs designed for African American men who have sex with men. *The Journal of Sex Research*, 36(2),p. 159-171

National Reference Group. (2001). Valuing gay men’s lives: Reinvigorating HIV prevention in the context of our health and wellness. Saskatoon, Saskatchewan: Canadian Strategy on HIV/ AIDS and the Gay and Lesbian Health Services of Saskatoon.

Parker, R. & Aggleton, P. (2002). HIV/AIDS-related Stigma and Discrimination: A Conceptual Framework and an Agenda for Action. New York: The Population Council Inc.

Peterson, J.L., Bakeman, R., Blackshear, J.H., Stokes, J.P. (2003). Perceptions of Condom Use Among African American Men Who Have Sex with Men. *Culture, Health & Sexuality*, 5(5), p. 409-424

Planned Parenthood of Toronto. (2005). Improving Access for Newcomer Youth to Sexual Health Resources and Services. Toronto: United Way of Greater Toronto

Public Health Agency of Canada (2003). Population Health Approach – What Determines Health? [Online accessed 14 April, 2007] URL: www.phac-aspc.gc.ca/ph-sp/phdd/determinants/index.html

Ray, N. (2006). Lesbian, Gay, Bisexual and Transgendered youth: An Epidemic of Homelessness. New York: National Gay and Lesbian Task force Policy Institute and the National Coalition for the Homeless.

Remis, R.S. (2001). The epidemiology of HIV infection among persons from HIV-endemic countries in Ontario: Presentation - HIV Endemic Task Force Community Forum. Toronto, Ontario. November.

Remis, R.S. (2006). Race or Ethnicity Among Persons Infected with HIV in Ontario. Presentation – Provincial Community Planning Meeting. Toronto, Ontario. June.

Remis, R.S., Swantee, C., Schiedel, L., Merid, M.F., Liu, J. (2006). Report on HIV/AIDS in Ontario 2004. Toronto, Ontario: AIDS Bureau- Ontario Ministry of Health and Long-Term Care.

Remis, R.S. & Liu, J. (2007). Epidemiologic trends in HIV infection among men who have sex with men in Ontario: The situation in 2006. Presentation – Gay Men’s HIV Prevention Summit. Toronto, Ontario. February.

Russel, S. T., & Joyner, K. (2001). Adolescent sexual orientation and suicide risk: Evidence from a national study. *American Journal of Public Health*, 91(8), 1276-1281.

Shahin, R. (2007). STI Update: January 11 2007. Presentation – Toronto Public Health STI Update Information Session. Toronto, Ontario.

Tharao, E., Massaquoi, N., Teclom, S. (2004). Silent Voices of the HIV/AIDS Epidemic: African and Caribbean Women in Toronto. Toronto, Ontario: Women's Health In Women's Hands (WHIWH).

Thoms, Michael. (2007). Leading an Extraordinary Life: Wise Practices for an HIV prevention campaign with Two-Spirit. Toronto, Ontario: 2-Spirited People of the 1st Nations.

Toronto Community Health Profiles Partnership. (2004). Health and Community Services in Toronto. [Online, accessed 14, February 2007]. URL: <http://www.torontohealthprofiles.ca/thematicMaps.php>

Trussler, T., Marchand, R. (2005). Prevention Revived: Evaluating the Assumptions Campaign. Vancouver: AIDS Vancouver.

Van der Meulen, Li, Lau, Bereket, et al. (2006). Principles for Conducting Community-Based Research with Gay, Bisexual, and Other Men who have Sex with Men from Diverse Ethno-racial Communities. Toronto, Ontario: AIDS Bureau, Ministry of Health and Long-Term Care.

Visions Centre of Innovation – Directory of Online Aboriginal Health Resources (2002-2003). Factors and Influences that Shape the Health of Individuals and Communities. [Online, accessed 12 April, 2007]. URL: <http://www.visions.ab.ca/content/healthdeter.asp>

Ward, G. E., (2005). Homophobia, hypermasculinity and the US black church. *Culture, Health & Sexuality*, 7(5): 493-504.

Wilchins, R., Taylor, T. (2006). 50 Under 30: Masculinity and the War on America's Youth. Connecticut, New York: Gender Public Advocacy Coalition.

Wright, Kai. (1999). Gay, bi men driving epidemic Black community's risk nearly tenfold. *The Washington Blade*. [Online, accessed 15 April, 2007]. URL: <http://www.aegis.org/news/wb/1999/WB990901.html>



Visibly Hidden:

Rethinking BSM & **HIV** Prevention