



TALKING BLACK.

**Understanding the HIV-related needs,
challenges and priorities of heterosexual
African, Caribbean and Black men in
Ontario, Canada**

Talking Black: Understanding the HIV-related needs, challenges and priorities of heterosexual African, Caribbean and Black men in Ontario, Canada

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SUMMARY

This report presents results from iSpeak, which was a research study implemented in 2011 to understand the HIV-related needs, challenges and priorities of heterosexual Black men (i.e., African, Caribbean and Black) in Ontario. The study was developed and implemented by a team of individuals and organizations affiliated with the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO). The team conducted two focus groups with HIV-positive and HIV-negative heterosexual Black men in Toronto and London, a focus group with service providers who deliver HIV-related services to Black communities throughout Ontario, and interviews with four Toronto-based researchers interested in health among Black communities.

In the focus groups, heterosexual Black men understood their 'heterosexual' identity in a very traditional way, while acknowledging the complexity of sexual identities. They understood health holistically, including the importance of emotional wellbeing and the surrounding environment. They acknowledged the many health and HIV services that may be available, but stressed that services were insufficiently available or accessible to heterosexual Black men. Though participants were disposed to discussing health issues with wives and girlfriends, they admitted being reluctant to engage people who are not healthcare providers. HIV-positive participants also spoke approvingly of constituting themselves as an informal support group.

Service providers were concerned that AIDS service organizations were somewhat disconnected from heterosexual Black men, even though Black men also appeared reluctant to access services. Service providers understood that Black men wanted to be involved in community responses to HIV, even at a leadership level. Service providers suggested that Black men were challenged establishing a livelihood, which was not conducive to prioritizing HIV.

Researchers noted a serious lack of research and paucity of researchers focussing on Black men's health and wellbeing, even though Black communities are sometimes conflicted about researchers. They agreed that concerted efforts are needed to build the relevant knowledge base, and recommended more attention to structural approaches and issues (oppression, poverty, etc.) rather than the current preoccupation with individual behaviour. One researcher also stressed that researchers need to disseminate information and knowledge in a form that people can understand and support.

The research team identified a number of possible 'next steps'. Research is needed to understand the issue of service access/inaccessibility among heterosexual Black men. AIDS service organizations may also develop and monitor initiatives to engage Black men at various levels in community responses to HIV. HIV prevention efforts may be strengthened by research to understand HIV transmission in Canada versus prior infection in Africa or the Caribbean, and the main drivers of HIV transmission among those infected in Canada. These efforts may be complemented by the development of a resource to apprise new immigrants about all aspects of HIV in Ontario. Research may also examine how the climate of criminal prosecution for non-disclosure of HIV-status in sexual encounters affects Black men. This research may be accompanied by interventions to support informed decision-making related to disclosure.

1. WHAT THIS REPORT IS ABOUT

What are the HIV-related needs, challenges and priorities of heterosexual Black men¹ in Ontario? iSpeak was a research study designed to explore answers to this question. We discuss the results in this report. But we also attempt to do somewhat more. We have taken identities that some people may consider privileged (e.g., being a man, heterosexuality) or self-evident (Black men are “difficult”, “reckless” or “wanton”) and critically examined our received wisdom.

In 2011, the iSpeak team organized two focus groups with Black men in London (in collaboration with the Regional HIV/AIDS Connection) and Toronto. The focus groups were for African, Caribbean and Black (ACB) men who were HIV-positive or HIV-negative (i.e., never diagnosed with HIV). In addition, the team also held a focus group with service providers from across Ontario who work with ACB communities on HIV prevention and support. We also spoke with a small number of researchers whose research has focussed on the health and wellbeing of ACB communities. The team implemented those activities after obtaining ethics clearance from the HIV/AIDS Research Ethics Board at the University of Toronto.

Our research was exploratory (it was originally funded by a Catalyst Grant from the Canadian Institutes of Health Research, which was later supplemented with financial assistance from the CIHR Social Research Centre in HIV Prevention). We hope that the research will help ACB communities, researchers, service providers and policy makers better understand some of the issues relevant to HIV prevention for Black men, as well as issues relevant to care and support for Black men who are living with HIV. We also hope that the report will generate serious dialogue about community engagement related to Black men, access to programs and services to enhance Black men’s health, and further research to address more comprehensively the priorities that emerge from this research.

2. GETTING ORGANIZED

A worrying trend

Ontario’s Black population accounts for approximately 4% of the total provincial population. However, among the estimated 27,420 people living with HIV in the province in 2009, 18.8% were ACB people infected through heterosexual contact.² Men comprised a clear majority (60%) of the estimated number of ACB people living with HIV, though in recent years HIV has spread more rapidly among women—from 2004 to 2009, the estimated number of ACB women living with HIV increased by almost 80% (from 1,160 to 2,190 women), while the estimated number of men increased by 40% (from 2,190 to 3,075 men). ACB men are also less likely than women to be diagnosed—in 2009, less than half (46.5%) of the estimated number of HIV-positive ACB men were diagnosed (the lowest proportion among all HIV-positive men), compared to almost two-thirds (64.5%) of ACB women.³ Late diagnosis may result in poor health; also, HIV-positive people who are undiagnosed may be more likely to spread the virus than those who are diagnosed and receiving treatment.

Hope and struggle

With increasing demands on their agencies by the mid-1990s, ACB service providers began to strategize collectively about an appropriate response to HIV. Based on an epidemiological report that confirmed the disproportionate effect of HIV among ACB communities, the initial group of service

providers established the HIV Endemic Task Force (HETF) to develop a strategy on HIV for ACB communities in Ontario. The process to develop the strategy included research and consultation with community stakeholders, policy makers and researchers. On completion of the Strategy in 2003, the expanded HETF emerged in 2005 as the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) to coordinate implementation, monitoring and renewal of the Strategy.⁴ Since 2005 the AIDS Bureau of Ontario's Ministry of Health and Long-Term Care has been supporting the Strategy by funding ACCHO and a network of HIV prevention programs delivered through established AIDS service organizations (ASOs) in Ottawa, Durham Region, Toronto, Peel Region, Guelph, Kitchener, Waterloo, London and Windsor.

However, among ACB communities, the response to HIV from researchers, policy makers and community-based agencies has focussed mainly on gay and bisexual men, and women. From a community-wide perspective, it is important to acknowledge that (a) heterosexual contact is the leading mode of HIV transmission among ACB people in Ontario, (b) men comprise the majority of heterosexually-infected ACB people, and (c) heterosexual transmission of HIV can be halted only if prevention efforts include both men and women. In other words, HIV will continue to be a challenge for ACB communities if heterosexual men are not meaningfully engaged in the response, and if their needs, circumstances and priorities are not understood and addressed. Indeed, one of the lessons from a recent study about HIV and health among women in Ontario (the Ontario Women's Study) was that "heterosexual men need to be more aggressively targeted for HIV prevention."⁵ That is, men and women share responsibility for halting the spread of HIV among ACB communities in Ontario.

iSpeak – cultivating hope, joining the struggle

The iSpeak research study, which is the basis of this report, was developed in response to the epidemiological, program and policy framework outlined above. The project was initially implemented in 2011, with the goal of engaging heterosexual Black men, service providers who work with ACB communities, and researchers in a dialogue to inform HIV research, programs and policy among ACB communities. In particular, we wanted to understand the HIV-related needs, challenges and priorities of ACB heterosexual men, which would also help to assess their potential for greater involvement in organized responses to HIV among ACB communities.

