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Members of Toronto's African Communities

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FOREWORD

A central focus around the world during the year 2001 is **Men and AIDS**. This year is bracketed by two World AIDS Day themes, **AIDS: Men Make a Difference (2000)** and **Men and AIDS: I Care. Do you? (2001)**. At the turn of the millennium Kofi Annan, Secretary–General of the United Nations noted that: men can make a particular difference; by being more caring, by taking fewer risks, and by facing the issue of AIDS head-on (Message for World AIDS Day, December 1, 2000). While not singling out the issues of gay and bisexual men, these statements and foci provide an opportunity for members of gay and bisexual communities to reflect within the broader societal, cultural, economic and political contexts of their masculinity, manhood and sexuality.

In order to meet its goal in reversing the spread of HIV/AIDS by the year 2015, the United Nations laid out the challenge of HIV/AIDS by emphasizing the importance of: strengthening leadership, alleviating the social and economic impacts of the epidemic, reducing vulnerability, intensifying prevention, increasing care and support, and providing international public good and increasing resources (United Nations General Assembly, February 16, 2001). This international perspective highlights that behaviours, attitudes and understandings of sexuality and masculinity are widely varied around the world.

This report, on the discussions within several ethnocultural communities of men who have sex with men (MSM) in Toronto, including Asian, Portuguese-speaking, South Asian, Spanish-speaking and members of Toronto's African communities, illustrates a similar diversity. The report is the product of partnerships between researchers of the HIV Social Behavioural and Epidemiological Studies Unit and these communities. The acronym MSM was selected to encompass a breadth of identities of men in many different cultural contexts. This report reflects many of the complexities in defining and describing these populations, particularly in light of complex cultural understandings of sexuality and masculinity. The discussions clearly revealed that within Canada, where there are many cultural influences including those of ethnocultural origin, the application of stereotypic North American designations of 'gay and bisexual' and reference to a single gay and bisexual community are inadequate. By culture we mean the system or framework of beliefs and values by which individuals define their world and express their feelings (Geertz, 1957). Within the gay community there may be multiple norms or meanings and or multiple cultures in operation. This includes those that arise in particular from ethnocultural diversity and others that may arise from patterns of sexual behaviour or sexual cultures. The intersection of these various cultures leads to many different forms of socialization, differences in individual lifestyle, and to different institutional responses.

Research undertaken by members of the HIV Social Behavioural and Epidemiological Studies Unit, University of Toronto has revealed that classic images and stereotypes of gay and bisexual men do not adequately reflect the breadth of behaviour and identities within the visible gay community, let alone the more hidden populations of MSM. In the Talking Sex Project, a focussed prevention intervention undertaken in 1988/89 through the AIDS Committee of Toronto, we learned that men who came forward as group facilitators for educational events did not fit a single image or mode. Individual facilitators were diverse in socioeconomic status, body type, lifestyle, ethnocultural origin – yes, and sexual preference. The BISEX Survey conducted in 1996, further illustrated that MSM vary greatly in their community affiliation, occupation, marital and relationship status. It must be acknowledged that much of the research conducted to date has not widely represented MSM from diverse ethnocultural communities because of factors such

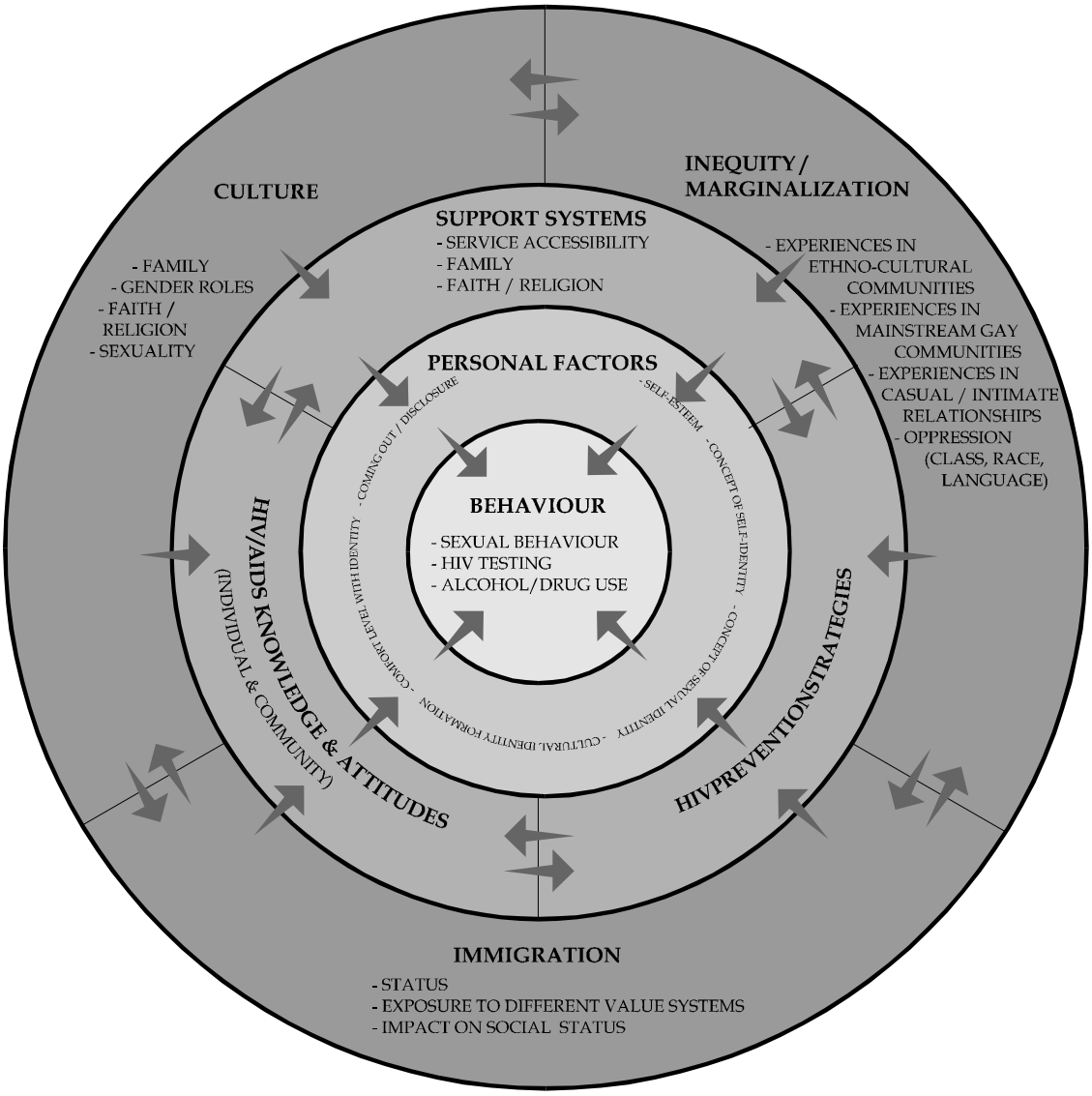
as language, patterns of socialization and issues related to marginalization within and outside specific communities. This needs assessment was undertaken as a result of the leadership, interest and participation from the diverse ethnocultural community. It was initiated in order to begin to understand some of the issues consider in establishing a research agenda and in developing partnerships for future research with MSM from ethnocultural communities.

Since the late 70's and early 80's when the HIV epidemic began to emerge, there have been dramatic changes in the organization and development of the gay and bisexual community in Toronto. During this same time the population and ethnocultural composition of the City of Toronto has continued to change. Members of various ethnocultural populations comprising the City have experienced varying degrees of integration, exclusion and influence within the so-called 'gay and bisexual community of Toronto'. Accompanying the development of the gay and bisexual community there has been varying degrees of community development and organization within ethnocultural communities of MSM. Some are well represented by specific ethnocultural gay and lesbian and AIDS service organizations. Others are onlookers and still others continue to experience lack of resources and support, and remain without formal or informal organizations to represent them.

This research needs assessment was undertaken in the context of HIV/AIDS prevention and care programs. As illustrated in 'The Dynamic Model for Ethnocultural Research', developed by the MSM ethnocultural research team to organize the important concepts, the core or central interests were on sexual risk-taking behaviour, HIV testing and service access. The model depicts that the layers of factors that influence behaviour are complex and dynamic. These factors vary with each ethnocultural community. In most ethnocultural communities there were common but different cultural factors that are dominant (i.e. language, religion, family structures and roles), and different experiences of immigration, and inequity/marginalization (i.e. external and internal, oppression or racism). The interaction within and between cultural environments greatly determines the effectiveness and development of social support systems, HIV education and prevention strategies, as well as an individual's knowledge, identity, and subsequent behaviour.

This report highlights the importance of culture in the broadest sense (beliefs, values, norms, and meanings) and complexity of interactions in understanding culture and community. It identifies many areas where there are serious gaps in research among MSM from diverse ethnocultural communities. It opens the door for further research and discussion to help understand the sexuality of men within and between different ethnocultural communities, and the importance of these for HIV/AIDS programming.

A dynamic model for ethno-cultural research



ORGANIZATION OF REPORT

The findings of this study are reported in five chapters, each relating to a specific ethno-cultural community. Each chapter was written with the hope of presenting the information in a systematic manner, while preserving the inherent uniqueness of each community. Each community chapter documents the different working partnerships that developed, as well as the unique themes, issues, suggested research questions and recommendations.

This report represents the product of many hours of collaborative work between researchers and communities. Individual community chapters reflect a consensus of the community working /advisory groups.

PROJECT BACKGROUND

Background

The Studies of Men who have Sex with Men (MSM) in Ethno-Cultural Communities Project emerged in June of 1999 from a community consultation conducted by the HIV Social, Behavioural and Epidemiological Studies Unit (HIV Studies Unit) with the Toronto-based Gay Men's Education Network (G-MEN). The purpose of that meeting was to seek community input in Toronto on the feasibility and content of future research initiatives related to gay and bisexual men, specifically, a venue-based survey focusing on self-identified gay and bisexual men. It was agreed at that consultation that a single study would be inadequate to address the HIV prevention research issues among MSM in Toronto's diverse ethno-cultural communities.

Given the complexity, scope and diversity of issues facing ethno-cultural MSM in Toronto, this developmental project was proposed to further identify interest, areas for research, in-depth research questions and appropriate research methods.

This project comprised an effort on the part of the HIV Studies Unit to build successful project partnerships with community agencies and individuals. This project also marks a milestone in Canadian HIV research: the identification of research issues and needs in several ethno-specific communities at once.

Project Goals

The specific goals of this project were to:

a) Develop a conceptual framework for HIV prevention research among specific ethno-cultural communities of MSM in Toronto;
b) Identify ethno-specific research issues and questions pertinent to MSM in Toronto;
c) Identify appropriate methods for the study of priority issues.

Strategic Partnerships

To meet the project objectives, partnerships were developed with the Alliance for South Asian AIDS Prevention (ASAP), Asian Community AIDS Services (ACAS), the Centre for Spanish Speaking Peoples (CSSP), VIVER (Portuguese-speaking HIV/AIDS Coalition), and individual members of the African communities (unfortunately, Toronto's Caribbean Black communities were unable to participate in this project). They were selected because members of these communities and agencies were present at the G-MEN consultation, and they reflect a key component of culture-specific HIV service provision.

Letters of understanding were sought from each agency/community; funds also were made available to facilitate the additional work and leadership placed on the MSM Outreach workers by this project in each community. Working groups were quickly established with each partner. These groups were comprised of agency staff members, community members and volunteers, and staff from the HIV Studies Unit. In order to be able to draw on the skills and experience of each Working Group member, the Investigators' Team, and the project staff, and to ensure efficient communication, roles and expectations of each were clearly defined (see Appendix I - Terms of Reference). Their principal task of the working group was to advise on appropriate methods for assessing research issues, and to facilitate the collection of information from key informants and focus group participants. In some cases, the Working Group felt they held sufficient information about their communities on their own, and served as a consultant group.

Note on Demographic Statistics

In the early phases of this project, it was noted that the MSM who were reached by agency staff through outreach initiatives in bars, bathhouses, parks, and other venues, were distributed across Toronto and its environs. Consequently, when MSM or specific ethno-cultural communities are referred to in this document, or where population figures or estimates are provided, they refer to the Greater Toronto Area (population of approximately 4.5 million).

AFRICAN COMMUNITIES

PROJECT PROCESS

Initiation of Project Partnership

Unlike the other ethno-cultural communities participating in this project, there is no designated social support group for African MSM and no designated MSM worker in African community agencies. During the initial phase of this project, individual members of African communities were contacted to assess their interest in participating in this project. An initial meeting was held with Esther Tharao, Community Educator, HIV/AIDS and Sexual Health from Women's Health in Women's Hands, to assess community interest and to identify key community contacts and informants. Through these contacts, an informal circle of African MSM emerged.

Method

To identify themes and issues in relation to HIV, a focus group lasting 4 hours was held at a key contact's residence, with 10 African MSM in attendance. Project staff worked in collaboration with two key contacts in the development of a questionnaire guide available in both French and English. This questionnaire was developed to serve as an ice-breaker and a basis for discussion. The results of the questionnaire were not tabulated. The focus group was audio-taped. Participants were between the ages of 26 to 35, had been living in Canada between 3 and 11 years (mean = 4), and identified with the following ethno-cultural groups, in response to an open-ended question about their ethno-cultural identification: African (4), Burundian (1), Somali (1), Black (1) and Black African (1). Countries of origin included: Burundi (5), Somalia (1) and Kenya (1).

In addition, three key informant interviews lasting between 2 and 3 hours were conducted with community workers (all had contact with MSM). Two interviewees were from African-based AIDS Service Organizations (ASOs): Africans In Partnership Against AIDS (APAA) and the African Community Health Services (ACHES). Informants identified Mali, Kenya and Canada as countries of origin. The ethno-cultural groups most strongly identified with were African, African/Canadian and Malian/Canadian. African communities most represented by the key informant interviews were East African. Unit staff developed a questionnaire guide for these interviews, which was reviewed by several key contacts. The interviews were audiotaped.

Project Strengths & Limitations

Unit staff and key African community contacts identified the following strengths and limitations of the project:

Strengths:

- This research needs assessment is a preliminary understanding of the HIV-related issues and themes for African MSM.
- This project provides a platform on which future research concerning African MSM, and future services, can be based upon.
- The project succeeded in hearing the voices and experiences from a small sample of African MSM.

Limitations:

- Several key contacts in the African communities who were approached were unable to be interviewed. It is believed these efforts may have failed due to the stigma related to homosexuality in the African communities;
  - Time and human resource constraints did not permit the contacting of all suggested key informants;
  - A small number of African MSM participated in this project, and the range of communities represented was limited primarily to Eastern African countries. There was no representation of Southern, Western and Northern African communities.
  - Key informant interviews, restricted to service providers, limited the depth of understanding of the issues of African MSM.

COMMUNITY PROFILE

The 1996 Canadian Census lists 224,000 people of African origin living in Canada; 139,000 reside in Ontario, of which 99,000 (70%) are in the Greater Toronto Area. The most populated communities represented in GTA are Somalia, Egypt, Ghana, Ethiopia, South Africa, Nigeria, Eritrea, Morocco, Sudan, Kenya, Mauritius, Zaire, Tanzania, Uganda, Algeria, Tunisia, Rwanda and Burundi. As the table below indicates, the majority of Africans living in Canada immigrated in the last 30 years.

Period of Immigration	African Immigration to Canada
Before 1961	4,945
1961-1970	25,685
1971-1980	58,150
1981-1990	64,265
1991-1996	76,260

Toronto's African communities are diverse in culture, language, values, education and employment status. In the countries of origin as in African communities off the continent, distinct religious, regional, tribal or clan lines are known to sometimes cause conflict.

According to one service provider, members of Toronto's African communities attempt to acculturate by adopting more North American values; at the same time, they strive to maintain their African values. This often is done for the advantage of children, who can learn their parents' mother tongue and African cultural traditions, while also being exposed to Western cultural values outside of the home.

African MSM Population

Remis (personal communication, 2000) estimates that between 4 and 6% of men between the ages of 18 and 65 in the GTA are MSM, suggesting that up to 3,000 African MSM reside in GTA. Paradoxically, community views about the size of African MSM populations vary. African MSM focus group participants insisted that a large gay African community exists in Toronto. On the other hand, one service provider did not believe African gay men existed; if they did, their numbers were very low and insignificant.

Services for African MSM

Though several gay and lesbian social support and advocacy groups have surfaced in some countries of origin, such as in Zimbabwe, Tanzania and Uganda, there are no similar organizations in Toronto. Moreover, in the two African community-based AIDS Service Organizations in Toronto, accessibility to African MSM is a concern (this is described later on). No formally mandated services for African MSM in Toronto exist. Some African MSM focus group participants believe this to be partially due to the recency of immigration of Africans to Canada as well as the lack of recognition by the community of the existence of homosexuality.

IDENTIFIED THEMES & ISSUES

The following themes and issues emerged from the key informant interviews with service providers and from the focus group with African MSM. It is important and necessary at times in the following discussion, to highlight issues raised either by service providers or African MSM participants to emphasize differences in opinions or beliefs between the two.