The impetus for iSpeak originated with Africans in Partnership Against AIDS (APAA), a small community-based ASO in Toronto. APAA is a founding member of ACCHO, and collaborates with the other ACCHO members and stakeholders to implement and monitor the strategy on HIV for ACB communities in Ontario. In addition to APAA, the iSpeak partners included ACCHO, the AIDS Committee of Toronto (ACT), and the AIDS Bureau of the provincial Ministry of Health and Long-Term Care. The partners also collaborated with the Regional HIV/AIDS Connection (RHAC) in London, Ontario.

3. THINKING ABOUT BLACK MEN AND HIV

In the early 1990s, an African immigrant who settled in southwestern Ontario was charged and prosecuted for failing to disclose his HIV status to a series of white female sexual partners.⁶ A post-mortem of his body (he died on the eve of his Ontario Superior Court ruling), in addition to evidence from the trial and stories in the media, revealed 'shocking facts' about him that would

later be reported in a popular rendition of his case and may have validated what many people suspected all along.⁷ He may have disregarded the wellbeing of his lovers; but, based on racialized codes transmitted from another era, this disregard was rendered potentially “African” through a racist construction of his erotic endowment. Since then, other Black men in Canada have been charged and jailed or deported. Black men appear to be over-represented among those charged with the various offences related to non-disclosure. Their cases and the stories of their sexual partners have been sensationally reported in the media.

Of course, men do not infect women with HIV because of their penile length or erectile durability. Nor are Black men perversely endowed in those characteristics. But ideas and images that caricature Black men as “violent”, “oversexed”, and “reckless” have a long and complex genealogy that permeates contemporary ways of understanding Black men.^{8,9}

Our response to HIV among Black communities in Canada requires us to rethink how we understand Black men. In other words, we need to reflect carefully on how we think about Black men, masculinity and gender. This involves being open to reconsidering categories, modes of thought, and practices which we have deeply internalized. In relation to Black men, it means being attuned to the categories buried in Black male iconography which shape commonsense knowledge and discourse about Black men. We are referring to those ideas we have about Black men that rarely get questioned, or that we take for granted because they seem consistent with what we think we “know” (e.g., Black men are incapable of turning down sex or practicing safe-sex, can’t/don’t talk about health, etc).

Black men are generally interpreted through racist and sexist frames of reference that reinforce, or naturalize, the commonsense ideas society has about them.¹⁰ For example, we often hear that Black men endorse dangerous behaviours and attitudes that have grave consequences for the transmission of HIV in Black communities.^{11,12} Critical race theorists would argue that, to understand how categories and discourses frame dominant thinking about Black men, we must understand how and why those discourses are taken up by Black people themselves.¹³

One way of imagining Black identity is to picture it as working along a script.¹⁴ Of course, there is never quite one script, but instead multiple scripts and subscripts.¹⁵ Figuratively speaking, scripts appear to collectively frame Black identity and make it culturally meaningful and intelligible. They also make us feel like we “know” Black men and thus can predict their behaviour. Our objective must be to get “beneath” and “beyond” Black identity scripts. We must heed the advice of critical theorists and look for ways of destabilizing and denaturalizing these scripts and appreciating the power relations that underscore them.

In more concrete terms, we must recognize the following: first, Black men’s behaviour cannot be separated from the multiple ways in which men, in different social circumstances, cope with vulnerability;¹⁶ second, while Black men handle their vulnerability strategically they do not always engage their vulnerability productively (in fact, sometimes men’s coping strategies are very counter-productive);¹⁷ and third, Black men do not always possess the resources to negotiate and challenge cultural and social scripts in the same way that White heterosexual men do. We have to forego debates about whether Black men are responsible or not. Generally speaking, no group or community is either inherently responsible or inherently irresponsible. Instead, we should try to understand what constitutes ‘responsible’ behaviour, how social relations determine, mediate or affect what is considered ‘responsible’ (or privilege some classes of people or some behaviours as more responsible than others), and how social relations challenge or enable the practice of responsibility.

The story of how the sexual behaviour of one African immigrant was racialized reminds us that old ideas never quite get old, but instead find a way of infusing and co-existing with democratic principles like “justice”, “equality” and “fairness”. HIV has reinvigorated a paradigm of difference that compels us to mine our concepts and categories and rethink how we understand Black men and can meaningfully support them. What we hope to demonstrate is that, despite their vulnerabilities, heterosexual Black men are also thoughtful and resilient, and this complexity should inform how service providers, researchers and policy makers engage Black men in the organized response to HIV.

4. IMPLEMENTING iSpeak

Talking with heterosexual Black men

iSpeak included two focus groups in Toronto and London (Ontario) with heterosexually-identified Black men—one for HIV-positive men (N=7) and the other for men who have never been diagnosed with HIV (N=7) (Table 1). To be eligible, participants had to identify as Black, African or Caribbean, be at least 18 years old, and reside in the city in question. Participants were recruited by word-of-mouth through a network of individuals and organizations, and through flyers posted at community-based organizations. The focus groups were 90-120 minutes in length, and were designed to elicit participants’ perspectives on issues related to HIV and health among Black men and among the wider ACB communities in Toronto and London. The focus groups were audio-recorded and transcribed verbatim. Members of the research team read the transcripts separately, and then met to highlight and discuss the thematic content of the respective focus group discussions. As Table 1 shows, none of the participants in the heterosexual men’s focus group was born in Canada. Perhaps more importantly, participants in the two focus groups reported low incomes, especially in relation to their level of educational attainment.

Engaging service providers who work with ACB communities

We also organized a one-hour focus group (by telephone) with community-based service providers (N=6) who deliver HIV programs to Black communities in Ontario. Participants had at least two years of experience working on HIV-related issues with Black communities and service users. Five of the six worked in community-based agencies with provincially funded HIV prevention programs for ACB communities. Black men and women comprised five of the six participants. The focus group for service providers was designed to assess how they understood heterosexual Black men (i.e., their needs, challenges and priorities), based on their experience providing services to Black service users and communities. The lead researcher and project coordinator read the transcript separately, and later discussed the content to identify the main themes and issues.

Chatting up researchers

We also interviewed four researchers in Toronto with a demonstrated interest in various aspects of wellbeing among Black communities. These interviews ranged in length from 45 minutes to an hour. Three of the four researchers were Black men. The purpose of those interviews was to identify gaps in the research knowledge related to heterosexual Black men, and also determine their interest in collaborating on research studies that may emerge from iSpeak. Each interview was conducted by two members of the research team—the team leader posed the interview questions, and the study

coordinator recorded notes of the discussion. The coordinator then wrote the interview discussion as standard text, which was reviewed by the investigator and then circulated to the respective researchers for their comments, changes or corrections.

5. BLACK MEN SPEAK

In this section, we discuss the main themes that emerged from our discussions with heterosexual (straight) Black men in Toronto and London, and illustrate the discussion with direct quotes from the participants.

Black men and heterosexuality

What it means to be heterosexual, or to be a heterosexual Black man

Focus group participants articulated their interpretation of ‘heterosexual’ and ‘heterosexual Black man’ in complex ways. On one level, they understood heterosexual men to have sexual relations (and accompanying emotional attachments) with women; for example, heterosexual Black man “means that as a black man, you are only attracted to a woman” (London). But some participants also understood ‘heterosexual’ in opposition to other forms of sexual relationships and sexual orientations, and demarcated a traditional or standard form of heterosexuality. For example, one Toronto participant identified heterosexual men as those who “eat from one plate” rather than trying to unreasonably “eat from different plates” (i.e., having sexual relationships with women and men).

In addition, they interpreted their heterosexuality in cultural terms—a traditional interpretation that they located in African culture, as opposed to new, emerging or different interpretations in ‘the west’.

“... over the years a lot of circumstances have arisen that the term heterosexual could move away from man and woman relationship to people who relate to men and also to women ... This is a new development. Having been in this part of the world for the past 20 years, I understand that culture has much to do in interpreting what it means. But there seems to be a clash and confusion of accepting what it actually means, practically, presently. But basically most men of African or Black background will look at it as man and woman.” (London)

If heterosexuality is understood differently in Africa than it is in Canada, then African men (or men of African descent from the Caribbean) may be ambivalent or uncertain about what it means for them to be (or to refer to themselves as) ‘heterosexual’ in Canada, or about whether the traditional “African” view of heterosexuality would be appreciated in contemporary Canada.

“... it means that relationship in the context with a female. But having said that, it is very broad; we’re talking about cultural diversity here and what those relationships look like, because there’s many forms of relationships in that context again, between male and female ... So I think the question should also be, “what does it mean to me to be able to share my views or maintain that type of relationship in a world today?”, so it’s having that balance as well, with the understanding that others may not share that view.” (London)

Table 1. Heterosexual men’s focus group participants: Toronto (N=7) and London (N=7)
(7 participants – 50% – were HIV-positive)

	Number	%*
Place of birth		
Africa	11	78.6
Caribbean	2	14.3
Other	1	7.1
Age		
<30 years old	1	7.1
30-39	3	21.4
40-49	4	28.6
50 or older	6	42.9
Length of residence in Canada**		
<3 years	2	20.0
3-5 years	1	10.0
>5 years	7	70.0
Annual income		
<\$20,000	10	71.4
\$20,000-29,000	3	21.4
\$30,000-39,000	1	7.1
Employment status		
unemployed	3	21.4
working part time	2	14.3
working full time	2	14.3
self employed	2	14.3
student	2	14.3
on disability	3	21.4
Marital status		
married/common law	8	57.1
single	2	14.3
divorced/separated	4	28.6
Highest level of education		
less than high school	1	7.1
completed high school	2	14.3
some university or college	6	42.9
completed university or college	5	35.7
Parent***		
yes	11	78.6
no	3	21.4

*percentages for each measure/variable add to 100; **only 10 participants responded to this question;
*** “yes” and “no” are the number (and percent) who reported having or not having children.

Women in the lives of heterosexual Black men

Participants' sexual exclusivity with women defines them as heterosexual men:

"... a black man attracted to a black woman, emotionally and physically. That's my own understanding." (Toronto)

"... I think we'll interpret the same as we do in Africa. It's a sexual relation between men and woman. That's it. It is heterosexual or straight man." (London)

Participants who were living with HIV also understood women as a source of support, appreciated women for their efforts to care for and support their men, and appeared to be more comfortable sharing some types of information with their female partner than with their doctor:

"For me the source of health like the people I can disclose to including my peers is my partner who is a woman. She is very supportive ... even if it's a simple cold, you know, I talk to her. I tell her this, although honestly I don't usually go to a doctor for headaches or colds yet for her she does. But I can tell her and she will say 'You know what? Here is some Tylenol' or 'You know, drink some juice. You didn't sleep enough.' So she's a major support. But also when it is my appointment with a doctor I tell them ... I have limits with the doctor." (Toronto)

Among men, women's involvement or interest in supporting their men could also be reified or naturalized as a feminine quality; that is, women are naturally pre-disposed to care-giving, and care-giving is synonymous with womanhood.

"Your woman partner could be very supportive and definitely she knows your status and all this. She could be very, very supportive and you are free to her. You can talk to her openly, and tell her everything, how you are feeling. She knows when you are very low and when you are in your normal self. You know women, I like to tell this to those who have sex with those like them, women are very understanding people. We all know that. When you want to be treated like a baby, she will treat you like a baby. And she knows exactly when to treat you like a baby." (Toronto)

However, in the sphere of service provision and access to HIV-related services, Black men may find themselves in competition with (or in opposition to) Black women (and gay men). In other words, in the response to HIV from service providers, policy makers and even people living with HIV (PHAs), some iSpeak participants claimed to be disadvantaged precisely because they are Black, male and heterosexual:

"The services for straight men are very limited, very limited. And to me it's annoying. We're not saying that gay men shouldn't have services but have a balance. In the city, if it's not white gay men, it's women of colour, like you said there is special attention to woman or white gay folks and we are left trapped there in the middle." (Toronto)

Health and access to services

Being healthy

Participants generally understood ‘health’ or ‘being healthy’ holistically:

“For me, healthy means generally to be healthy mentally, physically, spiritually and so on, everything healthy. As a person, you should be healthy.” (London)

However, some participants interpreted health and being healthy in broader but also more everyday terms, such as the characteristics or effect of one’s neighbourhood, and the need to be happy:

“Like for me I live in Scarborough but I used to live at [neighbourhood] which is known to be kind of a crime area. Honestly, I don’t think my mental health was okay in [neighbourhood]. I lost three bikes. And, I got better when I moved to Scarborough because, you know, the neighbourhood is fairly okay. You know you greet neighbours. So my mental health is okay. So I can get on the TTC even if it’s one hour to downtown, but my health is okay on top of, you know, going to see my doctor when appointment is there.” (Toronto)

“You have to be very happy for you to be healthy. Because I believe that happiness plays a very big role in your mental health. Being happy.” (Toronto)

Participants who were living with HIV tended to interpret health and being healthy through the prism of HIV. Therefore, health and being healthy included going to the doctor, taking one’s prescribed medications, regulating diet and exercise, and even regulating personal relationships as well.

“For me to be healthy is first, as he has said, to take my medication, to get enough appetite, to eat enough and if possible to do some exercise outside, run or whatever.” (Toronto)

“You are taking your drugs to put it back in time; you level up your systems a bit more ... You’re controlling it. But you cannot control it if you turn women at that corner and that corner then you cannot be healthy.” (Toronto)

Access to services

Participants in both Toronto and London acknowledged the availability of services that heterosexual Black men may access. Services may be accessible because some service providers make a conscientious effort to reach and engage service users.