Culture

Concern for Social Acceptance

Service providers and African MSM acknowledged general concern among Africans for social acceptance. As explained by one African MSM participant, "acceptance needs to come not only from one's families but more so from one's communities and governments", implying that many Africans put priority on approval from their communities.

Family Expectations / Pressure to Marry / Gender Roles

In many African cultures, fulfillment of family expectations is essential. Anything done beyond these expectations is considered private and not talked about. For example, both homosexuality and heterosexual promiscuity are understood in this way. For African men and women, there is pressure to marry; prescribed African gender roles emphasize that men will act as providers and carry on their family name, while women are expected to be nurturing and bear children. The pressure to fulfill one's cultural and familial obligations, such as marriage, is so great that despite their homosexuality, African MSM marry and raise their families.

Cultural Attitudes towards Sexuality

According to an African MSM participant, "everything in Africa that is not considered normal is taboo". This limits open discussion on sex, homosexuality, HIV/AIDS and condoms. Although community-driven HIV educational strategies are opening discussion in African-Canadian communities, resistance to speak with African youth about these issues still exists. Many parents will not discuss sexuality with their children and also lack HIV/AIDS information, leaving African youth relying on peers to learn about sex, and lacking information about how to protect themselves from HIV/AIDS.

Although service providers and African MSM agreed that African communities possess some knowledge of HIV/AIDS, the disease generally is not discussed in public. The word "AIDS" is taboo because of its association with immorality, including homosexuality and prostitution, as well as its association with sex. Further, a person's homosexuality is not openly discussed, even

if it is known. An African MSM participant attributed this to a cultural value that dictates "Keep it to yourself, don't act gay", "it's OK as long as you don't bring it to the dinner table". Others stated that while discussion about MSM and HIV occurs, it tends to be pejorative: "MSM are faggots", or "Gay men don't exist in our communities".

African MSM fear discussing their sexual orientation because they don't want to be ridiculed, beaten by peers, or have their families find out about their same-sex desires. Many participants recounted feeling discomfort when speaking openly about their sexuality with family members and also feared community reactions. Indeed, during the focus group, there was laughter, joking and embarrassment among participants when discussing sexuality.

Religious Proscriptions against Homosexuality

Service providers and African MSM spoke of the intense homophobia that is sanctioned by both the Christian and Islamic faiths; homosexuality is viewed as immoral, transcending all other sins. The impact on African MSM is significant: they fear disclosure of their sexual preference, experience social isolation and internalized homophobia, and lack support systems.

Cultural Values associated with Condom Use

Service providers and African MSM participants described some of the cultural values related to condom use. For some, sex is perceived as better without condoms. As an African MSM stated, "how can I eat a candy without removing the wrapper?" Others regard condom use mainly for contraception and not for sexually transmitted infections (STIs) or HIV/AIDS prevention.

It is regarded as mistrusting or questioning one's partner's fidelity to request that condoms be used in sexual relations. This may be particularly so in some African communities of origin, where women have limited power to request condom use.

Finally, trust and fate are significant determinants of condom use among some Africans. For many homosexual and heterosexual African couples, there is an assumption of trust after they have been together for one or two months, and condoms are viewed as no longer necessary. Further, one service provider drew attention to a belief held by some in African communities that if it is meant for you to contract HIV, it will happen regardless of what protection you use.

■ Sexuality ■

Many African MSM participants acknowledged inner conflicts related to their sexuality, with one African MSM stating: "There is no way they are going to accept you if you don't accept yourself". Another participant said that these inner conflicts affect the ability of African MSM to use condoms for anal sex, while others use alcohol and/or drugs to cope with these stressors.

Disclosure of one's sexual identity or behaviour was raised as an important issue for African MSM. Some of these men immigrate to Canada (leaving families behind) believing they can escape discrimination and live more freely. One participant revealed it might also be more difficult for first-generation African MSM to come out to their parents.

African MSM who choose to disclose their sexual identity tend to do so only in mainstream North American communities rather than in their ethno-cultural communities. As the African MSM participants explained, many African MSM feel a need to "step outside of one's culture" in order to identify as gay. This is also the same for Africans who are HIV-positive: in order for

them to access services and to disclose their serostatus, they feel they must leave their cultural roots behind.

Many African MSM encounter obstacles disclosing their sexual identity. For instance, it is taboo to have open discussions about sexuality. Many African MSM also fear adverse reactions from friends, families and communities. There exists concern over what others will say about an individual's sexuality. Many fear being isolated or taunted.

Some African MSM do not have any desire to disclose their sexual identity, and most do not identify with the label "gay". One informant stated that in Tanzanian communities, people don't identify with any particular sexual orientation; another suggested this may be due to the shame associated with being gay in African communities. Some African MSM participants expressed they did not feel the need to come out. As one participant stated, "Just be yourself and they end up accepting you as you are". Such a statement seems contradictory to the North American concept of coming out, but for some African MSM, "being yourself" is plausible with not disclosing one's sexual identity or behaviour. This can be problematic, for those non-gay identified African MSM who believe themselves to be at minimal risk for HIV, since AIDS is perceived as a gay disease. Perception of risk is also impacted by the belief that the active/insertive sexual partner is not gay and therefore not at risk.

■ HIV/AIDS Information ■

HIV/AIDS knowledge levels vary in African communities. Some informants and African MSM believed limited HIV/AIDS information exists, and others were concerned with whether it was being accessed. There also are varied opinions on the degree to which HIV/AIDS is a community concern. According to a service provider, many believe HIV/AIDS is not a problem in their communities, as they have no information about it. According to another informant, the level of awareness of individuals in African communities may depend on the amount of HIV education in their countries of origin. For example, Ugandans in Canada have more HIV/AIDS information because of the extensive prevention efforts in their country of origin.

African communities hold common misperceptions about HIV/AIDS, including the belief that HIV and AIDS are the same, and that they are only concerns for gay men. Unfortunately, this belief is reinforced by HIV educational materials that exclusively target gay men, reinforcing the myth that HIV/AIDS is synonymous with homosexuality. Some people believe gay men are more likely to contract HIV, since "sperm mixed with substance from the anus produces HIV". Such assumptions reveal a common misunderstanding that HIV risk is associated with sexual identity (as gay or bisexual) rather than sexual behaviour. Similarly, there is a false perception that those who engage in anonymous sex will inevitably have unsafe sex. Such beliefs falsely associate HIV risk with contextual factors rather than with sexual behaviours. Finally, "looking healthy" is falsely regarded as an indicator of HIV-negativity; HIV-positive individuals are expected to look visibly ill.

■ Attitudes towards Homosexuality & Bisexuality ■

African communities hold many stereotypes about homosexuality, including the beliefs that all gay men are either effeminate or into leather. Considerable misinformation about homosexuality also exists, including the association with transvestitism (cross-dressing), and believing it to be a sexual perversion or mental illness. One African MSM noted that bisexuality tends to be regarded as unacceptable and is questioned in African communities. Using his own experience

as an example, he recounted how others believe his bisexuality is a cover for his sexual desires for men. Marriage and cultural/familial obligations provide another explanation why the community believes bisexuality is simply a cover for homosexuality: the acknowledgement that African MSM get married encourages the belief that bisexuality is not legitimate. For these reasons, many African MSM hide their bisexuality from their male and female partners.

African MSM and service providers stated that there is a belief in Toronto's African communities that homosexuality is a white North American condition; gay Africans do not exist. Those who self-identify as gay are regarded as merely "adopting" a North American concept of homosexuality. This misperception also is held by some African MSM. One focus group participant recounted how an African MSM acquaintance who, believing African gay men did not exist, could not understand or interpret his own sexual desires for men.

Among Toronto's African communities, homosexuality is believed to be a choice, something that can be influenced by external factors. One service provider stated that MSM "choose to be gay…they decide to be like this…and must know the positive and negative consequences of making such a choice." Another explained that some parents blame themselves for their son's homosexuality, believing they did not do enough for their son's education, also implying a belief that external factors can influence sexual orientation.

In many African communities, shame and stigma are attached to homosexuality. African gay men are seen as failing their African culture if they come out as gay. One African MSM participant told of a gay African friend who feared being identified as gay if he went to an African AIDS Service Organization (ASO). African MSM also fear rejection and ostracization from family and friends. Consequently, they fear associating with other MSM.

African communities in Toronto are thought to be as homophobic as the countries of origin. Ignorance and lack of information about homosexuality are believed to be the roots of homophobia. One service provider explained that lack of awareness and education results in inaccurate stereotyping. Shame and internalized homophobia are the resulting experiences for some African MSM who have difficulty admitting their same-sex desires or activities to themselves and to others.

■ Social Support Systems ■

African MSM face discrimination in mainstream gay communities in Toronto. In gay organizations, African MSM face racism, as well as discrimination based on their lower social class. They are also often ridiculed, taunted and shunned by their own cultural communities, and direct hostility is not uncommon.

Participants spoke of the absence of social support systems for African MSM, and the ostracization experienced in their communities. Many don't want to be recognized by other community members, and fear associating with other MSM. They isolate themselves from other African MSM, denying the support they could provide each other. One African MSM participant clarified, "even between us (African MSM), we don't have that connection". There are few African gay role models to decrease this isolation. Further, some participants believed that many gay African men are HIV-positive but they lack support from gay-positive HIV services and are alienated from their communities.

■ Barriers to HIV-related Services ■

One service provider noted that despite the large number of HIV-related services in Toronto, very few African people or other people of color access them. One African MSM participant stated that Africans tend not to access mainstream services due to language and literacy barriers. Another barrier is faced by some African MSM who do not self-identify as gay ; since HIV is regarded as a gay disease in most African communities, many fear being associated with the disease.

There is varied knowledge of HIV-related services in Toronto's African communities. Many new African immigrants do not know where to get condoms or anonymous HIV testing. In fact, most participants did not know about the existing African ASOs.

Illegal immigrants cannot access any health services. Some HIV-positive African MSM who are here illegally, worry about disclosing their serostatus for fear of being deported back to Africa.

According to African MSM participants, there are no community support services for African MSM, especially for those who are HIV-positive. Service providers lack knowledge of sexual orientation issues, and do not recognize that HIV-positive men could be MSM. Consequently, services are unable to respond to the unique needs of African MSM. Some African MSM are concerned about confidentiality in these agencies. African ASOs are perceived by African MSM participants as providing the African communities with general HIV/AIDS information rather than specifically targeting gay African men. This perception is reinforced by the agencies' mandates, which confirm they target the general African communities. One African MSM stated you would never find an openly gay-identified person working at these agencies. Many African MSM perceived these agencies to be homophobic.

■ Barriers to Reaching African MSM ■

Service providers stated that African MSM are inaccessible to them and they therefore don't understand their needs. One informant explained how HIV prevention efforts with African MSM are difficult because they do not know how to reach them. This informant also said some service providers do not target African MSM in prevention work since they believe African MSM do not exist. These difficulties in reaching African MSM may be attributed to the taboo surrounding open discussion about sexuality. One service provider stated that she had never encountered any African gay men in her community work or her social life. Another service provider believed that some African MSM, fearing shame and discrimination, hide their sexual preference for men from their communities by integrating in these communities. Finally, one service provider said it would be easier to provide services to African MSM if they were more formally organized as a group.

■ Responses towards HIV/AIDS ■

Many African communities are mistrustful of HIV/AIDS information disseminated by mainstream institutions and are apprehensive about research findings related to their communities. This mistrust is rooted in a history of colonization and slavery of the African continent and its people. One informant explained the attitude, "why should we trust the white people and what they tell us is happening to us… Slavery and colonization may be over but the repercussions can still be felt today in African communities. "

Many Africans in Toronto believe HIV/AIDS is someone else's problem, denying it has any relevance to their communities. The perception that HIV/AIDS is a white man's disease is also pervasive. One service provider explained this perception derives from the fact that many of those who first began speaking out publicly about HIV/AIDS were white gay men. Africans living with HIV/AIDS do not want to reveal their serostatus since HIV/AIDS is stigmatized and perceived as shameful.

RECOMMENDATIONS

African MSM participants and service providers put forth the following recommendations:

Advocacy

Community Supports for African MSM

- Sensitize African communities about African MSM and their urgent needs and issues.
- Promote support for African MSM among community elders.
- Advocate for positive community role models for young African MSM.
- Promote more community organizing among African MSM.
- Advocate for accessibility in mainstream and ethno-specific ASOs for African MSM.
- Promote community strategies for increasing invisibility of African MSM (eg. Radio, TV, newspaper).

Support Services for African MSM

- Recognize that African MSM are a hidden population; many do not label themselves as gay, while others may be closeted.
- Identify and eliminate barriers for African MSM in mainstream and ethno-specific HIV services.
- Encourage dialogue between African MSM and ASOs so that service providers can better understand and respond to their needs.
- Provide counselling support services for African MSM.
- Provide counselling support services for African MSM who are HIV-positive.

Education & Prevention

- Educate African service providers about sexual orientation and HIV issues (African MSM should be involved in the design and implementation of such initiatives).
- Target HIV educational materials and programs to African MSM (targetting gay men will be ineffective).

Research

- Research must be community-driven and action-oriented.
- Researchers must recognize the diversity of African communities.
- The stigmatization of homosexuality and HIV make confidentiality and anonymity paramount research concerns. Audiotaping may not be acceptable to many Africans.
- Before conducting focus groups or interviews, it is important to consider the:
    a) ethnicity, gender, and sexual orientation of facilitators;
    b) literacy levels of group participants;
    c) knowledge base of facilitator related to African MSM and HIV issues;

d) diversity of understood languages.

- To reach non gay-identified African MSM, alternates to gay-identified venues need to be identified for places of recruitment.
- African MSM may be more likely to participate in community-wide research initiatives rather than those specifically targeted to MSM.
- Successful research methods might include:
    a) Anonymous phone surveys;
    b) Mail-out questionnaires;
    c) Face-to-face interviews and focus groups are possible methods for data collection (though these will raise concerns about confidentiality/anonymity);
    d) Honorarium to cover out-of-pocket expenses should be offered to research participants.

Accessing African MSM

- Random sampling of African MSM may be difficult to attain; therefore convenience and snowball sampling methods are recommended.
- Key community informants (including community leaders, religious leaders, health care, social service and ASO staff) should be involved in participant recruitment.

■ SUGGESTED RESEARCH QUESTIONS ■

■ Culture ■

Family / Gender Roles

- How do family expectations, pressure to marry, and gender roles impact on sexual identity formation for African MSM?
- How do family expectations, pressure to marry and gender roles impact on sexual risk-taking behaviour amongst African MSM.
- How do family expectations, pressure to marry and gender roles impact on how African MSM feel about themselves (self-esteem, depression, worry, fear, etc.)?

Sexuality

- How is homosexuality and bisexuality viewed in African communities? How do these views affect African MSM?
- How do cultural attitudes toward sexuality affect the sexual behaviour of African MSM?
- What cultural values and beliefs are related to condom use among African MSM?
- How are these values and beliefs related to sexual risk-taking among African MSM?

Religion

- How do religious beliefs about homosexuality affect African MSM in terms of:
    - disclosure of sexual orientation?
    - internalized homophobia?
    - social isolation?
    - access to support systems and services?

■ Immigration ■

Status

- Do factors related to immigration affect disclosure of sexual identity among African MSM?
- Are there differences between recent immigrant versus first generation African MSM with respect to disclosure of sexual orientation?

■ Marginalization / Inequity ■

Experiences in mainstream gay communities

- How do African MSM experience the mainstream gay community?
- How do gay men in the mainstream gay community view African MSM?

Experiences in ethno-cultural communities

- How do African communities view African MSM?
- How does the illegality of sodomy affect African MSM in their countries of origin?

■ Identity ■

Concept of Sexual Identity

- Is the North American conceptualization of sexual identity relevant for African MSM. If not, how do these men describe themselves sexually?

■ HIV/AIDS Knowledge & Attitudes ■

I. INDIVIDUAL

Knowledge & Attitudes

- What is the general level of HIV/AIDS knowledge among African MSM?
- What are common misconceptions held by African MSM regarding HIV/AIDS?
- Where do African MSM access HIV/AIDS information?

Knowledge of Risk Behaviours

- What do African MSM perceive as HIV-risk behaviours?

II. COMMMUNITY

HIV/AIDS Knowledge

- What is the knowledge base concerning sexual orientation issues among African health and social service providers in Toronto?

■ Behaviours ■

Sexual Behaviours

- How is knowledge of HIV/AIDS related to sexual behaviour among African MSM?

■ Alcohol / Drug Use ■

- How does substance use (alcohol and drug use) affect sexual risk-taking behaviour among African MSM?

■ Support Systems ■

Service Accessibility

- What social supports, health care and social services do African MSM require?
- What social supports, health care and social services do HIV-positive African MSM require?
- What are the barriers experienced by African MSM in African based-health care and social services?
    - What barriers do African MSM encounter in mainstream AIDS Service Organizations?
    - What barriers do African MSM encounter in ethno-specific AIDS Service Organizations?
    - What would reduce barriers for African MSM in mainstream and ethno-specific AIDS Service Organizations?

■ HIV Prevention Strategies ■

- What HIV prevention strategies are effective for African MSM?
- What are effective means of reaching African MSM with prevention initiatives?
- What are effective means for including African MSM in research initiatives?