“The other thing I wanted to mention is that there are some support workers at AIDS service organizations who treat you ... as if you are normal. And despite the fact that maybe you arrived five, ten minutes late and your appointment is only 30 minutes, they can go on for at least 45 minutes to an hour. And it shows that they care. They are connected with other services from legal, settlement, housing. I find that to be very, very good and informative. Some AIDS service organizations, not all.” (Toronto)

Nonetheless, sometimes Black communities may not have up-to-date information about available services.

“What I know is that service is available if you require it, and it has been for quite some time. So it is up to us. The opportunity to get tested is there if we want. One of the problems with our community is that we don’t read anything, some of us ... So we can’t blame other people; it has to be us. It’s hard to mobilize the community but as far as it goes I see service is available and it’s how we fan out from here.” (London)

The above comments notwithstanding, focus group participants (particularly those living with HIV) were generally concerned that services were not sufficiently available or accessible to heterosexual Black men. They spoke of a lack of cultural competency which persists because of institutional racism.

“The first time that I moved to London, I went to visit, to see a doctor. You know black skin gets dry, especially in winter time, so if you don’t use cream or something it’s dry. The doctor just took my hand because I was scratching and said “you must have cancer, skin cancer”. I was really ... I asked him, “Doctor how do you know I have cancer?” I think my question just touched him and he stopped ... That is just to show you how I am disappointed with services that I have received as a Black man here in London.” (London)

Participants who were HIV-positive remarked on the sense of exclusion and marginalization that they experienced in the realm of HIV service provision, which they attributed to a peculiar intersection of race, gender and sexual orientation, and a general belief that heterosexual Black men are socially advantaged because of their heterosexuality.

“A couple of years ago I worked in [neighbourhood]. I was doing HIV/AIDS work for an organization. And, I saw a huge gap because [neighbourhood] is one of the priority neighbourhoods but the few services that were there for youth HIV and AIDS services were for gay and bi youth of colour. So I asked, okay, this one caters for gay or bi youth of colour, how about services that are for straight youth of colour? There was nothing. I think the organizations not only in the city even outside like in [inner suburbs] there is a huge gap, huge gap for HIV services for Black straight men. I don’t know what the reasons are... but one reason is systemic racism, because honestly if you count even the Black organizations we know... some still don’t have services that cater for Black straight men, they are very limited.” (Toronto)

“All I got was being shut off in the cell phone (speaker banging the table for emphasis); and I never went there, I never went there again. I lost. But look at the girls, the way they get things here. Look at the gays they press any button. The gays they press any button. They win. I’m sorry to say that. Let’s forget about it. It’s very pathetic. It’s paining, it’s really, really paining us. We don’t get the resources we ought to. It should be 50/50 to everyone. We are falling under the same umbrella. Why the lie? Why the lie? Why the lie?” (Toronto)

These concerns precipitated talk about whether HIV-positive heterosexual Black men were “endangered” persons, based on their marginalization related to service provision combined with the growing threat of criminal prosecution for non-disclosure of HIV status to sexual partners.

“We are being accused [referring to criminal prosecution] of spreading HIV. So when I say that the straight black man is an endangered person I mean exactly what I am saying, with a lot of bitterness.” (Toronto)

Privacy, secrecy and access to health information

Many participants spoke about discussing their health with immediate family (e.g., wives) and trusted friends, and understood this as beneficial to their wellbeing.

“I feel very, very comfortable to discuss about health with my family, children and other people. Because sometimes like with checkups with physicians, Africans have many diseases like diabetes, high blood pressure; or sometimes we have diseases but we don't know. If we discuss with other people from back home, I have to check maybe unfortunately I may have this disease. For me it's very important for me to discuss my health with another person.” (London)

They also noted, however, that African/Black men are reticent to discuss health issues, and were perhaps secretive about their personal health concerns or challenges (which is also generally attributed to men of various nationalities and cultures). Participants invoked reticence and secrecy about health as something located in African and diasporic cultures, and as something that helps to define manhood. Yet, they acknowledged that secrecy was a protection against gossip.

“Another problem for Black men, they show too much pride to find information ... Many times, if I have a problem I would say, I'm OK. Three months later, the guy died or feels really badly in the hospital. If you don't want to talk about things with people from the same community, you can't find a physician or a person who has the ability to give you information, there is many, many services. The problem is finding it.” (London)

“But there are tendencies in African communities to hide issues because it is part of the way people like to gossip about others in our cultures. There is a need for us to be advised in this. So it would be nice if we had professional people who are qualified and trained and have experiences, who we can trust. We need to approach them so we can know because you can't sit down with disease in your body for years; it'll kill you in the end.” (London)

On balance, participants recognized the harm that could result from secrecy, such as illness that could be avoided or prevented, the complications due to late diagnosis, and even death:

“My problem is sometimes I saw many, many guys from my community die, or went to the hospital late, because they did not see the physician to tell about their disease. Maybe because they feel like shy about their reputation. You know, you feel reserved. And then if they feel like very, very sick, no other choice or possibility, they have to go see the physician, but it's late.” (London)

Focus group participants who were living with HIV appeared much more guarded and selective about discussing their health with others, due to the stigma and discrimination that could result from disclosing to others that they were HIV-positive.

“In most cases, we have difficulty to discuss it with our friends because you don't want to expose so much to someone who's not gonna help you. That's why we chose to go to specialist or go your dietician, someone from medical field who gonna help you, advise you how to eat healthy and she or he is gonna keep you up confidentially. Because once I started disclosing to my friend, sometimes in a bar or in a party, they start running away from me.” (Toronto)

Participants also drew attention to various systemic barriers that affected Black people's access to information about HIV and health. While acknowledging the barriers that may reinforce secrecy about health, some participants suggested that it's in Black people's interest to access appropriate information, and develop an infrastructure to ensure access.

"But when I talk generally about HIV and Black people in Canada ... we don't want to talk openly, we don't want to get open information ... Any barriers in getting information about HIV in Canada? There is no barrier, but my understanding is that White people say HIV is with Black people. So, even this is an obstacle towards getting information. If they don't have HIV, White people don't care about it. So how can I ask them for information. It's for me, a Black man. So I keep it a secret, I can't talk openly, that's a barrier for me." (London)

"I think HIV remains an underground issue because it's affecting Blacks. Because we have no megaphone, no media outlets, nothing ... Nobody's in a huge rush to provide us with information. Plus when we do have HIV, we don't reach out for information. If there's no demand for it, if it's only affecting a minority group, then why would they ever do anything about it?" (London)

Given the rising population of Francophone Africans in southern and southwestern Ontario, the lack of resources in French was also cited as a barrier. As one participant in London stated, "my first barrier is the language barrier." Still, focus group participants offered a few low-cost, straightforward suggestions for improving access to health information among ACB communities. One participant in London mentioned volunteering as a way to "keep[ing] current". Another mentioned using the Internet as a way to start engaging relevant information about health and HIV.