■ ASIAN COMMUNITIES ■

■ SUMMARY ■

The Asian Community AIDS Services (ACAS) is a charitable non-profit community-based organization based in Toronto serving the East and South East Asian communities. The agency provides HIV/AIDS education, prevention and support services based on a proactive and holistic approach and in a collaborative, empowering and non-discriminatory manner. Services are provided in four different languages: English, Chinese (Cantonese and Mandarin), Tagalog and Vietnamese.

ACAS participated as a response to the scarcity of published Asian MSM literature and research conducted with the Asian communities in Canada, particularly with Asian MSM in relation to HIV in Canada.

Under the principles of community partnership, ACAS, in close collaboration with the HIV Social, Behavioural and Epidemiological Studies Unit (HIV Studies Unit), created a Working Group for the project. This group determined that focus groups should be conducted with volunteers and service providers who had contact with Asian MSM in order to identify issues Asian MSM must face in relation to HIV/AIDS.

Convenience sampling resulted in the recruitment of participants who were of different age ranges, ethno-cultural backgrounds and who represented health and social support agencies in Toronto. Nineteen participants attended three focus groups.

Discussions raised a range of issues affecting Asian MSM on personal, interpersonal, community and societal levels. For instance, Asian MSM often face identity conflicts either because they must deal with multiple identities or because the notion of identity from their countries of origin is very different than in North America. Many experience additional pressures, due to racism in the gay and mainstream communities, and homophobia in the Asian communities, to adhere to their cultural and/or sexual identities. The ways Asian MSM experience and understand their identities influence HIV-related behaviour. Participants indicated that negative self-concept (low self-esteem) among many Asian MSM results from factors including: North American and gay mainstream's concept of beauty, the lack of positive Asian male images in mainstream and gay media as well as the inaccurate stereotypes associated with Asian MSM. Discussion also raised the importance of family for most Asian MSM. In general, many Asian MSM seek emotional and social support from their families. The interaction of the concepts of honour, shame and secrecy and how these impacted on the attitudes and behaviours of Asian MSM was explored. Participants discussed power imbalances existing in daily interactions and relationships of Asian MSM. For instance, participants explored the complexities of many inter-racial and inter-generational relationships involving younger Asian MSM and older Caucasian men and how these relationships may lead to power imbalances. Another major emerging theme was the systemic racism experienced by Asian MSM. In relation to this theme, participants identified such issues as the inappropriate homogeneous grouping of all Asian communities by society at large, the inadequate allocation of HIV/AIDS prevention and support resources for Asian populations, the lack of published literature about Asian MSM and Asian communities in Canada and the lack of accountability of health and social services towards Asian MSM.

The Working Group made the following recommendations related to the fields of community development, advocacy, education and community-based research. These recommendations are based on the findings of this research needs assessment on Asian MSM and HIV in Asian communities.

1. Community Development

- Create safe spaces and positive environments for Asian MSM to socialize and to develop social support networks.
- Increase support of existing initiatives geared for Asian MSM.
- Encourage more positive and diverse Asian MSM role models to contribute to a healthy sexuality of diverse Asian MSM communities.
- Promote more community leadership among Asian MSM and encourage the active participation of Asian MSM by developing volunteer and leadership training programs for Asian MSM and by recognizing Asian community leaders who work, or have worked, with Asian MSM.
- Promote partnerships between different health and social service organizations within Asian and mainstream communities.

2. Advocacy

- Advocate for inclusive, equitable and responsive services for Asian MSM in mainstream Asian and non-Asian service organizations and businesses (as well as Asian service organizations and businesses to develop policies and guidelines to ensure that services provided are inclusive, equitable and responsive to Asian MSM).
- Encourage funders to recognize and to re-dress the under-funding of Asian HIV/AIDS prevention programs in Ontario.

3. Education

- Promote anti-homophobia work with Asian communities.
- Promote the acceptance of sexual diversity in Asian communities.
- Promote anti-racism work with mainstream and gay communities.
- Develop language- and culture-specific HIV prevention and education materials for Asian MSM who are recent immigrants.

4. Community-Based Research

There is a need for more community-based culturally-appropriate research initiatives to address the issues identified in this report. The Working Group recommends that a broad study focusing on Asian Sexuality in historical, political, cultural and personal contexts be conducted.

To better understand the needs of Asian communities from a broad perspective, the particular needs of the following marginalized groups must be researched:

- Asian transgenders;
- Asian sex trade workers;
- Asian injection drug users;
- Asian bisexuals; and
- Other marginalized Asian populations not yet identified.

In close collaboration with the HIV Studies Unit, the Working Group devised suggested areas for future research related to Asian MSM and HIV. Suggested research questions focus upon the concept of identity, coming out/disclosure, self-esteem, sexual behaviours, anonymous sex, HIV testing patterns, HIV/AIDS knowledge & attitudes, perceptions of risk behaviours, marginalization / inequity, family and service accessibility.

The Working Group strongly recommends that such future research be developed in partnership with communities.

PROJECT PROCESS

Initiation of Project Partnership

In the Fall of 1999, the HIV Studies Unit project staff met on several occasions with Peter Ho, Gay Men's Education Outreach worker, and Keith Wong, Executive Director, to define and clarify the alliance between ACAS and the HIV Studies Unit for this project. The group drafted a Terms of Reference document which established their agreed-upon roles, responsibilities and expectations.

Working Group

To develop and implement a work plan to meet the goals of the project, ACAS formed an ad-hoc Working Group, consisting of the following members:

Peter Ho (Gay Men's Education & Outreach Worker - ACAS)
William Lau (Coordinator - Gay Men's Education Network)
Wayne Lee (President - Gay Asians Toronto)
Trinh-Nguyen Tran (Chairperson of Research Committee - ACAS)
Josephine Wong (Health Education Consultant - Toronto Public Health)
Chris Lau (Project Assistant - HIV Studies Unit)

Method

In accordance with the project's overall objectives and given the limited time and resources, the Working Group felt it was most appropriate to hold focus groups to discuss issues relevant to Asian MSM and HIV. Data collection via focus groups was advantageous since ACAS already had established personal and working relationships with many Asian MSM as well as volunteers and service providers who work with Asian MSM. Focus groups would also provide a positive participatory environment that facilitates issue identification.

A questionnaire was developed to allow service providers who could not attend focus groups to participate in the project. Unfortunately, this questionnaire was not administered due to time constraints.

Facilitated by Wayne Lee and Chris Lau, focus groups were held separately for volunteers and service providers. Working Group members identified individuals to be invited to participate in these focus groups. They selected volunteers and service providers of diverse ethnicities and who represented both mainstream and ethno-specific agencies as well as health and social support networks.

At the beginning of each focus group, facilitators summarized the objectives of the project and the purpose of the focus group. They explained the stipulations of the consent form, noting especially principles of confidentiality. Participants were asked to sign the consent form to indicate their agreement to participate and to be audiotaped for note-taking purposes. Also, participant data sheets were distributed to the group. Working Group members also attended the focus groups to observe and record the proceedings. However, they did not actively participate in the discussion.

Three two-hour focus groups were held: one for volunteers and two for service providers. The nineteen participants who attended included one Asian female service provider and four non-Asian male service providers. The remaining fourteen participants were Asian men. It was not verified whether any of these men considered themselves to be MSM. The participants' ages ranged from 23 to 51. Participants indicated the following to be the ethno-cultural groups to which they individually identified with most: Asian, South East Asian, Chinese, Vietnamese, Filipino-Canadian, Caribbean-Canadian, Italian/French Canadian, white, WASP.

Volunteers were drawn from social support groups such as Gay Asians Toronto, Tong Zhi Group (gay and lesbian Mandarin-speaking group) and Gay Vietnamese Alliance.

Service providers represented agencies such as the David Kelley Lesbian and Gay Community Counseling Program, Hassle Free Men's Clinic, AIDS Committee of Toronto, Central Toronto Youth Services, Regent Park Community Health Centre, Hong Fook Mental Health Association and ACAS.

■ Participant Feedback Session ■

The Working Group held a Participant Feedback Session after a first draft of the "Themes and Issues" section was completed. The goal of this session was to allow focus group participants to validate the interpretation of the data. This process further contributed to greater community ownership of the project. Three individuals attended this session. Some participants who could not attend provided their input directly to Working Group members.

■ Project Strengths & Limitations ■

Working Group members identified the following strengths and limitations of the project:

Strengths:

- The presence of project staff on the Working Group was effective in creating a sense of equal partnership between the Unit and the Working Group.
- Focus group participants reflected a diversity of backgrounds and experiences, contributing to the richness of collected data.
- Separate sessions for volunteers and service providers allowed each group to concentrate on issues most relevant to their line of work.

Limitations:

- Time constraints did not allow for other data collection strategies to be implemented.
- Focus groups were conducted only in English and not in Asian languages.

AGENCY PROFILE

Mandate

ACAS is a charitable non-profit, community-based organization in Toronto formed on World AIDS Day, December 1st 1994. ACAS provides HIV/AIDS education, prevention and support services to the East and Southeast Asian communities. These programs are based on a proactive and holistic approach to HIV/AIDS and are provided in a collaborative, empowering and non-discriminatory manner. ACAS offers services in four different languages: English, Chinese (Cantonese and Mandarin), Tagalog and Vietnamese.

Programs

ACAS provides services through three main programs:

1. Support Program
The Support Program provides confidential, practical and emotional support to East and Southeast Asians living with HIV/AIDS, their partners, their families and friends through a variety of services and programs:

- Counseling, referrals and case management;
- Buddy support and home visits;
- Advocacy, help accessing financial assistance, social & medical services;
- Computer training for PHA's;
- Support Volunteer Program;
- Asian-language interpreters;
- Resource center of HIV/AIDS information in Asian languages;
- Peer support group for Asians living with HIV/AIDS and their partners.

2. Education and Outreach Program
The Education and Outreach Program provides HIV/AIDS education and information targeted to Asian Canadian communities:

- Anonymous phone and personal counseling;
- Peer support, outreach skills development for gay men, youth & sex trade workers;
- HIV/AIDS and sexual health workshops in Asian languages.

Under the Gay Asian AIDS Project, ACAS conducted a survey on Asian MSM titled "Asian Men Sex Survey" (1997) to better understand this target population and to assist in the development of future programs and educational campaigns. Additionally, a program developed to do outreach on the internet, titled *Ask Sexpert*, was developed and implemented.

In 1999, ACAS conducted a study of queer Asian youth to better understand their needs and issues in relation to HIV/AIDS and their sexual behavior. As a result, a series of activities and services have been developed to meet their needs.

Under the Asian Youth Peer Outreach Program, ACAS organized 3 conferences in 1998-99 on HIV-related issues that attracted over 150 Asian youths. Additionally, *JIV*, The Asian Canadian Youth Group, was developed to promote a proactive and holistic approach to HIV prevention by adopting a three-component strategy of education, emotional and behavior development, and assisting Asian youth to find a purposeful direction in life. ACAS has also developed *Smart*

Cookies, a peer educator program aiming to train Asian youths aged 16-25 to provide education and outreach on HIV/AIDS to other Asian youths.

The Asian Sex Trade Worker Project provided HIV/AIDS and STD information and safer sex education for Asian sex trade workers. On top of conducting workshops where sex trade workers volunteered as peer educators, ACAS also performed outreach and provided health referral services. This project is currently inactive due to funding cuts.

3. Volunteer Program
The volunteer program coordinates the recruitment, training and support of ACAS volunteers. ACAS depends on them to help with the following:

- Practical and emotional support for people living with HIV/AIDS;
- Outreach and education;
- Language interpretation;
- Clerical assistance;
- Special events.

■ Community Development ■

ACAS provides support to a number of community developments and collaborations such as Gay Asians Toronto (GAT), Gay Vietnamese Alliance (GVA), GenerAsians Together (Parents and Families of queer Asians), Sa Pinay Ka (queer Filipino social support group), Asian Lesbigay peer Support and Counselling Services (ALPSS) and the Coalition Against Homophobia.

ACAS is also part of various networks such as Youth and HIV Network, Scarborough Community AIDS Network, Toronto Chinese Health Education Committee, Toronto Coalition for Lesbian Gay Bisexual Youth, Canadian AIDS Society, Ontario AIDS Network, the Key Partners, Gay Men's Education Network, Chinese Interagency Network and Vietnamese Interlink. These networks provide important information and resource sharing, peer support, advocacy and skills training opportunities for ACAS staff and volunteers.

ACAS also produces a bi-annual newsletter and maintains a website (www.acas.org) in order to keep the target communities informed about ACAS' programs and activities.

■ Research & Development ■

In 1999, ACAS undertook a research project entitled "Legal, Ethical and Human Rights Issues Facing East and South East Asian Canadians in Accessing HIV and AIDS Services In Canada". The goal of this project was to explore the many challenges faced by Asian PHA's in Canada.

■ Funding ■

ACAS is funded by Health Canada, the Ontario Ministry of Health and Toronto Public Health. It is also supported by private donations and institutions such as United Way of Greater Toronto, Trillium Foundation and the AIDS Committee of Toronto's Community Partners Fund.

COMMUNITY PROFILE

Asian Communities

According to Statistics Canada (1996), there are more than 500,000 Canadians of East and South East Asian descent living in the Greater Toronto Area (GTA). This population is represented by a diverse background of ethnic origins, of which the major groups are Cambodian, Chinese, Filipino, Japanese, Korean, Malaysian, Taiwanese, Thai and Vietnamese. However, the Chinese, Taiwanese, Filipino and Vietnamese communities collectively represent over 90% of the total East and South East Asian populations in the GTA. There also exists a diversity of religious backgrounds within the Asian communities in the GTA; prominent faiths include Buddhism, Christianity and ancestral worship. Many other faiths are also practiced.

Of all recent immigrants in the GTA, 60% are from Asia. For many, English is not their first language. There are many Asians that are first-generation born outside of Canada. The Asian immigrant populations reside throughout the GTA. Despite the significant proportion of Asians among the GTA's immigrant population, there are also many second- and third-generation Asians living throughout the GTA, many of whom speak English fluently. Contrary to popular belief, there exists a wide range in socio-economic status of Asians, especially amongst Asian immigrants. This diversity amongst the Asian communities is also captured through their cultural identification: there exists a range of cultural affiliation with their own ethno-cultural backgrounds.

Asian MSM population

In Canada, there are no accurate data concerning the impact of racism, homophobia, or other HIV risk factors on Asian MSM. Approximately 500,000 people of East and Southeast Asian origin reside in the Greater Toronto Area (Census Data, Statistics Canada, 1996). Remis (personal communication, 2000) estimates that between 4 and 6% of men between the ages of 18 and 65 are MSM, suggesting that up to 20,000 Asian MSM reside in GTA. Most do not congregate in any specific location, but live, work and/or socialize in their ethno-cultural communities or within mainstream communities (often with their immediate and/or extended families). While current HIV prevention outreach to Asian MSM is conducted through bathhouses, gay bars, parks, and via the internet, only a limited proportion of the overall Asian MSM population is reached.

Of all health and social services in the GTA dealing with HIV/AIDS and of all gay-oriented social services, only ACAS provides a specific funded program targeting Asian MSM. However, there exists four other known groups that provide social support and/or advocacy for Asian MSM in the GTA: Gay Asians Toronto (GAT), Gay Vietnamese Alliance (GVA), Tong Zhi Club (Mandarin-speaking gay and lesbian group) and Long Yang Club (social group for gay Asians and non-Asians). Some of these groups were formed to combat the existing homophobia within Asian communities, as well as the racism within mainstream and gay communities. For example, GAT was formed to build a sense of community, to develop a unique identity and to provide social support for its members. As well, the creation of Coalition Against Homophobia, initiated by GAT, stemmed from reactions against the homophobia within the Chinese community, as expressed through an article written in a local Chinese newspaper in 1997.

■ IDENTIFIED THEMES & ISSUES ■

The Working Group organized themes and issues identified from the focus groups under a three-level framework: individual, interpersonal and societal. It is important to note that identified issues are interrelated and interdependent. Also, many are common to two or three levels of framework: an issue classified under the individual framework may be re-framed to be understood from an interpersonal and/or societal perspective. For example, Asian MSM sense of attractiveness is presented under an individual framework, but can be easily understood in an interpersonal perspective when associating it with the issue of inter-racial and inter-generational relationships.

■ INDIVIDUAL ■

■ Self-identity ■

Self-identity, how an Asian MSM sees himself, was identified as a critical issue. Asian MSM, like all people, must deal with multiple identities, whether they be sexual, cultural, ethnic, class-related, etc. Participants focused on the interactions of specific aspects of multiple identities (ethno-cultural, sexual and immigrant/citizenship identity) and the ways these self-identifications affect the lives of Asian MSM in relation to HIV.

In most Asian societies, individuals tend to be defined in relation to different societal institutions, such as family, religion, school or profession. However, participants viewed identity in North American communities to be more defined by one's individual characteristics, such as sexual orientation.