However, as we shall explore in the next section, HIV-positive participants developed their own networks of support where they could freely discuss issues and exchange information related to their health and wellbeing.

Men supporting men

The participants in one focus group were affiliated with a loosely structured network of HIV-positive men supported by an ASO. The men met from time to time but, unlike a formal support group, they were free to participate in meetings without necessarily committing to a strict regime of attendance. The camaraderie among group members was recognized as a source of strength.

"For me I don't find it an issue, discussing HIV with any of my peers. Whether it's men or women or they are mixed, I get a lot of strength from them and I think everybody in this group discuss HIV openly. We have a society of our own, very close knit society where we know each other ... But I find myself very, very comfortable because even when we started meetings as a group of men, as straight men when we sit down we discuss all these kinds of issues. We share jokes. We tell each other, "You look as if you're going to expire", these kinds of jokes (laughter). We are very free with each other. This kind of support, the support that we give each other is very, very therapeutic. I don't think this kind of support you get from this kind of a group you can get it from any doctor." (Toronto)

The equanimity among the group meant that serious issues pertaining to members' health could be discussed in a way that inspired confidence and hope, and promoted health.

“If I need a doctor, we discuss ‘oh you don’t have a doctor, go to this doctor’ ‘oh we went to this one, No, let’s try this one’, ‘this one definitely.’ And even the resources that we get ‘this resource is no good. Try this one. We go to it. Let’s try this one’. You go to it. We all need to back each other up ... You come in here sad but you move out laughing ... As for me I come here sick and I move out happy ... And I win all the time.” (Toronto).

Getting heterosexual Black men more involved in HIV issues

Focus group participants offered their perspectives on how Black communities, heterosexual men in particular, may become more involved in the response to HIV and be better served by the organized response among service providers and policy makers. Their varied actions and strategies for inserting heterosexual Black men into programs, policy and research were premised on the requirement that those actions and strategies should be championed by an alliance of stakeholders, with PHAs playing a leadership role. For example, advocating for policy that is informed by research would mean that “we work as a team, the researchers, academics and us straight Black men ... to increase the services for folks who are like us” (Toronto). But “the voices of PHAs on these boards [of directors or trustees] should be key to telling the organizations that straight Black men matter” (Toronto). In London, one participant suggested an advocacy effort focussed on Local Health Integration Networks (LHIN) as a way of trying to ensure that programs were appropriately funded.

Participants identified various ways of mobilizing PHAs and Black men more generally as a force to press for change. For example, participants in Toronto mentioned mass demonstrations or rallies, organizing a Pride-like event for Black and/or heterosexual people, and writing letters to the appropriate government ministries. In London, one participant used the idea of the focus group to speak about organizing meetings and forums to share experiences and ideas that can be passed on to “service-givers”. As one participant in London stated, “No information, no good community, no good family.”

In London, participants spoke at some length about the importance of mobilizing ACB communities though infrastructures that may already exist.

“Well, I am familiar with the organization here; even when they are doing their BLACCH [Black African and Caribbean Canadian Health] study, the health research. They should try to come up with a good testing program that will go to the community through the community organizations and the churches, not just making it a government program, but that we’ll be able to speak to the community leaders so people can come voluntarily and come and get tested. That is the only way.” (London)

“... the government has already taken a preventative approach; it’s already in place. What we need to do [with] the information already provided is how we’re able to take that to the community to mobilize them to participate ... So again it’s to tap into all these organizations and structures that they already have and have them develop the outreach pieces and it’s how we communicate that to the rest of the community and how we mobilize them.” (London)

However, some London participants cautioned that community engagement efforts must be sensitive to the circumstances of the communities in question. One participant framed this perspective as looking for the “least intrusive way”.

“I am looking at our community, we are looking at the hiding. That’s a barrier right there. People say things like, “we don’t have that [HIV], just those folks have that”. So how do you get that to them in the least intrusive way? I am not being critical but culture sensitive. But I am talking about the least intrusive route to effect change.” (London)

Though community engagement efforts should be sensitive to the respective communities, how those efforts may be designed or implemented depends on their purpose. For example, one London participant advised that condom distribution is very important in ACB communities because “some people cannot afford condoms”. However, another participant located the promotion of condoms within a wider process of community engagement.

“We’re talking about the issue of culture and community because in Africa we respect the elders. There are some words that you cannot go to an older person and tell him or her. It’s not that it’s not important, it’s because that is the culture. Will I go out and ask people to put condoms? I am not against it but I will not distribute them. I would rather educate the people about the importance of not having unprotected sex ... I would be willing to get the conversation, the committees, get to know who they are and who’s in charge and what are the problems, so you can promote and educate them about the scourge of AIDS; why it happens, how it happens, and not necessarily only saying “here, take condoms”. (London)

6. THE VIEW FROM SERVICE PROVIDERS

Heterosexuality and Black men

Service providers described Black male heterosexuality as something taken for granted in the context of service provision. This inclination to treat Black men’s gender and sexuality as fixed made it difficult, they said, to imagine Black men as gay or bisexual.

“... the issue of heterosexual men or straight men does not usually arise because, I think, especially working with the African, Caribbean and Black communities in most of the cases they assume that they are seen as straight or heterosexual, men who have sex with women. So in the first place when I see them that is an assumption” (service provider)

“... the term heterosexual black men, it almost seems like almost oxymoronic when I think about it, when a lot of people think about what a black man is it often doesn’t enter into their consciousness that he might be gay, so you know, heterosexual men and black men are almost equivalent almost. So often in our community we don’t spend a lot of time recognizing that, you know, black men are also gay.” (service provider)

In general, communities play a vital role in perpetuating normative ideas about heterosexuality. This applies to Black communities and to Black men themselves. In the focus groups with Black men,

participants often enthusiastically endorsed 'heterosexual' as a natural sexual preference for women. To some extent, the same is also true for service providers.

"For me, when someone comes to me as a straight man I don't even think that he can be bisexual at all. This is not in my conscious, I don't ...I don't realize that!" (service provider)

But service providers also considered stereotypes as highly problematic. For example, monolithic categories like "gay" and "straight" were in their view simply too restrictive to account for the interesting ways in which masculinity and heterosexuality are played out in ACB communities.

"They'll say I'm actually gay but as an African man I have to have a wife and children. So publically they will never come out as gay, but they tell me "I'm actually gay". And on the flip side we've had women who say 'my husband is actually gay' we don't even have sex, you know, because he is gay but we are married." (service provider)

Access to HIV services

Service providers reported that heterosexual Black men were less inclined to access HIV services, compared to Black women and white men. One explanation for this was that HIV is commonly seen by Black men as a 'gay disease'. Another possible explanation was that Black men cope with vulnerability as solitary individuals. However, one service provider explained that if Black men are disinclined to seek help unless they were in a state of crisis, this was not simply a Black cultural issue.

"I think it's true among many cultures. It's around, you know masculinity and asking for help I think it's, you know for men in general, I think it's a hard thing to do." (service provider)

A particular enduring theme was that Black men, like many other men, will try to contain their vulnerability to protect their masculine ego, which ultimately diminishes their ability or willingness to seek help.