Some participants believed the notion of identity was defined differently in Asian communities, thus making it difficult for Asian MSM to fit into mainstream's concept of identity. For example, an Asian MSM who does not self-identify as gay must deal with a gay Asian identity imposed upon him by mainstream and gay communities that tend to define sexual orientations according to sexual behaviours. This type of imposed sexual identity may consequently contribute to identity conflict among Asian MSM.

Some participants noted that the adherence to an Asian identity by some recent immigrant Asian MSM is related to the exclusion and racism they experience in the mainstream and gay communities. To cope with rejection, discrimination and prejudice, many Asian MSM turn to their own communities for support and security. Similarly, Asian MSM also experience pressure from their Asian communities to assume an Asian identity, to be model citizens and achievers.

Many Canadian-born Asian MSM experience pressures similar to those of recent Asian immigrant MSM. They often struggle between their integrated Asian and Western identities. Their acculturation of Western values and beliefs usually leads to a clash with those of their parents.

Some participants suggested that many Asian MSM who do not self-identify as gay tend to use anonymous spaces (bathhouses, adult video stores, parks, etc.) when seeking sex with men. They also observed that many of these men are married. Some Asian MSM feel they must step outside of their Asian communities to have sex with men since acknowledging and acting upon same-sex attraction is difficult for them to do in their ethno-cultural communities. However, when these men "step out" of the Asian communities to have sex with men, they are confronted with racism,

stereotypes and a lack of Asian MSM role models in mainstream and gay communities, which will be discussed later.

Some Asian MSM, who do not self-identify as gay, nor express the need to seek gay-identified spaces to socialize and meet men, might engage in higher-risk sexual behaviors because their sexual needs and desires are often suppressed due to social stigma and discriminations. When these MSM do not see themselves as gay or bisexual, they do not acknowledge their potential risks in contracting HIV and therefore do not see any need for HIV/AIDS information or HIV testing. As a result, most HIV educational materials, whether they are gay-oriented or not, may be irrelevant because in their minds, HIV is a white gay disease.

Depending on their identity affiliation, some Asian MSM may choose to use Asian agencies which offer a safer and culturally/linguistically more appropriate space and services while some will use mainstream rather than Asian agencies for services. For others, it may be lesser of a choice. Due to the fear of being recognized and identified by members of their own communities, some Asian MSM might use mainstream services despite their encountering cultural/linguistic barriers of having unmet needs.

■ Sense of Attractiveness ■

According to participants, most Asian MSM struggle with the ramifications of a perceived unattractiveness. The concept of beauty promoted by mainstream and gay communities rarely fits into the realities of Asian MSM: "Caucasian" nose, chiseled jaw, large blue eyes, blond hair, light complexion and muscular build. Some Asian MSM, especially gay Asian men, turn towards cosmetic surgery, changing their physical appearance to fit this standard of beauty. Most participants identified the prevalence of inaccurate stereotypes of Asian MSM in mainstream gay communities: subservient, effeminate, passive, quiet, smooth, small penis, asexual, exotic, etc. In essence, physical features of Asian men were viewed as being more feminine, whereas those of Caucasian men as more masculine. Many Asian MSM internalize these inaccurate pervasive stereotypes and this leads many Asian MSM, especially gay Asian men, to have poor self-concept (low self-esteem).

The lack of positive Asian male images in mainstream and gay media greatly affects Asian MSM sense of attractiveness. One Asian service provider pointed out: "there is no public celebration of one's Asian identity, thus compounding the sense of alienation". Many Asian MSM internalize and look up to Western standards of beauty due to the pervasiveness of such images in media. According to participants, these unrealistic standards of beauty derive from embedded racist and homophobic values in mainstream and gay communities and they in turn perpetuate discriminatory actions, practices and behaviors towards Asian MSM. The under-representation of positive Asian images exists not only in the gay community but also in mainstream and Asian communities. The perception of being unattractive impacts negatively on the self-concept and self-acceptance of Asian MSM. As a result, some Asian MSM maybe at higher risk of contracting HIV/STDs because when an individual does not feel good about himself, he has less power to negotiate safer sex or refuse to participate in unsafe sex. The need to be accepted and to feel desired by a potential partner may take priority over one's own health. This is an example of how one's knowledge of HIV often does not necessarily correlate with one's sexual practices.

■ Integration & Acculturation ■

Participants identified culture, language and immigration experience as HIV-related issues for Asian MSM. Many recent immigrant Asian MSM have a desire to connect with others from their own ethno-cultural communities to maintain a sense of cultural identity and belonging. Some might do so because of their sexual preference for other Asian men. Participants viewed this as being challenging since it is often difficult to find other MSM from their communities. Connecting with others who speak the same language was of great importance. Since languages are culturally-bound, they could better express themselves in their own language and develop a greater bond with people who share their language.

According to participants, many Asian MSM who immigrate without their families feel liberated from certain family pressures. They are more able to explore their sexuality and to engage in sexual activities with other men without the fear of being discovered by their families. For many, visibility and relative openness associated with being gay is now a possibility in North America due to their newfound privacy. This, coupled with the lack of knowledge or miss-information of HIV/AIDS, might put these men at greater risk since they do not know about safer sex.

Some immigrants, whether they come with family or not, are faced with financial instability and employment-related difficulties. The focus on coping with settlement stress leads many Asian MSM immigrants to place their health, including sexual health, as a low priority and are therefore less likely to seek health-related services.

Participants also noted that the length of settlement in Canada might influence the sexual values and level of acceptance of a member's homosexuality. One service provider suggested that as the Asian communities become more acculturated in Canada, recent immigrant Asian MSM might find it harder to fit in their own ethnic communities because of the different levels of acculturation. This element of diversity is of great importance when considering service provisions for Asian MSM.

■ INTERPERSONAL ■

■ Sense of Belonging ■

For some Asian MSM, because they do not self-identify as gay, there is no desire to connect with neither gay nor gay Asian communities. At the same time, many Asian MSM who self-identify as gay experience difficulty fitting into the gay community because they perceive it to be exclusively white. This difficulty stems in part from the clash of values, languages, beliefs, lifestyle, as well as from racism and unequal power dynamics. For example, the concept of a gay man being out and being able to publicly announce his sexual orientation is viewed by participants as a Western concept, foreign from the concept of coming out in most Asian societies. As participants stated, in many Asian cultures there is no clearly defined concept of coming out or of being gay. Nevertheless, many Asian MSM experience pressure from mainstream gay communities to come out publicly. Being out is perceived to be the healthier way of living one's sexual orientation. Some Asian MSM who desire to come out and to affirm themselves as gay find it difficult to do so since they cannot identify with what they see in the gay media or what they experience in the gay community. This further contributes to their identity conflicts. According to participants, physical attractiveness was perceived to be important in the gay community and since most gay Asians do not fit into the ideal physical appearance depicted by this community, many of them feel alienated from it. The lack of Asian representation in the gay and mainstream media and the unequal power dynamics make it hard for Asian MSM to have a sense of belonging in the gay

community. Due to the exclusion of positive Asian MSM images, many gay Asians feel they do not belong to the gay community.

According to participants, physical attractiveness was perceived to be important in the gay community and since most gay Asians do not fit into the ideal physical appearance depicted by this community, many of them feel alienated from it. Due to the exclusion of positive Asian MSM images, many gay Asians feel they do not belong to the gay community.

The exclusion and unequal treatment of Asian MSM by various gay establishments (i.e. bars, bathhouses, phone lines, dating services, restaurants, etc.) results in a lack of suitable and accessible venues for Asian MSM. A commonly acknowledged attitude within mainstream gay communities is that gay Asians seemingly congregate and socialize among themselves. However, mainstream communities will not criticize Caucasian men for socializing only with other Caucasian men. Many do not consider the possibility that there are no suitable and accessible venues for gay Asians to socialize with each other and to comfortably access HIV information (or other health-related information). Consequently, many Asian MSM turn towards anonymous spaces (such as bathhouses, gay cinemas, etc.) to meet their needs.

Another issue raised by participants was the fact that the communities (gay, mainstream and Asian communities) with which an Asian MSM could identify with, espouse different and sometimes contradicting, values. For instance, most Asian communities tend to be more family-oriented, whereas North American communities tend to be more individually-focused.

■ Family Honour / Shame / Secrecy ■

According to one focus group participant, "there is still a need to push for wider acceptance in the Asian communities because family means so much to you and if they can accept you, it makes your life so much easier".

In general, many Asian MSM seek emotional and social support from their families. Embedded in the traditional family values, this support can be defined in relation to the cultural concept of "saving face", or honouring one's family. This concept is based on a set of cultural values and practices that place collectivism above individualism.

For some Asian MSM, family honour is an important component to consider; it often impacts on their behaviour. To honour their families means to avoid causing their families pain or suffering and this is often achieved at considerable cost to themselves. For instance, Asian MSM may make excuses to their parents' friends about why they are not married so that their parents could avoid the embarrassment of their sexual preference. Asian MSM preserve others' respects towards their families by avoiding shame. According to participants, if one is out, one will lose respect from his community.

Family support and acceptance were perceived by participants to be important for many Asian MSM. Family rejection would thus have a significant impact for them. This leads many Asian MSM to live a life of secrecy about their sexuality. This secrecy leads to a number of fears and consequences: fear of being found out about their sexual behavior and identity, fear of being discovered with HIV educational materials (which would imply one's homosexuality) by family members, sense of isolation, suppression of sexual needs to fit in with family expectations, desire to seek out anonymous sex, fear being recognized by members of his own ethno-cultural community in spaces where they seek anonymous sex. According to service providers, this secrecy might lead some Asian MSM to be reluctant to approach Asian-based health services.

These men tend to go to mainstream health services, which might not meet fully their range of needs.

Similarly, Asian MSM who are HIV positive feel ashamed because they believe they have let down their parents. Thus, many Asian MSM are forced into a life of secrecy about their health status as well as their sexuality.

■ Power Dynamics ■

Another issue identified by participants was the power dynamics that often exist in the everyday lives of Asian MSM. In this context, power dynamics is understood as the imbalances created by factors such as sexual orientation, social class, economic position, race, age, language, immigration status, poverty, and health status.

Inter-racial and Inter-generational Interactions and Relationships

For many Asian MSM, power imbalances exist due to a marginalized status in mainstream society. This particularly applies to many Asian MSM involved in inter-racial and inter-generational interactions and relationships, especially with older Caucasian men. Some Caucasian men tend to assume power over their Asian partners. The power imbalance between them is commonly manifested tangibly in terms of financial and/or sexual control. According to participants, there is a local gay dating service that charges Asian MSM for using their services, while Caucasian men interested in Asian men can use the services for free. Participants believed many Caucasian men perceive Asian men to be subservient and lesser persons. Explaining the importance of this perception, a participant explained that "in sexual relationships, if others don't respect you, they can take advantage of you and force you to do something you don't really want to do". Consequently, many Asian MSM are left in positions where they do not have the power to negotiate safer sex. Participants said that many younger Asian MSM in such relationships with Caucasian men suffer from low self-esteem and are dis-empowered. They feel, for example, a loss of control and self-confidence.

Lack of Positive Asian MSM images

Participants expressed concerns that many Asian MSM do not perceive themselves to be attractive due to the lack of positive Asian MSM images in the media, coupled with the different standards of beauty promoted by mainstream, gay and Asian communities. For the same reasons, members of the mainstream and gay communities do not view Asian men as desirable. This, according to many service providers and volunteers, has a significant impact on Asian MSM youth. Many Asian MSM are faced with a limited choice of men with whom they can have intimate and sexual relationships. An Asian male volunteer confirmed, "(if) you're Asian (MSM), you're limited in many ways in finding a potential lover". Many Asian volunteer participants said that some Caucasian men who are exclusively interested in Asian men (commonly referred to as "Rice Queens") take advantage of younger Asian men's inexperience, perceived limited choices in sexual partners and exclusively target them. When Asian MSM, especially gay identified Asian, feel the pressure of exclusion and being rejected, some of them are more likely to engage in unsafe sexual behaviors because of their lack of negotiation power in the current power dynamics in the mainstream and gay community.

■ S O C I E T A L ■

■ S y s t e m i c R a c i s m ■

Systemic racism refers to policies and practices, entrenched in established institutions, that result in the exclusion or advancement of different groups of individuals based on race. Participants identified the following issues related to systemic racism.

Homogeneous grouping of all Asian communities

Most participants felt that mainstream communities, including gay communities, tend to lump all Asian communities and peoples into one homogeneous category. There is a tendency to overlook the cultural differences in Asian communities, where individuals have different languages, beliefs, values, immigration experiences, social class, economic position and family organization.

One non-Asian service provider added that immigrant communities might not be similar to the communities from the country of origin. This participant said that immigrant Asian communities in Canada might differ from those in Asia because they might have adopted to varying degrees different Canadian values. Thus, a recent immigrant might find it difficult to associate with their Asian communities in Canada, creating personal conflict. Some Asian service providers felt that immigrant communities tend to be more conservative, in reaction to pressures upon them to be model citizens.

Inadequate Allocation of Resources for Asian populations

Allocation of resources to Asian health service organizations is inadequate. Some participants perceived that Canadian MSM AIDS funding is controlled by a small group of individuals who do not recognize the diversity of Asian communities nor the specific needs of MSM in these communities. Funding criteria often neglect the unique situations of various Asian communities, thus making it difficult to formulate health services that meet the diverse needs of Asian communities. Some participants also felt there was a lack of resources being allocated to HIV prevention in Asian communities, especially smaller and less populous ones.

■ L a c k o f P u b l i s h e d L i t e r a t u r e o n A s i a n M S M & A s i a n C o m m u n i t i e s i n C a n a d a ■

Participants said there is a lack of published literature about Asian MSM and the Asian communities in Canada. There are only a few known Canadian studies focusing on Asian MSM sexual behavior. This lack of data about Asian MSM leaves decision-makers uninformed and unaware of the need to address Asian MSM health issues which is reflected in the lack of priority in funding for this target population. As a result, health service organizations, which include servicing Asian MSM in their mandates, are unable to effectively meet the range of needs of Asian MSM. One service provider noted that "with better knowledge, the better we can provide services and more effective programming".

An example of the lack of understanding of Asian communities is the lack of cultural appropriateness of sexual health educational materials for different Asian communities. There is a lack of awareness that word-for-word translations of English educational materials might not be suitable because some Western concepts relating to HIV/AIDS and sexuality have no Asian equivalents and thus cannot be translated literally into Asian languages. As a result, sexual

health educational materials that are simply translated word-for-word into Asian languages might not be effective with Asian populations.

Lack of Accountability of Services Towards Asian MSM

Participants identified a lack of accountability of mainstream and Asian health service organizations towards Asian MSM. For example, participants pointed out the lack of cultural competence of many service providers. Many service providers in mainstream agencies are not familiar with cultural specificities when working with Asian MSM. One service provider pointed out that although his agency roughly has 30% Asian clientele, the overwhelming majority of their service providers are Caucasian, who might not be able to fully understand the complexities of working with Asian MSM clients.

The lack of accessibility to systems and services is reflected by this lack of culturally-competent service providers who do not understand the cultural nuances or speak the languages of Asian clients, despite the reality that a large proportion of their clientele is Asian. Due to communication barriers, the Asian MSM's needs and concerns might not be fully met and understood by the service provider. Language barriers will also limit an Asian MSM's access to the health services he requires.

Another participant stated this is not to say that having Asian service providers in mainstream agencies will ensure cultural competency. An example of the lack of accountability was given by one of our Asian service providers. This service provider recounted how, twelve years ago, his first Asian HIV-diagnosed client was referred to him by the hospital after being mis-diagnosed by an Asian physician. Twelve years later, another Asian HIV-positive client was referred to the service provider for the same mis-diagnosis by the same Asian physician. This service provider raised the question of how a treating physician could not be held accountable not only for mis-diagnosis, but also for not making himself more sensitive to the needs of Asian MSM. This participant expressed the view that such a lack of accountability not only exists within Asian but also within mainstream health services.

HIV testing is another example identified by participants to being an inaccessible system. An Asian service provider suggested that Asian populations were more likely to get tested if the method of testing were to be changed from blood drawing to a swab (saliva) test. No Canadian study has examined the rates of HIV testing among Asian MSM as well as the possibility to encourage more Asians to get tested. According to one Asian service provider, one of the possible reasons behind the low reported numbers of infections among Asian MSM in Canada is due to the fact that many Asian MSM do not even get tested since they do not think HIV concerns them. Asian MSM who do not see themselves as gay or bisexual might not see the need for getting HIV/AIDS information nor for HIV testing. Several Asian service providers explained that many Asian PHAs are diagnosed late, possibly due to a number of reasons: their perceived lack of need for testing, the inaccessibility of testing venues, fear of a positive result, stigmas associated with testing and the view that testing is an option only when they become symptomatic.

Sexuality in Asian Communities

Participants pointed out a difference in the ways Asian, other ethno-cultural communities, and North American communities discuss sex and sexuality. The degree of openness of these discussions also vary in Asian communities. Participants expressed the idea that sexuality is not

openly discussed in most Asian communities. Some communities prefer that sexual issues remain in the private discussions of close friends. According to most participants, sexuality is not discussed between family members.