"... And sometimes, it's the whole idea of "men are men" and they don't need a lot of help and can take care of themselves and also because they may sometimes rely on their women partners to come in and get whatever it is that they need." (service provider)

According to one service provider, some men can be so self-conscious about being seen by other service users that in some cases they will refuse to enter the agency.

"They don't want to be seen seeking help except when they are really, really in crisis and they need help. My experience is a lot of times they will call me and say "I'm at the parking lot come and meet with me and then go to [café] or some other place." And I suggest come and pick it up from here and they say 'No I will not come. I need food but I will not come for my food voucher. Please come and bring it to me.' So it's their comfort level and the stigma associated with HIV, so they don't want to be anywhere near the organization." (service provider)

While service providers recognized that culturally inscribed ideas about being a man, as well as the stigma surrounding HIV, made it difficult for men to seek help, they were also concerned with the

lack of HIV programming available for heterosexual Black men. There was a generalized sense that, to some degree, Black men were being ignored by ASOs. According to one service provider, the problem was not so much the fact that Black men didn't want help, but that agencies claiming to be inclusive were failing to acknowledge their own disconnect with ACB communities.

"... agencies need to internally look at what they have that is of use or productive or resourceful to an African, Caribbean straight man. I think that's a big question that needs to be seen into by agencies if they want more involvement or engagement by that particular group of people. I think a huge responsibility is on the agencies." (service provider)

"... we have women's workshops for example, we organize workshops only for women but we never had one only for men. So in my view, we also have to produce some more interventions that really address the specific needs of heterosexual men." (service provider)

In addition to the lack of programming targeting Black men, service providers also claimed that agencies were not doing enough to ensure that heterosexual Black men were visible in their support staff and volunteers. Service providers spoke at length about the discomfort that heterosexual Black men associated with spaces that they considered predominately White and gay.

"... there is some level of discomfort observed when they are in a setting that is primarily gay. There is a certain level of discomfort ... a certain level of disassociation because they do not want to be identified in that category—even if they might be, you know, involved with men as well." (service provider)

Another enduring theme was that agencies needed to do more to reach out to heterosexual Black men. This could involve targeting heterosexual Black couples and families, conducting more ethno-specific media campaigns, and reaching out to faith communities for support. The bottom line, however, was that agencies need to be more reflexive about their services and about their commitment to serve communities that might not have traditionally formed their user base.

"I think agencies should also take on that responsibility and be more accountable to make sure that heterosexual African, Caribbean men are comfortable. It's up to the agencies to build that comfort zone. Yes as an individual service provider, if I don't have a comfort zone I can't just let that be. There has to be ways and means to build that comfort zone, or we are just going to see this problem get bigger." (service provider)

Notwithstanding their hesitation accessing services and the possible limitations of service access, Black men demonstrate an interest or even readiness to be more involved in the organized response to HIV.

"I did have good number of Black heterosexual men participating in activities. Their status is unknown so they were not coming in as service recipients. For example when we did the [event] we actually had quite a number of them taking part. We were able to recruit them from the community and ... most of them were actually leaders in the community, leading different ethno-cultural communities ... So I think the issue, we did a lot of training HIV training so they got a bit more comfortable with that ... When we said we were gonna take the play to the community, then they said 'I'm interested as long as it's within the community. I'm interested'." (service provider)

“I have probably like two active clients from the ACB community who volunteer and participate in every event that we do. But, in most cases I have volunteers, which is a group that I call African Caribbean and Black committee which try to help me advocate in the community that’s one of the objectives. So, they either state their status or whether they’re positive or not, but they like to do activities during Black History Month and also [event]. (service provider)

Accounting for the circumstances of heterosexual Black men

Service providers articulated that the social issues facing Black men were considerably different from those experienced by White men. This was not to suggest that White men do not have important issues of their own, but rather that the issues affecting Black men are experienced in a particular culturally-specific way. As one service provider commented, social pressures take many different forms in Black communities.

“It could be stigma. It could be you know, being seen in an agency, being seen among people, you know being identified among people who are of other sexual preference or gender preferences or even HIV. Or it could even be family pressure or it could be pressures of having to work and really not being able to actually have the time or the opportunity to go to agencies to seek assistance or it could even be lack of knowledge. There’s so many people in communities today who have no clue about the services available out there.” (service provider)

In the case of Caribbean and African newcomers the pressure can be even more acute. Faced with the challenge of finding housing and work, as well as family responsibilities, newcomers do not always know where to find HIV-related information and services. One service provider reported that many newcomers also do not have sufficient understanding of HIV risk in Canada.

“... some of the people are puzzled when you tell them the statistics for living with HIV in Canada... they’ll start telling you stories ‘oh I thought it was only back home’ which means they don’t see anything, any messaging on HIV here in Canada and then become, not reluctant but they don’t really care as much as they would probably back home.” (service provider)

Several service providers emphasized that it was crucial not to assume that African and Caribbean newcomers, particularly men, were automatically more risky than settled immigrant and Canadian-born Black men. Most Black male newcomers, they claimed, do care about their health even if they are relatively unaware of HIV in Canada.

“I think too they are responsible. Probably from the [male] newcomers’ perspective when they come here they are regarded as bread winners, right. So they don’t have time to take care of their health and be involved in the HIV movement for example. Because they have to work like two, three jobs to make sure their family is well taken care of and stuff like that. So I think that they are responsible. It’s just that we expect too much maybe from them and then it’s hard to balance all those things.” (service provider)

7. CONVERSATIONS WITH RESEARCHERS

Our conversations with four university-based researchers in Toronto were about how Canadian Black men figure (or not) in the research landscape, what has been learned from research about Black men in Canada, gaps in the knowledge base, and their appraisal of research trajectories related to Black men and HIV.

All four researchers noted that, with a few exceptions, research with/among Black men in Canada was rather scarce. For example, when asked to name any researchers whose work demonstrates an interest in Black men's health, all four interviewees mentioned the same three or four researchers, and a similar number of research studies apart from their own. However, they underscored the need for and importance of research by noting how stereotypes prevail in the absence of good research. One researcher suggested that there is growing interest in peculiar health-related problems, rather than a broad range of health issues.¹⁸

Our research informants identified two main reasons for the apparent lack of Canadian research on Black men's health and wellbeing. First, as one of the research informants stated, in Canada there seems to be an aversion to informed discussion about the wellbeing of Black communities.¹⁹ Second, researchers seem reluctant to engage with issues of race. These silences, together with the more general problem of the shortage of research, result in huge gaps in the knowledge base related to Black men's health. In this regard, all four research informants mentioned issues of gender and masculinity in relation to Black men's health and wellbeing. One informant also identified religion as an important issue among Black communities that hardly emerges in research with/among those communities. For example, religion and spirituality may be important cultural assets for helping to address the transmission and management of HIV among Black communities.