Another difference recognized by participants was the understanding of homosexuality. Participants said that stigmas associated with being gay in most Asian communities are stronger than in those found in mainstream communities. One participant also stated that there exists a perception that being gay means having multiple sex partners. Another participant mentioned that promiscuity is also stigmatized. Thus, gay men are not only stigmatized for their sexual orientation but also for the perceived promiscuous behavior. As a result, Asian MSM are being alienated and are not being respected. Furthermore, many participants felt that most Asian communities still view HIV/AIDS and homosexuality as being white men's issues. By not acknowledging the existence of HIV/AIDS nor of homosexuality, Asian communities also have not taken "community ownership" of HIV. This also impacts on many Asian MSM who believe HIV/AIDS is not a concern for them since they are not gay and since AIDS is a gay disease.

Another perceived difference between the Asian and mainstream communities is the association between the gay and AIDS movements. For example, according to one Asian service provider, in some Asian countries, gay and AIDS are two movements with independent histories. However, in North America, they have been historically interlinked. Thus, for some Asian MSM arriving into North America, any association with the AIDS community is threatening due to its perceived ties with the gay communities.

RECOMMENDATIONS

The Working Group puts forward the following recommendations related to the fields of community development, advocacy, education and community-based research, based on findings from this research needs assessment on Asian MSM and HIV in Asian communities.

Community Development

- Create safe spaces and positive environments for Asian MSM to socialize and to develop social support networks.
- Increase support of existing initiatives geared for Asian MSM.
- Encourage more positive and diverse Asian MSM role models to contribute to a healthy sexuality of diverse Asian MSM communities.
- Promote more community leadership among Asian MSM and encourage the active participation of Asian MSM by developing volunteer and leadership training programs for Asian MSM and by recognizing Asian community leaders who work, or have worked, with Asian MSM.
- Promote partnerships between different health and social service organizations within Asian and mainstream communities.

Advocacy

- Advocate for inclusive, equitable and responsive services for Asian MSM in mainstream Asian and non-Asian service organizations and businesses (as well as Asian service organizations and businesses to develop policies and guidelines to ensure that services provided are inclusive, equitable and responsive to Asian MSM).

- Encourage funders to recognize and to re-dress the under-funding of Asian HIV/AIDS prevention programs in Ontario.

■ Education ■

- Promote anti-homophobia work with Asian communities.
- Promote the acceptance of sexual diversity in Asian communities.
- Promote anti-racism work with mainstream and gay communities.
- Develop language- and culture-specific HIV prevention and education materials for Asian MSM who are recent immigrants.

■ Community-Based Research ■

There is a need for more community-based culturally-appropriate research initiatives to address the issues identified in this report. The Working Group recommends that a broad study focusing on Asian Sexuality in historical, political, cultural and personal contexts be conducted.

To better understand the needs of Asian communities from a broad perspective, the particular needs of the following marginalized groups must be researched:

- Asian transgenders;
- Asian sex trade workers;
- Asian injection drug users;
- Asian bisexuals; and
- other marginalized Asian populations not yet identified.

■ SUGGESTED RESEARCH QUESTIONS ■

The following are suggested areas for the future development of research. Such questions can be further explored by researchers in partnership with communities.

■ Identity ■

Concept of Self-identity

- How do Asian MSM identify themselves socially and sexually (e.g., gay, MSM, straight)?
- What are the attitudes, beliefs and understandings held by Asian MSM concerning the notion of self-identity?

Coming Out / Disclosure

- Does the concept of coming out exist for Asian MSM?
- If so, how is it experienced by Asian MSM?
- How is it understood by Asian MSM?
- Is there a relationship between the concept of coming out and HIV? If so, what is this relationship?

■ Interpersonal Factors ■

Self-esteem

- What factors influence self-esteem among Asian MSM?
- How does self-esteem impact their HIV risk-taking behaviour?

■ Behaviour ■

DESCRIPTIVE

Sexual Behaviours

- How many Asian MSM are married to women? Who do they choose as wives? Who do they choose as male sexual partners?
- What are the patterns of sexual behaviour of Asian MSM who only have sex with men?
- What are the patterns of sexual behaviour of Asian MSM who have sex with men and women?
- What are the patterns of sexual behaviour of Asian MSM who are married?
- How do Asian MSM negotiate safer sex with their partners? Are there any identifiable patterns?
- How do Asian MSM who have sex with men and women negotiate safer sex with their male partners? With their female partners? Are there any identifiable patterns?

Anonymous Sex

- How is anonymous sex perceived by Asian MSM? What is their understanding of anonymous sex?
- Among Asian MSM, how prevalent is anonymous sex? For which sub-groups of Asian MSM is anonymous sex important? What are the characteristics of Asian MSM who frequent anonymous spaces for sex?
- Why are Asian MSM who frequent anonymous spaces going to such spaces? Does loneliness play a factor?
- Where specifically are they going for anonymous sex?
- What are their patterns of sexual behavior regarding anonymous sex?
- Who tend to be their sexual partners?

HIV Testing Patterns

- What are the patterns of HIV testing among Asian MSM (differences, variations)?
- What factors influence HIV testing patterns among Asian MSM?

■ HIV/AIDS Knowledge & Attitudes ■

INDIVIDUAL

Perceptions of Risk Behaviours

- How is HIV risk perceived by Asian MSM?

Knowledge & Attitudes

- Where do Asian MSM seek information about HIV/AIDS?
- How accurate is their knowledge about HIV/AIDS?
- What impact does their knowledge have on their attitudes towards HIV/AIDS?

■ Marginalization / Inequity ■

Experiences in Mainstream Gay Community

- How are Asian MSM represented in mainstream gay media?
- What impact does this representation have on the self-image of Asian MSM and other MSM of color?
- How is racism experienced by Asian MSM in the mainstream gay community?

- How do Asian MSM experience discrimination based on social class and economic position?

Experiences in Ethno-Cultural Community
- How is homophobia experienced by Asian MSM in their Asian communities?

Experiences in Casual & Intimate Relationships
- What are the dynamics within inter-racial and inter-generational relationships involving Asian MSM in Toronto?
- How do Asian MSM experience power in intimate and/or casual relationships? Does this experience of power differ in relationships where partners are casual versus more intimate/ long-term?
- How do cultural and language differences impact on their inter-racial, inter-generational, intimate and casual relationships?

■ Support Systems ■

Family
- How are Asian MSM perceived by their extended families? By their immediate families (if they are married)?
- How do religious, cultural and family values impact family responses to Asian MSM disclosure?
- How do Asian families react to a family member who discloses he is MSM?
- How do Asian families cope with a family member who is MSM?
- What factors contribute to the acceptance of a family member who is MSM?
- What factors contribute to the rejection of a family member who is MSM?

Service Accessibility
- What factors motivate Asian MSM to seek out services?
- What health services are available to Asian MSM in mainstream communities? In their ethno-cultural communities?
- What health services are Asian MSM accessing in mainstream communities? In their ethno-cultural communities?
- What barriers do Asian MSM encounter when accessing services?

■ CONCLUSION ■

The Working Group hopes this study represents the beginning steps towards:

1. Further examining and understanding HIV-related issues of Asian MSM in Toronto and in Canada;
2. Continuing to define community-based HIV research partnerships.

The identification of key themes and issues was clearly an important first step towards future research regarding Asian MSM and HIV in Toronto and in Canada. However, this is not to say that the attitudes, behaviors and experiences described in this chapter are recent in nature and occurrence. They simply have never been documented as this project has succeeded in doing.

The Working Group wishes to highlight the importance of further research initiatives focusing on MSM from various ethno-cultural communities. Such ethno-specific MSM research has already

succeeded in breaking down the misconception that MSM is synonymous with gay. Similarly, such research has exposed the rigid western concept and understanding of "Asian" as a homogeneous construct. Finally, as clearly demonstrated through project findings, the Working Group wishes to highlight the complexity and diversity existing within the Asian communities as well as within the Asian MSM populations.

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■ PORTUGUESE-SPEAKING COMMUNITIES ■

■ SUMMARY ■

The Portuguese-speaking communities' enthusiasm for this project emerged in response to the absence of research in relation to HIV and Portuguese-speaking gay men, bisexual men and MSM.

A partnership between the HIV Social, Behavioural and Epidemiological Studies Unit (HIV Studies Unit), the AIDS Committee of Toronto (ACT) and members of the VIVER Coalition was developed to identify issues, themes and research questions relating to HIV/AIDS among Portuguese-speaking gay, bisexual and other groups of men who have sex with men. Two focus groups were conducted with Portuguese-speaking gay men (recruited from a local Portuguese-speaking gay and lesbian group) and service providers who work in, or with, Portuguese-speaking HIV-related services. Convenience sampling was used to ensure diversity in age and ethnicity. In the service providers' focus group, a range of health care and social service agencies were represented. A total of 18 participants attended focus group discussions.

Varied themes emerged from the focus groups including concerns related to sexual identity and behaviour (for example, the inappropriateness of the term "MSM"), identity conflicts, disclosure of sexual orientation, gender roles and family expectations. In addition, there are problems with access to HIV/AIDS information and services, and negative community attitudes toward Portuguese-speaking men who have sex with men.

Significant concerns were raised about Portuguese-speaking men who have sex with men who have anal sex without condoms. Some of these men erroneously believe they are not at risk for HIV/AIDS if they are not gay-identified, or if they are the insertive partner ("top"). Some Portuguese-speaking gay men believe condom use is an indication that a person is "not clean" and may thus engage in high-risk behaviours to prove they are not HIV-positive.

For some Portuguese-speaking gay or bisexual men, fear of alienation and scorn by their ethno-cultural community affects disclosure of their sexual identity. Since HIV is linked with homosexuality in Portuguese-speaking communities, MSM living with HIV/AIDS fear their sexual orientation and HIV status will be disclosed to other community members. Communication barriers between parents and children and the lack of culturally-relevant terms for sex and sexuality are also barriers to open discussions about sex and sexuality. Finally, cultural stigma related to HIV presents a serious threat to those accessing services.

While Portuguese-language HIV/AIDS material are available, they are limited, resulting in a lack of community knowledge of HIV/AIDS. Other factors, including religion, pose barriers to information seeking, further contributing to low knowledge levels.

Although participants acknowledged the existence of services for people living with HIV/AIDS, they were critical of limitations and barriers, including a lack of consensus in Portuguese-speaking communities regarding appropriate models of service delivery. Moreover, the cultural relevance of Portuguese-speaking services was perceived as non-representative of the diversity of Portuguese-speaking communities in Toronto.

Other access barriers included concerns related to confidentiality, linguistic differences, immigration/refugee status, and inadequate HIV/AIDS knowledge among Portuguese-speaking health care and social service providers.

Priority groups identified for future research included non gay-identified men who have sex with men, women, injection drug users and individuals from Portuguese-speaking communities not limited to continental Portugal and the Azores.

Suggestions for culturally-appropriate research were also made. The following areas were identified as priorities for future research:

- The experience of Portuguese-speaking gay, bisexual and other men who have sex with men;
- Factors impacting upon cultural and sexual identity formation;
- Sexual behavioural patterns among Portuguese-speaking gay, bisexual and other men who have sex with men;
- HIV testing patterns among Portuguese-speaking gay, bisexual and other men who have sex with men;
- Knowledge of HIV/AIDS in Portuguese-speaking communities;
- Attitudes towards HIV/AIDS in Portuguese-speaking communities;
- Service barriers for Portuguese-speaking gay, bisexual and other men who have sex with men.

PROJECT PROCESS

Initiation of Project Partnership

In October, 1999, staff from the HIV Studies Unit worked in partnership with ACT and with members of the VIVER Coalition to identify HIV-related research questions concerning men who have sex with men in Toronto's Portuguese-speaking communities.

Working Group

Comprised of staff from ACT, the HIV Studies Unit, and members of the VIVER Coalition, the Working Group included:

Humberto Carolo (ACT / VIVER Coalition)
Jorge Da Costa (Volunteer, VIVER Coalition)
John Maxwell (ACT / VIVER Coalition)
Jose Medeiros (David Kelley HIV/AIDS Community Counselling Program / VIVER Coalition)
Luis Medeiros (ACT / VIVER Coalition)
Rui Pires (ACT / VIVER Coalition)
Michelle Reis-Amores (St. Stephens Community House – Wellness Program / VIVER Coalition)
Ilda Cordeiro (HIV Studies Unit)

Method

Focus groups were held to discuss HIV-related issues with Portuguese-speaking men who have sex with men, and Portuguese-speaking service providers.

The Working Group recruited Portuguese-speaking health care and social service providers and volunteers from both mainstream and ethno-specific agencies.

A Portuguese-speaking man from the Working Group facilitated both focus groups. A Portuguese-speaking woman from the Working Group acted as co-facilitator and recorder for both sessions.

Twelve individuals (age 26 to 51) participated in the focus group for Portuguese-speaking men who have sex with men; nine self-identified as gay, while three did not declare any sexual label. Countries of origin included Portugal (3), the Azores (3) Brazil (2) and Canada (3). Portuguese (3), Brazilian (1), Mediterranean (1), Latino (2), Canadian (1), Luso-Canadian (1) and Portuguese-Canadian (2) were the ethno-cultural groups most strongly identified with.

Six individuals (4 men, 2 women, age 31 to 53) participated in the focus group for Portuguese-speaking service providers. Portugal (1), Brazil (1), the Azores (1), Canada (2) and Hungary, Brazil and Canada (1) were identified as countries of origin. Participants represented mainstream and ethno-specific health care and social service agencies, including Access Alliance Multicultural Community Health Centre, Ministry of Health AIDS Hotline, Brazil-Angola Community Information Centre, St. Stephens Community House – Wellness Program, The Works Needle Exchange Program, David Kelley HIV/AIDS Community Counselling Program, and the Hassle Free Clinic (anonymous HIV testing clinic).

Focus groups were audio-taped and thematic summaries were prepared from the transcripts and written notes.

This chapter, based upon these themes and issues, was drafted and revised by Working Group members and HIV Studies Unit staff.

Project Strengths & Limitations

Working Group members identified the following strengths and limitations of the project:

Strengths:

- A partnership initiative between the HIV Studies Unit and members of the VIVER Coalition allowed for extensive input from Portuguese-speaking communities and a resulting sense of ownership in this research needs assessment.
- This research needs assessment is the first initiative of its type to be conducted on Portuguese-speaking MSM.
- Data were retrieved from a broad range of Portuguese-speaking men who have sex with men from continental Portugal, the Azores and Brazil, as well as Portuguese-speaking service providers from continental Portugal, the Azores and Brazil.

Limitations:

- Time constraints and limited resources restricted us to a focus group method, restricting our ability to probe more deeply into some thematic areas.

- Much of the project's focus was on non gay-identified men who have sex with other men and less on Portuguese-speaking gay and bisexual men.
- A number of Portuguese-speaking communities (Angola, Mozambique, Cape Verde, Guinea Bissau, Sao Tome & Principe, Macau, Goa, and East Timor) were not represented among focus group participants.
- There was limited participation from the Brazilian participants in both focus groups, in comparison to participants from the Azores and continental Portugal. Consequently, issues identified are not relevant to all of Toronto's Portuguese-speaking communities of Toronto. As such, in the following chapter, the term "Portuguese" is used to mean Portuguese-speaking communities from Portugal (including the Azores and Madeira).

AGENCY PROFILE

VIVER Coalition

In 1997, St. Stephen's Community House initiated a public forum on HIV/AIDS for Portuguese-speaking communities. Following this, the VIVER Coalition, a Portuguese-speaking HIV/AIDS coalition, was established to conduct a needs assessment regarding accessibility and availability of HIV/AIDS services to Toronto's Portuguese-speaking communities. The VIVER Coalition identified a significant gap in services to people infected with or affected by HIV/AIDS. Portuguese-speaking men who have sex with both men and women were of particular concern. Given their marginalization in Portuguese-speaking communities and their limited contact with the gay community (most do not self-identify as gay), it became essential to raise awareness of HIV/AIDS. Broad community outreach was necessary to decrease stigma and denial related to HIV/AIDS, injection drug use and same-sex sexual activity.

The VIVER Coalition's mandate is to:

- Reduce the spread of HIV infection and to enhance the quality of life of Portuguese-speaking people living with, or affected by HIV/AIDS;
- Promote awareness and advocate on behalf of people living with HIV/AIDS, and break down AIDS-related taboos in Portuguese-speaking communities;
- Promote the development/delivery of culturally-competent and language-specific HIV/AIDS services.

AIDS Committee of Toronto (ACT)

ACT, a non-profit community-based AIDS Service Organization (ASO), provides health promotion, support, education and advocacy for people living with HIV/AIDS and those affected by HIV/AIDS. ACT provides a range of free programs including counselling, support groups, health enhancing workshops and practical supports (including drives, moves, free furniture, medical equipment) for people living with HIV/AIDS. ACT provides HIV prevention education programs to at-risk women, youth, gay, bisexual, and other men who have sex with men, and has the largest publicly accessible HIV/AIDS library in North America.

ACT sponsors and houses VIVER's Portuguese-speaking Men's Outreach program and the Youth Community Development Program, two programs participating in this research needs assessment initiative.