The research informants also advised about methodological approaches to research on Black men's health. Three of the informants noted that health research appears to be driven by individual level approaches to risk, behaviour and behaviour change. They called for greater attention to structural factors. One researcher suggested that standard survey questions about individual behaviour (e.g., "Do you use condoms?" or "How many sexual partners do you have?") may not yield useful results. In contrast, an approach that addresses structural issues may seek to understand the links between poverty, oppression and HIV, for example. Another informant speculated that standard questions about individual behaviour may in fact turn Black youth away from talking about sexuality.

One researcher observed that Black communities appeared ambivalent about the need for (or the role of) research to address community issues, and sometimes distrusted researchers. On the other hand, he suggested that researchers often neglect to disseminate information in a form that people can understand and support. He called for a major research effort on 'the state of Black Canada' where different groups of researchers collaborate on a cross-section of issues related education, economics, health, and so on.

8. REFLECTION, IMPLICATIONS, ACTION

We have demonstrated that, to a notable degree, heterosexual Black men may not conform to familiar renditions of Black masculinity. For example, Black men care about their health and wellbeing, and the wellbeing of their communities. Black men do engage their vulnerability in meaningful ways. However, Black men are complex, in that they also attempt to resolve their vulnerability in ways that are unproductive. For example, though our participants spoke at length about how they engage their spouses and partners about their health, they sometimes appear to naturalize women as caregivers. The Black men who participated in our focus groups also do not have access to the resources that are more broadly available to White men, and which allow certain classes of White men to engage their vulnerabilities in ways that are socially approved, even if destructive. And, though many focus group participants understood ‘heterosexual’ in a very conventional way, others articulated the complexity associated with this identity or orientation.

The implications of iSpeak may be far-reaching, but we offer a few fairly practical ideas on the next steps.

Though our participants spoke approvingly about the health-related services that are generally available, they also harbour deep reservations about the ability and willingness of service providers to productively engage them. This raises a few questions: to what extent do their reservations influence their willingness to engage community-based health agencies and service providers? To what extent do their reservations influence their health behaviours? How should community-based health agencies and service providers (particularly ASOs) address Black men’s reservations? These questions may be research issues. However, the third question could be the subject of an intervention. For example, on the basis of consultations with Black men and other relevant stakeholders throughout Ontario, ACCHO or another competent organization may (a) identify and prioritize specific outreach or engagement initiatives, (b) undertake the required feasibility assessments, and (c) design, implement and evaluate the preferred initiative as an intervention among heterosexual Black men in the province. In addition, respective ASOs may engage advisory committees of stakeholders (including Black men, and structured to ensure that heterosexual men’s voices are not overwhelmed) in reviewing their program descriptions, promotional materials, board recruitment practices and board composition to determine whether those crucial aspects of the organization may be facilitating or impeding accessibility and, where necessary, recommend specific improvements.

There is also a rhetoric of blame that circulates among many community stakeholders, which holds that men are to blame for HIV among Black communities while women are disempowered victims of men’s bad behaviour. This oversimplified perspective is an injustice to Black men and women. What may be required among researchers and service providers is critical reflection on gender and sexism which strengthens women’s agency while also recognizing men’s legitimate claims for better access to various services.

Heterosexual Black men who participated in iSpeak are concerned about the wellbeing of Black communities, and are willing to be more involved in the community response to HIV. Some service providers suggested that Black men ought to be encouraged to demonstrate leadership in the response to HIV. This is an interesting suggestion. Currently, throughout Ontario there are 12 ACB Strategy Workers (i.e., positions in ASOs funded by the AIDS Bureau, Ministry of Health and Long-Term Care, to work on HIV prevention or support with local ACB communities), only two of whom

are men. Hence, it is possible that Black men's needs, challenges and potential may not receive a level of attention that compares well with other ACB groups or issues. We are suggesting that the Strategy Workers may benefit from recruiting and supporting men to advise and assist in engaging their counterparts around HIV prevention.

HIV-positive Black men are concerned by the tide of criminal prosecutions for non-disclosure of HIV status to sexual partners, and the likely over-representation of Black men in media renditions of non-disclosure charges. This issue was raised by one participant in the Toronto focus group. Media reports may help to fuel the more long-standing inhospitable view that Black men are out of control, and destroying themselves and Black communities. This situation raises a few questions that may be explored in new research: How does the climate of criminal prosecution affect the lives of Black men? What impact does the climate of criminal prosecution, and the way in which cases are reported in the media, have on Black men's behaviours related to HIV?

From a program development and advocacy perspective, it is important for organizations to maintain or even strengthen current efforts to ensure a measured and nuanced application of criminal prosecution by criminal justice authorities. However, many PHAs still struggle with disclosure in a variety of different contexts. There are also strategic considerations about how and where people disclose aspects of their background—disclosing anything about oneself depends on what's at stake. Certainly, organizations should give serious thought to developing programs and interventions that build people's ability, confidence and consciousness to assess how, when, where and to whom to disclose their HIV status.

iSpeak is perhaps the fourth study in which new immigrants from Africa claimed to be initially unaware of HIV in Canada, or bemoaned the lack of public acknowledgement and discourse about HIV in Canada.²⁰ Throughout much of sub-Saharan Africa and the Caribbean, people are exposed to various ongoing health promotion and social marketing campaigns about HIV prevention. In Canada, however, there is relatively little public discussion of HIV, and campaigns tend to be restricted to a few neighbourhoods and agencies. This means that new immigrants may not be sufficiently cognisant of their personal stake in HIV prevention as would have been the case in their home countries. In response, ACCHO, together with its community partners, related agencies, and provincial and municipal health authorities may develop a resource to apprise newcomers about HIV trends and HIV risk in Ontario, and provide an annotated list of immigration, settlement and health agencies where newcomers could access HIV-related services or receive more information. This resource could be made available to its intended audiences as part of the immigration and settlement process, but also through physicians' offices, ASOs and other community-based agencies. It would help to engage new immigrants about HIV in Ontario, promote HIV prevention, and help to improve access to appropriate information and services.

A related issue concerns HIV transmission in Canada among African and Caribbean people. Despite popular opinion that immigrants from so-called HIV-endemic countries in Africa and the Caribbean are bringing HIV to Canada, there have been no studies to examine transmission in Canada versus prior infection in Africa or the Caribbean and, for those infected after arrival in Canada, the main drivers of transmission. This new research will not only address an important gap in the knowledge base about HIV transmission, but may also inform new perspectives on HIV prevention among African and Caribbean people in Ontario.

iSpeak participants articulated their interest in and potential for greater involvement in community

responses to HIV in Ontario. They also spoke about the relative lack of attention from service providing institutions. All groups of participants (heterosexual Black men, service providers and researchers) indicated that issues related to Black men's health and wellbeing are somewhat overlooked. This situation calls for renewed community engagement and research efforts related to health and HIV. Though the iSpeak research study was principally concerned with HIV, efforts to engage communities in the response to HIV are not just about HIV. There is a broader health imperative at stake, which situates health and wellbeing in relation to the social determinants of health, and supports community action that is informed by critical reflection on their vulnerabilities and their strengths.²¹ It is also worth remembering that stigma associated with HIV is still pervasive. Consequently, from a community engagement perspective, it is prudent to address HIV in the context of health and wellbeing, rather than as an isolated condition that ails Black communities.