■ Portuguese-speaking Men's Outreach Program ■

In 1999, the VIVER Coalition and ACT established a partnership that included the hiring of a permanent/part-time Portuguese-speaking male outreach worker, funded by Toronto Public Health's AIDS Prevention Grants program. For the past three years, the Portuguese-speaking Men's Outreach worker has worked in collaboration with the Gay Men's Education Network to conduct outreach to Portuguese-speaking MSM in bars, public parks, and bathhouses. In addition, the Outreach worker collaborates with the VIVER Coalition in the development and delivery of broad community outreach initiatives, such as anti-homophobia and HIV/AIDS training and the translation of HIV/AIDS information into Portuguese. Prior to this, the position was housed at St. Christopher House, an organization that sponsored the Men's Outreach Project from July 1998 to June 1999.

■ Youth Community Development Program ■

ACT's Youth Community Development program works in partnership with other organizations to develop educational strategies for youth at risk for HIV infection.

This program offers volunteer opportunities to individuals who are interested in becoming involved with projects such as the Peer Outreach Project, and the African/Caribbean Young Women's Resource Development Project. It also offers workshops and education opportunities for youth and service providers who work with them. The program also works collaboratively with other organizations to raise awareness, decrease the rates of HIV infection among at-risk youth, and improve the quality of life for youth living with HIV/AIDS.

■ St. Stephen's Community House Wellness Promotion Program ■

St. Stephen's Community House is a United Way member agency and provides a variety of services including Wellness Promotion, Childcare, Employment Training, Language Training, Conflict Resolution, Community Development and targeted services for youth, seniors, newcomers and the homeless.

St. Stephen's Community House Wellness Promotion Program provides education services, group support as well as information and referrals related to HIV/AIDS, sexuality, family health and nutrition in Portuguese and Chinese. Their AIDS education and outreach began in 1988 and was the first initiative targeting the Portuguese and Chinese communities using linguistically and culturally appropriate approaches.

■ David Kelley HIV/AIDS Community Counselling Program ■

The David Kelley HIV/AIDS Community Counselling Program provides professional counselling and support services to people living with or affected by HIV/AIDS. This includes group and individual counselling, referrals and advocacy. It is a program of the Family Service Association of Toronto (FSA), a non-profit social service agency that helps over 20,000 individuals and families in need each year. FSA provides a variety of community support and counselling programs to people struggling with a range of problems, including depression,

physical abuse, sexual orientation issues, marital problems, developmental disabilities, and the challenges of growing older.

COMMUNITY PROFILE

Portuguese, the fifth most widely used language in the world, is spoken by more than 200,000,000 people in Portugal, Brazil, the Cape Verde Islands, Sao Tome & Principe, Guinea-Bissau Angola, Mozambique, Goa, Macao and East Timor (Grosner, 1995).

Migration

Portuguese immigration to Canada began in the early 1950s when Canada sought agricultural and railway construction workers from Portugal. During this time, 17,114 Portuguese arrived. Sponsorship and family reunification accelerated the process in the 1960s (59,677) and 1970s (79,891). However, since the mid-1970s, fewer Portuguese have arrived, partly due to changes in Canadian law. Modest increases in the late 1980s may be attributed to refugee claims. In the late 1980s, 38,187 Portuguese immigrated to Canada (Teixeira, 1999).

Portuguese-speaking Communities in Toronto

Toronto's Portuguese-speaking communities are dynamic and comprised of individuals from Portugal as well as Portuguese-speaking immigrants from Brazil, Angola, Cape-Verde, Mozambique, Goa, Guinea-Bissau, and Macao. According to the 1996 Census, the population of Portuguese-speaking communities in Canada was 211,290; in Ontario 150,630 and in the Greater Toronto Area (GTA) 107,795. The majority of Portuguese-speaking Torontonians are from the nine islands making up the Azores archipelago, followed by a much smaller group from continental Portugal and the Madeira archipelago. The second largest group of Portuguese-speaking Torontonians are from Brazil, particularly Sao Paulo and Rio de Janeiro. There are also Portuguese-speaking people in Toronto from Angola, Mozambique, Cape Verde, Guinea-Bissau, Sao Tome & Principe, Macao, and Goa.

Portuguese-speaking Gay, Bisexual, and other Men Who Have Sex with Men

Portuguese-speaking gay, bisexual, and other men who have sex with men reside throughout the GTA and socialize in heterosexual bars, dances, gay venues, Portuguese pool halls, and cultural events. Some men meet partners in these social venues, while others meet sexual partners in parks, bathhouses, and public washrooms.

With a membership of over 200, Arco-iris is a formal gay and lesbian group and hosts large social events, produces a regular newsletter and liaises with the heterosexual Portuguese-speaking communities to offer social support to Portuguese-speaking gay, bisexual and other men who have sex with men. The Victim Assistance Program at the 519 Church Street Community Centre offers information on gay-bashing in Portuguese. This organization is currently recruiting Portuguese-speaking volunteers to provide support for fellow community members victimized by gay-bashing.

■ Portuguese-speaking HIV-related Services ■

HIV-related services accessible to Portuguese-speaking communities include both "potential" and "designated" services. Potential services are those employing Portuguese-speaking employees/community workers but who are not solely funded to serve Portuguese-speaking communities. They are also agencies in Portuguese-speaking communities who have some knowledge of HIV/AIDS but who are not solely mandated to work on HIV/AIDS. Potential services include Abrigo, Access Alliance Multicultural Community Health Centre, ACT Youth Community Development Program, the David Kelley HIV/AIDS Community Counselling Program of the Family Services Association of Toronto, St. Christopher House, the Works Needle Exchange Program, Hassle Free Clinic, Immigrant Women's Health Centre, Parkdale Community Health Centre, and the Working Women Community Centre. Designated services are those specifically targeting Portuguese-speaking communities in a context of HIV/AIDS and include the AIDS Hotline, VIVER's Portuguese-speaking Men's Outreach Program (sponsored and housed at ACT), and St. Stephen's Community Wellness Program.

■ IDENTIFIED THEMES & ISSUES ■

The following themes emerged from issues identified in the two focus groups with gay-identified men who culturally-identify with Brazil or Portugal and Portuguese-speaking service providers. Communities represented in focus groups were Portugal and Brazil. Hence, issues identified in this chapter are most reflective of Portuguese-speaking communities from the Azores and continental Portugal. As previously mentioned, the term "Portuguese" is used to mean Portuguese-speaking communities from Portugal (including the Azores and Madeira). "Portuguese-speaking" is used to mean those who speak Portuguese but who are not necessarily from Portugal. This chapter uses the term "Portuguese-speaking" to refer to all Portuguese-speaking peoples, regardless of their country of origin.

■ Sexual Identity & Behaviour ■

A. Sexual Identity

The acronym "MSM" is not frequently used in the Portuguese community, but it is used in the AIDS movement to designate a group of men who have se x with other men but do not label themselves. This notion is particularly useful to this report as many Portuguese-speaking men may not identify their same-sex sexual activity with the sexual labels "gay" or "straight". They simply may be married men who discretely seek sexual pleasure with men and who, according to one participant, "do not associate having sex with other men as being a gay activity…it is seen only as a sexual act". The Working Group thus strongly recommends the use of the following terms:

- Portuguese-speaking gay men (men who have sex with men and who self-identify as gay);
- Portuguese-speaking bisexual men (men who may have sex with men and women and who self-identify as bisexual);
- Portuguese-speaking MSM (men who have sex with men but who do not label themselves)

In the Portuguese community, sexuality is compartmentalized and attached to culturally-prescribed gender roles and notions of family, fatherhood and the role of provider. This does not fit with a "gay identity" because it is assumed gay men will neither marry nor have children. As such, an inner struggle, or identity conflict, can emerge for men who have sex with men because their behaviours do not fit these traditional expectations. This seems to be one reason why Portuguese-speaking MSM do not attach a sexual identity to their sexual behaviours. Adopting a gay identity may mean that traditional roles and notions of "self" (as husband, father and provider) are threatened and sometimes lost. This can be especially true for men who became infected with HIV through same-sex sexual behaviours. As one Portuguese-speaking gay man said in response to losing one's status as husband, father and provider, "you feel very naked".

Many participants spoke of denial of homosexuality in the Portuguese community. Many people believe that Portuguese-speaking gay men do not exist; "straight" men can have sex with both men and women because they are not gay. Bisexuality may be more acceptable by the community at large if it remains discrete and also because it does not threaten the prescribed gender roles of father, husband and provider.

B. Sexual Roles

Participants frequently hear other Portuguese-speaking MSM deny being gay because they have "never sucked off or been fucked by another man". A belief exists that a man is gay if he performs fellatio. As one participant explained, "getting sucked is more acceptable than sucking".

C. Sexual Behaviours

There is growing concern that some Portuguese-speaking MSM have anal sex without condoms. Some believe they are not at risk for HIV/AIDS since they do not self-identify as gay. Being gay is synonymous with being HIV-positive; some Portuguese-speaking MSM believe being the "bottom" puts one at risk for HIV, while being on "top" ensures one's safety.

Some Portuguese-speaking gay men believe that condom use is an indication that a person is "not clean", thus individuals might engage in high-risk behaviours to prove they are not HIV-positive. There is also a perception that HIV risk is denied by the broader community because it is seen as a disease that only affects gay men, prostitutes and other marginalized populations. This has implications, later discussed in this chapter, for Portuguese-speaking gay men.

D. Attitudes Towards Homosexuality

The Portuguese community is perceived by many participants as being out-of-date in their knowledge of, and attitudes towards, sexual diversity. Heterosexuality, marriage and procreation are generally upheld. Some participants believed the Brazilian community is more open-minded and accepting of homosexuality. Brazilian participants emphasized, however, that "not all Brazilians are open-minded. They may be a community more willing to discuss homosexuality but there is also more discrimination towards gay men who are HIV+". It was noted that HIV/AIDS in Brazil is not only related to the gay community but also to poverty and class. HIV/AIDS spreads rapidly in poorer communities because they don't have the assistance or the information available to them on HIV/AIDS.

■ Disclosure of Sexual Orientation ■

A. Coming Out

Most non-gay/bisexual-identified Portuguese-speaking men have difficulty disclosing about their same-sex desires. In general, Portuguese men tend not to openly discuss their sexual activities since it is culturally taboo.

For some Portuguese-speaking gay or bisexual men, fear of rejection and alienation from their ethno-cultural community affects disclosure of their sexual identity. The duality of identity again emerges: some participants felt that as gay men, they had nothing in common with the Portuguese community and thus rejected their Portuguese heritage, instead finding support within the mainstream gay community. Later in life, however, many desire a re-identification with their ethno-cultural roots, and immerse themselves in the Portuguese community.

For other Portuguese-speaking gay or bisexual men, the community has no significant impact on their decision to come out. As one participant stated, "as long as my family accepts me for who I am and they love me I really don't care what others think". Some felt coming out to parents was very important because "it seems easier to talk about one's sexuality once you have come out to parents or to people with whom you feel close".

Because HIV is linked with homosexuality in the Portuguese community, men who have sex with men who are HIV-positive are "outed" as gay. Fearing rejection and judgement from their ethno-cultural community, men who are HIV-positive find it difficult to admit they became infected through unprotected sex with another man. They also fear their sexual orientation and serostatus will be disclosed to other community members. For these reasons, many are not willing to talk about their sexual activities with other men, especially if they are married. This fear is further heightened for those who are non-landed immigrants and who thus risk deportation.

B. Communication and Language

Communication

Immigration and its impact on the Portuguese family is multi-faceted. Many immigrant parents do not learn English, living in an environment segregated from mainstream Canadian society. Their children, however, learn English and integrate. This can create communication barriers between parents and children as well as conflict, resulting from exposure to new norms and values in the mainstream culture. This is further compounded by the issue of sexual identity. For many Portuguese gay youth, inter-generational communication is problematic and words for explaining gay and sexuality are difficult to find.

Lack of Culturally-Relevant Terms for Sex & Sexuality

According to a participant, second-generation, or more "Canadianized", Portuguese-speaking individuals feel "there is a lack of healthy language to talk about sex and sexual behaviour in the Portuguese community". Sexual terms commonly and traditionally used in Portuguese tend to be pejorative. More specifically, there is a lack of appropriate Portuguese terms to discuss sex and sexuality in a positive and non-threatening way. Some participants also believed there are not as many words in Portuguese, as in English, to explain certain sexual terms.

However, Portuguese-speaking service providers claim there exists appropriate Portuguese terms to discuss sex and sexuality but they have been lost through the process of immigration. Today, in continental Portugal, open dialogue regarding sexuality occurs, where in Toronto's Portuguese community, the older generation (parents) who immigrated 50 years ago had the experience of living with the Salazar regime when it was culturally inappropriate for people to openly discuss sexuality issues with their children or anyone else. Thus, terminology for various aspects of sexuality was not acquired and passed on from parent to child. Many parents are still conservative in their attitudes and comfort levels related to sexuality, and, as a result, many Portuguese youth suffer. Youth learn derogatory words labeling or stigmatizing men who are gay and bisexual, or are forced to seek sexuality and HIV/AIDS information outside their ethno-cultural community. Some participants stated that more positive labels to identify certain sexual activities would make it easier to have open discussions about sexual behaviour. One Portuguese-speaking service provider said "labels can be positive if we had the appropriate terms/language to express sexual identity and orientation". In view of this, many Portuguese youth feel isolated and outcast when they are forced to seek information outside their own ethno-cultural community that for many prohibits them from learning the Portuguese terminology.

In order to foster better communication among families and to promote positive attitudes toward sexuality, Portuguese-speaking service providers are beginning to use more appropriate Portuguese terms in their outreach initiatives.

■ Access to HIV/AIDS Information ■

A. Lack of HIV/AIDS Information

According to most participants, Portuguese-language HIV/AIDS educational materials are limited. Consequently, community members possess little knowledge of HIV/AIDS. Many do not make efforts to understand HIV/AIDS due to misperceptions about the disease and denial that HIV/AIDS exists in Portuguese-speaking communities.

Some gay-identified Portuguese-speaking men claim they have never seen HIV/AIDS literature in Portuguese. As a result of their assimilation into mainstream culture and their comfort levels with English, they tend to access English-language materials.

B. Barriers to Community Information Seeking

Some participants expressed concern that many members of Portuguese-speaking communities are not accessing existing educational material because of a misconception that AIDS is a "disease that only happens to gay people." There is a perception that only gay men are at risk to HIV infection so the need to access information on HIV/AIDS is irrelevant for "straight and bisexual Portuguese men and women." This misconception is not to Portuguese-speaking communities.

Another barrier identified was the lack of culturally -- and conceptually -- relevant HIV/AIDS educational literature available. Literature as a means of raising awareness is also seen as problematic, as many Portuguese-speaking immigrants in Canada adhere to a predominately "oral culture".

C. Misconceptions about HIV/AIDS Information

Despite some signs of greater openness in discussing HIV/AIDS, Toronto's Portuguese-speaking community from Portugal still appears reluctant to broach the subject(s). Many find it difficult to discuss the subject while in their larger community, while expressing only somewhat less reserve to do so if in a depersonalized, objective context, as might be the case at a public forum on the topic(s). Many are more likely to discuss sexuality when amongst their own gender only, or when they are confident that confidentiality and acceptance by the listener is ensured.

This restricted level of dialogue has allowed the continuation of some misconceptions regarding the assumed connection between sexual orientation and HIV status. Many in the community believe that all Portuguese-speaking gay men, bisexual men and non-gay identified men who have sex with men (MSM) are not only HIV-positive, but also have full-blown AIDS. fail to see the difference between living with HIV versus living with AIDS.

> Because of the belief that HIV/AIDS is a gay disease, there is a misconception that you can "fuck anyone and if you are on top you won't get AIDS." This puts Portuguese-speaking MSM who do not identify as gay at risk of practicing unsafe sex, such as anal sex without a condom.

D. Religion as a Barrier to HIV/AIDS Information-Seeking Behaviours

Although the Catholic Church continues to be perceived as a potent force of social control in various Portuguese-speaking communities, it is important to realize that fear of being talked about, or socially ostracized, have become equally important influences for many Portuguese-speaking persons. While some people fear 'going to hell' and opposing the Church, now many more fear for their own social currency, some of which is based on Catholic values. This being said, religion and the Catholic Church still hold a significant role in Portuguese culture and Portuguese identity, particularly for its older generation. Some participants perceive religion as a barrier for community acceptance of homosexuality and for holding open dialogue regarding MSM. For Portuguese-speaking MSM, religion does not appear to dictate their sexual behaviour but does dictate their information-seeking behaviours and attitudes. Some participants feel that, given its capacity and resources to reach out to a large audience, the Church should play a significant role in educating the community on issues about homosexuality and HIV/AIDS. Many Portuguese gay men perceive the church as disseminating negative messages to the community on sexuality and fostering homophobic attitudes.

Given that the Church has not played a role in HIV prevention, there is a community perception that it is not concerned with the needs of Portuguese-speaking MSM or community members living with HIV/AIDS. The Church has also refused to comment on injustices aimed at lesbian and gay people and HIV-positive individuals. In one example, the Church refused to comment on homophobic flyers distributed in the community falsely attributed to a Church based organization. Participants regarded the Church's silence as a significant barrier to HIV prevention work in Portuguese-speaking communities.

Through the preaching of the sanctity of marriage, the Church may further hamper HIV prevention efforts. Feeling trapped by religious teachings, women may remain silent if they know of, or suspect their husband's sexual encounters with other men. But religion is not the only barrier that traps women in these relationships; community pressure instills the belief that Portuguese women should do everything in their power to keep marriages intact for the well being of their children and to avoid shaming families. Portuguese women fear "what the

neighbours will say" if they leave their husbands. If their husbands are having unprotected sex with other men, their risk for HIV infection will be heightened.

■ HIV/AIDS Service Barriers ■

Community Perceptions of Services

There is a lack of consensus in the Portuguese-speaking communities regarding appropriate models of service delivery. Though service providers acknowledge the existence of services for people living with HIV, they are critical of service limitations. Moreover, there is little historical and cultural experience with secular social services, and family is traditionally relied upon for support. However, MSM are reluctant to turn to their families for support related to sexual orientation issues. There was also evidence that Portuguese-language services may not be culturally relevant because they do not represent the diversity of Portuguese-speaking communities in Toronto.

Community members agree that reactions to HIV infections are individual and it is difficult to predict whether people will seek services. Some service providers believe that Portuguese-speaking people tend to use HIV-related services only when they become HIV-positive, or when they are presented with a serious health concern. Some service providers spoke of readiness on the part of individuals to seek HIV prevention information if they take sexual risks, but reticence on the part of HIV-positive individuals to seek services related to their infections. Cultural stigma related to HIV presents a very serious threat to those accessing services. For example, a Portuguese man who considers himself "straight" but has sex with other men will not seek services from a gay identified agency. Some service providers emphasized that barriers to HIV-related services do not exist for those who are information seekers and have an established pattern of using social services before their HIV diagnosis, particularly if the person speaks English. Barriers for accessing HIV-related services exist for people who are not information seekers and who have been very independent and have previously not used social services of any kind. It is these people who have the most difficult time reaching out to services being offered when they are in need.

Confidentiality & Anonymity

Portuguese-speaking gay men identified lack of anonymity and confidentiality as barriers to HIV/AIDS services in their own communities. Some believe remaining anonymous is impossible in a community service where they fear their sexual orientation and sero-status will be disclosed to others, resulting in pity and alienation. These fears were heightened for individuals highly integrated into Portuguese-speaking communities.

There was a further concern that Portuguese-speaking service providers tend to share information about their clients with friends, family and other community members, further breaching confidentiality. Participants reported that this occurs in hospital settings among Portuguese-speaking nurses and translators who work with people living with HIV/AIDS. Although this breach may be sometimes unintentional, it becomes a solid foundation for mistrust. It is important to state that not all participants shared these views; some trust Portuguese-speaking health providers and access services in both the mainstream and the Portuguese-speaking communities.

It should also be noted that while the social service providers in our focus group felt confidentiality was important and integral to social service provision, they did not perceive lack of confidentiality as a barrier to services, as did the gay men in our group. Additionally, conflicting ideas about what constitutes confidentiality in the community was evident among service providers. In particular, service providers were concerned about the lack of community accountability or concern.

Language as a Determinant of Access

Language is a significant barrier to services for some Portuguese-speaking MSM. One service provider noted that mainstream AIDS Service Organizations might be insensitive to ethno-cultural communities and uncomfortable environments for Portuguese-speaking people who do not speak English. Some Portuguese-speaking people feel more comfortable speaking in English because they are more assimilated to Canadian culture: "The longer you are here (in Canada) the less you identify with your ethno-cultural community and the less likely you are to access services in the Portuguese community". Another reason for accessing mainstream Canadian services has to do with fear of disclosure that may happen as a result of accessing Portuguese-speaking services.

Immigration Status

There are no services for HIV-positive, Portuguese-speaking people who are non-status refugees or immigrants. HIV drug treatments, access to clinical trials and the Trillium Drug Plan, housing, and legal services are only accessible to those who are landed immigrants, citizens, or refugees.

For those seeking to reside in Canada (and hoping that family members will join them) their HIV status may threaten their plans. This seems to be of particular concern to the Brazilian community, where fragile legal status coupled with HIV puts them at higher risk for deportation (especially if someone from their community sees them accessing HIV/AIDS services).

Finally, despite the length of residence in Canada, many Portuguese-speaking immigrants have not yet obtained their Canadian citizenship and fear their HIV status could be used as grounds for deportation. This fear keeps many from learning their rights as landed immigrants and furthers misunderstanding of the Canadian immigration system.

HIV/AIDS Knowledge among Portuguese-speaking health providers

There was a perception among participants that Portuguese-speaking health providers (including physicians) lack knowledge of HIV/AIDS. Assuming they have no gay clientele keeps many Portuguese-speaking physicians from learning about HIV. Again, HIV is mistakenly assumed to be synonymous with being gay. Of greater concern to our participants was the fact that Portuguese-speaking physicians are not choosing to specialize in HIV care, nor do they seem interested in acquiring further information about HIV/AIDS.

Participants further noted that Portuguese-speaking doctors do not know where to refer HIV-positive clients. "I had to teach my doctor about the services that exist in mainstream society," said one Portuguese gay man.

Participants felt with some frustration that there are many prominent physicians from Portuguese-speaking countries (Portugal, Brazil) who are not allowed to practice in Canada without Canadian experience. Their professional experience in their country of origin does not

qualify them to immigrate and practice in Canada even though participants feel they are good candidates. The College of Physicians and Surgeons guidelines state that Canadian experience is required to practice in Canada, thus disqualifying Portuguese-speaking family doctors or physicians who specialize in HIV/AIDS.

■ Community Response to Portuguese-speaking MSM and HIV ■

It is important to point out that varied opinions exist within the Portuguese-speaking communities in relation to the issues outlined below. The community is changing and there is an emerging tolerance of homosexuality, and acknowledgement of HIV-related issues. There are, however, sectors within the various Portuguese-speaking communities that are particularly affected by the following community responses.

Shame

Many Portuguese-speaking gay and bisexual men, and other MSM will not disclose their sexual orientation for fear of bringing shame to their families or communities. These men try to be invisible, distancing themselves from openly gay individuals. This is reinforced by cultural norms making "what will the neighbours say if they find out you're gay and/or HIV-positive" paramount. Increasing the family fortune and/or continuing the family name through children are important to Portuguese-speaking families. Gay sons are viewed as failures in these domains, morally unacceptable, and less than men. Frequently ignored or shut out of the family, they must cope with their parent's feelings of shame.

Given the pervasiveness of the beliefs that only gay men, prostitutes and drug users are at risk of HIV infection, HIV-positive Portuguese-speaking people fear stigmatization. The shame of contracting HIV from sexual behaviour with men (especially if he is an older man) is so intense that some men prefer to blame their infection on a sex trade worker or injection drug use.

Denial

Many participants spoke of the Portuguese communities' considerable denial of both homosexuality and HIV. Some social service providers, in particular, believe that the community thinks Portuguese-speaking MSM do not exist. With respect to HIV/AIDS, the silence surrounding AIDS-related deaths is particularly difficult for family members; community members would prefer to falsely believe that a man who dies from AIDS, contracted it from a prostitute.

Finally, it should be noted that a sizable minority of participants strongly contested that community denial of homosexuality and HIV is a myth that is causing damage to the gains that have been made in those social service agencies that have been working with the community for a very long time. Whether or not there was denial in the community about HIV or MSM became an issue for the Working Group, especially in view of the fact that the participants from social service organizations felt there was a lot of denial in the community. Some Working Group members cited concrete examples of how denial simply was not the only part of the experience around these issues. However, others cited examples of outspoken gay men, public events involving a Portuguese gay & lesbian group, public events involving awareness of HIV, as well as overt acts of homophobia and discrimination in the media and in community institutions.

Discrimination

Extreme ostracization and pity are common responses toward HIV-positive people in Portuguese-speaking communities. "There is a lack of medium … a lack of a balanced mental state of acceptance." The Church is seen as particularly discriminatory against men who have sex with men and people living with HIV. "The priests never say homosexuals are human, there is a lot of discrimination." Gay men are ignored and not seen as legitimate sections of the community by many with strong influences in the Portuguese Catholic parishes. Those with strong influence in the Church regard gay men negatively, emphasizing the role of "sin" in their infections. These beliefs are broadly disseminated in the community and impact greatly on some Portuguese-speaking gay men and MSM by instilling fear of disclosure of their sexual identity and HIV status to community members.

Discomfort with Sexuality

Open discussions about sexuality, HIV and homosexuality are taboo in the Portuguese community. Many Portuguese-speaking people find it uncomfortable discussing their HIV status because of cultural taboos, shame, and fear of rejection from community and family members. Some counsellors also feel that these taboos cause HIV-positive Portuguese-speaking people to avoid speaking about the impact of HIV on their lives.

However, changes are occurring. Through the media, individuals with a strong commitment to social justice are speaking publicly. In addition, social service organizations, and seniors, parents and women's groups, have begun open dialogue about sexuality and HIV infection.

Homophobia & Heterosexism

Homophobia affects Portuguese-speaking communities. The past position of the Catholic Church denouncing homosexuality as sin, and their current silence reinforces cultural heterosexism (the belief in the superiority of heterosexuality). It should be noted that the Church's influence in many of the Portuguese-speaking communities is weakening and the influence of secular values has increased. Portuguese-speaking communities fear the scorn of others in relation to homosexuality; "what will others think," determines how people react to Portuguese-speaking gay and bisexual men and other MSM. Additionally, the presence of visible gay, lesbian and bisexual Portuguese-speaking individuals within the Portuguese-speaking communities impact positively on other MSM.

Another way in which homophobia serves as a means of social control is through housing, an important issue for low income Portuguese-speaking people or those experiencing problems with immigration. Often, the only housing available to them are flats in houses with Portuguese-speaking landlords sharing the dwelling. This makes it impossible for MSM to bring home sexual partners, thus inhibiting sexual activities.

Many participants believed Brazilians to be more open to sexual diversity in general, while others argued that Brazilian class structure determines the degree of homophobia experienced by Portuguese-speaking MSM. MSM from poorer social classes are more likely to experience overt homophobia. Well-educated Brazilian gay and bisexual men and other MSM from higher social classes experience less overt hostility. In Brazil, language denotes one's class and social status much more so than in Portugal and the Azores. For example, 'poor' and 'unsophisticated' grammar reveals one's lower social class. In addition, the choice to use certain words to describe sexual activities also has class implications.

RECOMMENDATIONS

The Working Group proposes the following program and research recommendations:

- "Men who have sex with men (MSM)" is not a commonly used term in Portuguese-speaking communities. Therefore, the use of this umbrella term should be avoided in future research initiatives.

The target groups to be addressed in future research initiatives are:

a) Non-gay identified men who have sex with men
This group is difficult to access through outreach strategies and little is known about their HIV prevention needs. They should be therefore given priority in future research initiatives.

b) Women
Portuguese women are at high risk for HIV infection if their male partners are practicing unprotected anal sex with other men. Identifying effective HIV prevention strategies for these women is a research priority. Implementation of these strategies is also a priority.

HIV-positive Portuguese-speaking women are isolated and may have difficulties accessing services due to language and economic barriers. A needs assessment identifying the following among Portuguese speaking women should be considered a priority:

- General health and sexual health concerns.
- The means by which they became HIV-positive.
- HIV prevalence and the number currently living with HIV.
- Barriers faced by women in:
    - health care and social services
    - bettering their economic standing
    - attaining assertiveness skills
    - acquiring the ability to have open dialogue about sexuality and addictions

c) Injection Drug Users (IDUs)
HIV incidence continues vis-à-vis injection drug use and accounts for the majority of new infections in continental Portugal. MSM-IDUs are the second largest group living with HIV in Portugal. Given that Portuguese-speaking individuals from Canada travel abroad frequently, there is a need to identify the prevalence of HIV risk-taking through injection drug use among these individuals.

d) The diversity of Portuguese-speaking communities
Future research initiatives should be inclusive of the diversity of Portuguese-speaking communities in Toronto and not just the Portuguese (continental Portugal, the Azores and Madeira) community.

The Working Group has also identified some recommendations for culturally appropriate research methods when doing future research initiatives with this specific community.

1. Recognize the heterogeneity of, and power imbalances within Portuguese-speaking communities in terms of language, religion, social status, and cultural norms (given the large population of Portuguese-speaking Azoreans there is a tendency to imply their issues and needs represent all other Portuguese-speaking communities.
2. Recognize that power imbalances based on social class, place of residence (rural versus urban), employment status, and literacy levels, may affect the ability of some to participate in groups where issues concerning sexuality and HIV are being discussed.
3. When conducting research in Portuguese-speaking communities, language should be appropriate to each target group involved in the research process.
   a) Conduct interviews and focus groups either in Portuguese or Portuguese and English.
   b) Ensure that written materials are available to participants in both Portuguese and English.
4. Given community taboos related to open discussions of sexuality, the following will help ensure maximum participant comfort levels when conducting research, and will help to facilitate reaching non-gay-identified MSM:

   - Ensure sampling is community-wide and inclusive of all Portuguese-speaking people (i.e. not restricted to self-identified gay/bisexual men or MSM)
   - Ensure that the confidentiality and anonymity of participants is safeguarded- this may best be facilitated via telephone methods
   - Provide gender-specific focus groups and match facilitators/interviewers based on gender
   - Ensure that research tools (i.e. discussion guides and survey tools) are appropriate to varied literacy levels
   - Use culturally-appropriate terms to describe sexuality and sexual activities
   - Use visual aids to stimulate discussion about sexual behaviors and HIV, when conducting focus groups
   - Ensure that definitions of such terms as "social service" are commonly agreed upon and understood by participants

■ SUGGESTED RESEARCH QUESTIONS ■

■ Marginalization / Inequity ■

Experiences within Ethno-cultural Community

1. What do self-identified gay and bisexual man and non-gay MSM experience in Portuguese-speaking communities?

Experiences within Mainstream Community

2. What do self-identified gay and bisexual men, and non-gay identified MSM experience in the mainstream community?

■ I d e n t i t y ■

Cultural Identity Formation

3. What factors impact on cultural identity formation for:
   a) Portuguese-speaking self-identified gay and bisexual men, and non-gay identified MSM born in Canada?
   b) Portuguese-speaking self-identified gay and bisexual men, and non-gay identified MSM who are new immigrants?
4. What is the relationship between factors that influence cultural identity formation and HIV risk-taking behaviour?

Concept of Sexual Identity

5. How do the following factors affect sexual identity formation among Portuguese-speaking MSM?
   a) immigration status (i.e., whether they were born in Canada or not)
   b) geographical region they came from,
   c) year of immigration,
   d) age at immigration,
   e) living at home with family
   c) number of siblings living at home
   d) educational level of parents
   e) language(s) spoken by family
6. What is the relationship between these factors and HIV risk-taking behaviour?

■ B e h a v i o u r ■

I. Descriptive

Sexual Behaviours

7. What are the patterns of sexual behaviour among Portuguese-speaking MSM;
   a) who identify as gay or bisexual?
   b) who do not identify as gay or bisexual?
   c) who are married?
   d) who are single?

HIV Testing Patterns

8. What are the HIV testing patterns among Portuguese MSM?
9. What factors influence HIV testing in the Portuguese-speaking communities?

■ H I V / A I D S K n o w l e d g e & A t t i t u d e s ■

II. Community

HIV/AIDS Knowledge

10. What is the general level of HIV/AIDS knowledge in Portuguese-speaking communities?

Attitudes towards HIV/AIDS

11. In the Portuguese-speaking communities there is denial that HIV/AIDS exists. Do groups in the Portuguese-speaking communities differ with regards to denial? If so, what accounts for these differences?
12. How does this denial impact on the funding of HIV/AIDS services?

13. How does the perception of community denial of HIV/AIDS affect an individual's access to services?
14. How does the perception of community denial of HIV/AIDS affect a Portuguese-speaking gay man, bisexual man and non-gay identified MSM's access to services?

III. Access to Information

15. Where do Portuguese-speaking communities get information on HIV/AIDS? How appropriate are these sources?
16. How accessible is this information to the Portuguese-speaking communities?

Individual Knowledge

17. What common misconceptions do Portuguese-speaking gay and bisexual men, and non-gay identified MSM hold about HIV/AIDS?

■ Support Systems ■

Service Accessibility

16. How does identity formation affect access to services?
17. How does community-wide denial concerning HIV/AIDS affect access to services for Portuguese-speaking MSM?
18. What HIV-related health/social services are available to Portuguese-speaking MSM in their ethno-cultural community? In mainstream community? What barriers are there to accessing these services?
19. What do Portuguese-speaking MSM need from health and social services in their ethno-cultural community? From the mainstream community?
20. What access barriers in AIDS Service Organizations do Portuguese-speaking MSM encounter?
21. What would make AIDS service Organizations accessible to Portuguese-speaking MSM?
22. Where do health care and social service providers refer their Portuguese-speaking clientele, in relation to MSM and HIV issues?
    a) Are there other identifiable referral patterns?
    b) What factors influence the formation of these referral patterns?
    c) Is there a difference in referral patterns between Portuguese-speaking and non-Portuguese speaking service providers?