In the spirit of thinking anew about what we claim to know, we hope that iSpeak may be a platform for the emergence of new, informed perspectives on sex, sexuality, and masculinity related to Black men, how we (communities, service providers and researchers) understand the spread of HIV among Black communities in Canada, and how to mount an appropriately informed response to HIV. Traditionally, African and Caribbean peoples have been reluctant to entertain meaningful, public discourses on sex and sexuality. Since slavery, this silence has been filled by prejudiced discourses on Black men's alleged hypersexuality and destructive masculinity. These peculiar discourses have even been taken up by Black communities—some Black men understand themselves as “saga boys” and “players”, while Black women lament their men's abundant irresponsibility. But why would Black men join a movement or avail themselves of services in an environment where they are considered suspect and blameworthy? Whose interests are served by the one-dimensional identity of the wild Black man versus the suffering, aggrieved Black woman? How we answer these questions may well shape how we emerge from the HIV epidemic.

iSpeak was never intended to answer all the questions related to heterosexual Black men and HIV. In this regard the project appears to have fulfilled its promise by: (a) challenging us and our colleagues to re-evaluate what we think we know about Black men, and to think creatively about Black men in relation to health and HIV; (b) engaging heterosexual Black men and listening to their stories and perspectives on HIV and health; (c) showing that Black men are more caricatured than understood in Canadian society; (d) pointing to the need to strengthen research on health and wellbeing among Black communities (particularly among Black men), and perspectives to guide that work; and (e) identifying opportunities to strengthen heterosexual Black men's involvement in community responses to HIV, and build the knowledge base to inform those efforts.

NOTES

¹The term “African, Caribbean and Black (ACB)” is often used in Ontario to accommodate a range of Black identities. In this report we use “ACB” and “Black” interchangeably. “Black” has the benefit of simplicity and avoids referring to people by an acronym.

²Epidemiological data are from: (a) Remis, R., Swantee, C., Liu, J. (2012). *Report on HIV/AIDS in Ontario 2009*. Ontario HIV Epidemiologic Monitoring Unit; and (b) Remis, R., Swantee C., Schiedel, L., Fikre, M. and Liu, J. (2006). *Report on HIV/AIDS in Ontario 2004*. Ontario HIV Epidemiologic Monitoring Unit.

³The high proportion of diagnoses among women may also reflect testing associated with pregnancy.

⁴HIV Endemic Task Force (2003). *Strategy to Address Issues Related to HIV Faced by People in Ontario from Countries Where HIV is Endemic*. Toronto: African and Caribbean Council on HIV/AIDS in Ontario (www.accho.ca/pdf/ACCHO_strategy_ENGLISH_Dec2003.pdf).

⁵Leonard, L. (2013). What HIV-positive African, Caribbean and Black women have to say about HIV prevention. Presented at the Annual KTE Forum: African, Caribbean and Black Women Living with HIV. Toronto. March 16.

⁶Since then, several other Black men have been charged with various non-disclosure offences related to sex with female partners. See: (a) Mykhalovskiy, E., Betteridge, G. (2010). Who? What? Where? When? And with what consequences? An analysis of criminal cases of HIV non-disclosure in Canada. *Canadian Journal of Law and Society* 27(1), 31-53; and (b) Larcher, A., Symington, A. (2010). *Criminals and Victims? The Impact of the Criminalization of HIV Non-Disclosure on African, Caribbean and Black Communities in Ontario*. African and Caribbean Council on HIV/AIDS in Ontario.

⁷see Miller, J. (2005). African immigrant damnation syndrome: The case of Charles Ssenyonga. *Sexuality Research & Social Policy* 2(2), 31-50.

⁸Wai, Z. (2012). *Epistemologies of African Conflicts: Violence, Evolutionism, and the War in Sierra Leone*. London: Palgrave Macmillan

⁹hooks, b. (2004). *We Real Cool: Black Men and Masculinity*. New York: Routledge, pp. 47-68.

¹⁰ibid.

¹¹Bowleg, L., Teti, M., Massie, J. S., Patel, A., Malebranche, D. J., Tschann, J. M. (2011). ‘What does it take to be a man? What is a real man?’: ideologies of masculinity and HIV sexual risk among Black heterosexual men. *Culture, Health & Sexuality* 13(5), 545-559.

¹²Mahalik, J. R., Burns, S. M., Syzdek, M. (2007). Masculinity and perceived normative health behaviors as predictors of men’s health behaviors. *Social Science and Medicine* 64(11), 2201-2209.

¹³see Frosh, S., Phoenix, A., Pattman, R. (2003). Taking a stand: using psychoanalysis to explore the positioning of subjects in discourse. *British Journal of Social Psychology* 42(1), 39-53.

¹⁴Scripts work in tandem with categories, discourses and systems of representations to provide dominant cultural frames of reference. We use the term script here interchangeably with the conceptual terms “category” and “discourse”.

¹⁵see Husbands, W., Makoroka, L., Walcott, R., Adam, B., George, C., Remis, R., Rourke, S. (2013). Black gay men as sexual subjects: race, racialization and the social relations of sex among Black gay men in Toronto. *Culture, Health & Sexuality* 15(4), 434-449.

¹⁶The argument here is that men’s ability to cope with vulnerability in their environment will vary depending on the individual and the nature of his social circumstance. Men don’t all cope with vulnerability in the same stereotypical way.

¹⁷Williams, R. (2009). Masculinities and vulnerability: the solitary discourses and practices of African-Caribbean and White working-class fathers. *Men and Masculinities* 11(4), 441-461.

¹⁸These peculiar health-related problems include gun violence and other issues related to crime and the criminal justice system.

¹⁹That is, except the type of issues understood as peculiar health-related problems (see note above).

²⁰The other studies are: (a) Lawson, E., Gardezi, F., Calzavara, L., Husbands, W., Myers, T., Tharao, W., and the Stigma Study Team (2006). *HIV/AIDS Stigma, Denial, Fear and Discrimination: Experiences and Responses of People from African and Caribbean Communities in Toronto*. ACCHO and the HIV Social, Behavioural and Epidemiologic Studies Unit, University of Toronto; (b) Husbands, W., Makoroka, L., George, C., Adam, B., Remis, R., Rourke, S., Beyene, J. (2010). *MaBwana: Health, Community and Vulnerability to HIV among African, Caribbean and Black Gay and Bisexual Men in Toronto*. ACCHO and ACT; and (c) Shimeles, H., Husbands, W., George, C., Fenta, H., Afzal, A., Baidooobonso, S., Mbulaheni, T. (2013). *Staying Alive: Evaluation of the “Keep it Alive!” HIV Awareness and Prevention Campaign for African, Caribbean and Black Communities in Ontario*. ACCHO.

²¹see Campbell, C. (2003). *‘Letting Them Die’: Why HIV/AIDS Programs Fail*. Oxford: International African Institute and James Currey (pp. 35-60).

TALKING BLACK: Understanding the HIV-related needs, challenges and priorities of heterosexual African, Caribbean and Black men in Ontario, Canada

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