■ SOUTH ASIAN COMMUNITIES ■

■ SUMMARY ■

The Alliance for South Asian AIDS Prevention (ASAP) is a non-profit community-based agency committed to the prevention of the spread of Human Immunodeficiency Virus (HIV) in the South Asian communities and enhancing the lives of South Asians living with, and affected by, HIV/AIDS.

In close partnership, ASAP and the HIV Social, Behavioural and Epidemiological Studies Unit (HIV Studies Unit) established a Working Group for this project, comprised of individuals connected with and knowledgeable about South Asian MSM. A series of brainstorming sessions was held with Working Group members to identify major themes and issues in relation to South Asian MSM and HIV/AIDS. During this process, it became clear that experiences of South Asian MSM often are linked to immigration status. As such, participants sought to differentiate between concerns of new immigrant South Asian MSM (up to 5 years residence in Canada) and first-generation South Asian MSM (those born in Canada to South Asian immigrant parents and those who immigrated to Canada at an early age). The following is a synopsis of those themes and issues:

Language Skills
- Fluency in English and ability to comprehend HIV educational materials varies among MSM.
- Language sometimes presents communication barriers between service providers and clients.

Religion
- Religion may be an HIV prevention barrier in many South Asian communities:
    - Homosexuality is expressly forbidden by most religious scholars.
    - HIV/AIDS is regarded as a punishment from God, for people with "loose morals".

Family / Marriage / Gender Roles
- In South Asian cultures, the family unit is considered paramount and is often an important source of support.
- Prescribed gender roles view men as providers, the head of the family household.
- Formal social services are not traditionally part of South Asian culture.
- South Asian men are expected to marry.
- Concern about how an individual is perceived & how this reflects upon one's family is very important in South Asian communities.

Low priority of Sexual Health
- Basic settlement needs such as finding employment, adequate housing and learning English preoccupy new immigrant South Asian MSM.

HIV/AIDS Knowledge
- Misperceptions and mis-information about HIV/AIDS exist, especially among new immigrant MSM.

Racism & Power Dynamics
- Overtly racist attitudes are held by some new immigrant South Asian MSM, though these same men are victimized by racism.

- Many South Asian MSM are vulnerable to racist attitudes and behaviours because they may be unable to identify racism when it occurs.
- The Canadian Census used to group all South Asians into one category, neglecting that South Asians come from different countries of origin.

Internalized Racism
- Participants related internalized racism to a history of imperialism in South Asia.
- Whiter skin often is seen as desirable and regarded as powerful, whereas darker skin often is devalued.
- Internalized racism may manifest in preference of Caucasian men for sexual and intimate relationships.
- Preference for Caucasian men could impact HIV prevention efforts among South Asian MSM who may take undue sexual risks if requested by their Caucasian partners.

Sexual Freedom
- North American culture offers more opportunity for sexual freedom for new immigrant South Asian MSM:
- In countries of origin:
    - Sex is not openly discussed.
    - Sexual abstinence before marriage is a normative expectation; dating is often prohibited.

Fear of Recognition
- Many South Asian MSM fear being recognized by other community members in venues where they seek sex or gay bars/clubs.
- South Asian MSM may fear accessing South Asian services such as ASAP, preferring the anonymity of mainstream service organizations.

Issues concerning Identity
- The concept of a community of MSM does not exist among South Asians.
- There is no concept of sexual identity among many South Asian MSM.
- The social invisibility of alternative sexualities perpetuates the dominance of heterosexuality.
- Individuals who define themselves by their sexuality or gender may be shunned.
- Some South Asian MSM who do not identify as gay or bisexual, as they still believe HIV/AIDS is a gay disease, may not seek HIV testing services.
- The passive sexual role is considered by some to be degrading, akin to being "womanly", whereas the active sexual role is considered "manly".

Self-esteem
- Some new immigrant MSM suffer from low self-esteem as a result of various socio-cultural pressures.
- Some first-generation MSM experience difficulties fitting into the gay community, contributing to lower self-esteem.

Use of ASAP Services
- Many South Asian MSM use ASAP services because they can communicate in their own languages while others perceive ASAP as an opportunity to socialize with other MSM.
- A deficit exists in suitable and accessible venues in which South Asian MSM can socialize.
- Mainstream South Asian communities hold the view that ASAP's services are directed more towards South Asian MSM/gay men, making it difficult to reach the broader South Asian communities.

- ASAP services towards South Asian populations are limited because of funding.
- South Asian communities' support of ASAP also is limited since HIV/AIDS often is not considered a priority.

Based on these themes and issues, the Working Group recommended the development of strategic education and prevention initiatives, including the establishment of program priorities, core prevention principles, community development, outreach and education capacity building and program needs.

Further, the Working Group identified the following areas as future research priorities: culture & sexuality, HIV/AIDS knowledge & attitudes, access to HIV/AIDS information, sexual behaviour, sexual identity, self-esteem, immigration status, oppression, service accessibility, family, faith / religion and HIV prevention strategies.

PROJECT PROCESS

Initiation of Project Partnership

In November 1999, ASAP and the HIV Studies Unit established a partnership to identify research questions related to South Asian MSM and HIV. A Working Group was established and terms of reference agreed upon.

Working Group

Members of this Working Group included:

Jose Franco (PHA Life Enhancement Coordinator - ASAP)
Mohammed Khan (Volunteer - ASAP, Volunteer Coordinator - Peel HIV/AIDS Network)
Indra Ramkissoon (Executive Director - ASAP)
Zavare Tengra (MSM Outreach Worker - ASAP)
Ilda Cordeiro (Project Coordinator - HIV Studies Unit)
Chris Lau (Project Assistant - HIV Studies Unit)

Method

Given their experiences in South Asian communities and their knowledge of HIV/AIDS, Working Group members were viewed as key informants. Three brainstorming sessions were held to identify themes and issues. The four individuals (1 woman, 3 men, age 24-50) self-identified as South Asian, and were born in Pakistan or Trinidad. All had some contact with South Asian MSM, either through outreach or counselling support.

The brainstorming sessions were conducted in February and March 2000 and lasted 3 to 4 hours. During the first session, project objectives were reviewed and consent for audio-taping was attained. HIV Studies Unit staff acted as recorders of the discussion.

Summaries of each session were prepared and verified by the Working Group. HIV Studies Unit staff prepared drafts of this chapter for reviewing, editing and approval by Working Group members.

Project Strengths & Limitations

Working Group members identified the following strengths and limitations of the project:

Strengths:

- Given that the Working Group consisted of individuals who work in the field of HIV/AIDS and who have direct contact with South Asian MSM, they brought considerable knowledge of issues related to MSM and HIV.
- Bias was minimized by having HIV Studies Unit staff, instead of Working Group members, summarize information from brainstorming sessions. Similarly, cultural mis-interpretation was minimized through presenting themes back to the Working Group for verification.
- The Working Group had opportunity to decide the most appropriate research method to be employed.
- Working Group members critically challenged each other, exploring their own assumptions and reaching a better understanding of the complexity of life experience of South Asian MSM.
- The Working Group and Unit worked together to articulate and compile a professional summation of the issues that South Asian MSM encounter from the perspectives of service providers. Hopefully this report will lead to opportunities for further initiatives in collaborative research.

Limitations:

- The Working Group consisted of service providers in AIDS Service Organizations (ASOs) and was limited in its representation of South Asian communities in terms of class, language, nationality, geographic region, religion/faith, sexuality and sexual identity.
- Directly speaking to South Asian MSM would have enriched the data.

AGENCY PROFILE

Mission

ASAP is a non-profit, community-based agency committed to the prevention of the spread of HIV and to enhancing the lives of South Asians living with and affected by HIV/AIDS. ASAP was initiated in 1989 by members of Khush, a Toronto queer South Asian group, in response to the death of a South Asian couple from AIDS-related complications who, due to linguistic and cultural barriers, could not access the services of existing AIDS Service Organizations (ASOs).

ASAP serves the Indian, Pakistani, Sri Lankan, Bangladesh, Indo-Caribbean (Trinidad, Tobago, Jamaica) and South American (Guyana) communities of Greater Toronto (though the majority of clients are from the first three communities).

Programs

ASAP provides the following services:

- Education and outreach to South Asian youth, men who have sex with men, new immigrants, and women.
- Support for people living with HIV/AIDS via advocacy, counselling, social and other practical supports, information and referrals, health education, translation services, accompaniment to medical appointments, and emergency financial assistance.
- A Resource Centre including culturally-sensitive resources in English and South Asian languages.
- Research via information gathering through networking with health care professionals, community agencies, ASOs, members, clients and supporters.
- Volunteer Development through recruitment, management and retention of volunteers to assist in program and service delivery.

Previous Research Initiatives

In 1999, Health Canada funded ASAP to investigate the legal, ethical and human rights aspects of discrimination against people infected and affected by HIV/AIDS in the South Asian communities of Greater Toronto. Entitled "Discrimination and HIV/AIDS in South Asian Communities. Legal, Ethical and Human Rights Challenges: An Ethnocultural Perspective", this study reports:

> "South Asian people living with HIV/AIDS experience "felt stigma" within a silent community that basically denies that HIV/AIDS is a South Asian problem or issue. They also experience everyday racism living in Canada. Thus, they must cope with two kinds of discrimination…. The larger implication of these findings is that South Asian communities that are already vulnerable to racism and marginalization within the broader Canadian context are also at risk for the spread of HIV/AIDS. The denial, ignorance, stigma and silence are all conditions for people to continue to engage in high-risk behaviour, and for community education strategies to be rendered ineffective. Overall, this could contribute to the proliferation of a disease that should be controllable."

COMMUNITY PROFILE

South Asians trace their origins to the countries of India, Pakistan, Sri Lanka, Bangladesh, Burma, Nepal, Bhutan or the Maldives, reflecting the cultural, religious, ethnic and class diversity of South Asian communities around the world. Of new immigrants to Toronto, India, Pakistan and Sri Lanka are among the top ten source countries for the years 1994 – 1996.

Approximately 330,000 people living in the Greater Toronto Area (GTA) self-identify as South Asian (Census Data, Statistics Canada, 1996). Statistics Canada (1996) projects in the year 2000, there will be over 470,000 South Asians living in Ontario, accounting for 8% of the province's population. The vast majority will live in the GTA.

Language

Many languages are spoken in South Asian communities and there also is great diversity in dialect within these languages. The most frequently observed South Asian mother-tongue in GTA is Tamil. According to participants, the following are the main languages spoken in each South Asian country (the most common language is in bold):

- Bangladesh: **Bengali;**
- India: **Hindi**, Punjabi, Gujerati, Tamil, Telegu, English;
- Indo-Caribbean: **English**, Hindi (used strictly for religious purposes), Spanish, French;
- Pakistan: **Urdu**, Punjabi, Pushto, Sindhi, Balochi;
- Sri Lanka: **Sinhalese**, Tamil, English.

Immigration

According to ASAP (1999), South Asian immigration to Canada has taken place in three distinct phases:

1900-1960:	Sikhs began arriving in British Columbia, facing an overtly racist immigration policy (for further information about these policies, please refer to "Continuous Journey. A Social History of South Asians in Canada", by Norman Buchignani);
Late 1960s-late 1970s:	skilled and semi-skilled workers began arriving from East Africa, Britain and the Caribbean, when immigration from non-European countries was liberalized;
1980s:	Tamil and other South Asian refugees began arriving in Canada to escape civil unrest in their homeland.

Today, a smaller number of South Asians arrive annually in Canada. Most come as part of the Family Class Sponsorship category. Until recently, people from the Punjab region of India were the largest group of South Asians in the GTA. However, Tamils now constitute a larger number (ASAP, 1999).

Most new immigrant MSM from India and Pakistan arrive as landed immigrants (based on the point system). In addition to fluency in Hindi and Urdu, these individuals tend to understand English. ASAP's MSM Outreach worker observes that a larger proportion of new immigrant MSM of Tamil descent originating from Sri Lanka arrive in Canada on refugee status. These individuals tend to be fluent in Tamil rather than in English (or perhaps they simply feel more comfortable speaking in Tamil). It is uncertain whether the majority of new immigrants from Bangladesh arrive as refugees or on landed immigrant status. ASAP's MSM Outreach worker has limited exposure to new immigrant MSM from Bangladesh and therefore is unaware of the language skills of this sub-group.

■ Religion ■

Religion is an important and inextricable part of South Asian life, and frequently is expressed through cultural norms, practices and values. South Asians practice a diversity of faiths. The following are the primary religions in each country (the most common faith is in bold):

- India: **Hinduism**, **Islam**, Jainism, Buddhism, Zoroastrianism, Christianity, Sikhism;
- Pakistan: **Islam**, Christianity, Hinduism;
- Bangladesh: **Islam**, Hinduism, Buddhism;
- Sri Lanka: **Buddhism**, Hinduism, Christianity, Islam;
- Indo-Caribbean: **Hinduism**, Islam, Christianity.

■ Community Infrastructure ■

There are significant concentrations of South Asian communities in the GTA. The vigorous cultural and religious organizations, which form a vital part of most South Asians' lives, provide important community services and supports. In the GTA, a number of ethno-specific health, settlement and social service agencies, operate under the umbrella of a 60-member Council of Agencies Serving South Asians (CASSA) umbrella. Several mainstream organizations with South Asian staff who speak various South Asian languages are also CASSA members. Access to services from many mainstream organizations depends on South Asians' ability to speak English and/or fit with admissions criteria and their ability to benefit from the program style/format. ASAP is the only established South Asian ASO in Canada.

■ Indo-Caribbean Populations ■

Indo-Caribbean communities are a less "collective" culture. As such, they tend to integrate and not to seek out the South Asian communities upon arrival in Canada. Also, they tend to be exposed to more western than traditional South Asian cultural values, such as the importance of extended family units and marriage within one's own community. Nevertheless, South Asian Indo-Caribbeans maintain many of their South Asian cultural values, practices and beliefs.

■ IDENTIFIED THEMES & ISSUES ■

Many of the issues for South Asian MSM that participants related to HIV/AIDS were linked to immigration status. As such, differentiation is often necessary between concerns of new immigrant South Asian MSM (up to 5 years residence in Canada, and also including refugees) and those of first-generation South Asian MSM. First-generation is understood as those born in Canada to South Asian immigrant parents, as well as those who immigrated to Canada at an early age. With exceptions, new immigrant MSM do not self-identify as gay or bisexual, whereas first-generation MSM likely do.

■ Language Skills ■

Language skills are an important issue for South Asian MSM (especially new immigrant Tamils). Most Indian, Pakistani and all Indo-Caribbean MSM immigrants understand English, allowing them access to a broad range of HIV educational materials. However, some Tamil MSM are less likely to have English as their first language, and therefore have less access to HIV prevention literature. A service provider observed that in bathhouses HIV information most frequently picked up is written in Tamil. Moreover, communication with some Tamil clients is hindered when outreach workers do not speak this language.

■ Religion ■

In many South Asian communities, religion may be a barrier to HIV prevention. This is perhaps most true for Muslim communities (though almost all other South Asian religions also condemn homosexuality) where homosexuality is expressly forbidden by most religious scholars. South Asian MSM are exposed to teachings prohibiting homosexuality from their religious leaders and imams (religious clerics). Indeed, according to participants, the view of many religiously-orthodox and politically-conservative South Asians is that HIV/AIDS is a punishment from God, for people with "loose morals" (including prostitutes, pedophiles and homosexuals).

For South Asian MSM, these attitudes can result in significant internal conflict regarding their same-sex desires. Consequently, they may not identify as gay or bisexual, and disregard HIV prevention messages targeted for gay men. Moreover, the hostility of many religious leaders makes open discussion about sexuality very difficult. Thus, many MSM are left without access to HIV-related information and services.

■ Family / Marriage / Gender Roles ■

In South Asian cultures, focus on the family unit and its values, rather than on the individual, significantly impacts the lives of MSM. Often, a double standard exists where South Asian families will tolerate domestic violence, but shun homosexuality, expecting South Asian MSM to hide their sexuality.

Culturally-prescribed gender roles view men as providers and the head of the family household, and women as home-makers and nurturers. South Asian MSM find it difficult to reveal their sexuality to their parents; men who come out and are effeminate are marginalized because they challenge these gender roles.

The importance of the extended family unit was described as having an impact on the lives of South Asian MSM (though less so for Indo-Caribbeans). Individuals are expected to rely on the extended family unit for support, which is viewed as more appropriate than other more "western" supports. In part, this explains why more formalized social services are not part of South Asian culture.

Another expectation is that men will marry. Same-sex relationships would bring shame to the family, thus new immigrant and first-generation MSM marry to maintain family honour. Most MSM that ASAP's MSM Outreach worker comes in contact with in bathhouses are married or are planning to do so. This was regarded as highly important by participants because of the potential threat to spouses' health, if South Asian MSM are practicing high-risk behaviours. Women risk social disapproval. Consequently, wives of South Asian MSM may tolerate their husbands' extra-marital relations, further heightening their risk.

Further, parents are seen as "investing" in their children's future, especially through education and marriage, which are both highly valued. In return, South Asian children are expected to attend to their parents in old age. Many first-generation South Asians have difficulty with this expectation, as it challenges their autonomy, especially their sexual autonomy.

Social acceptance, concern over how one is perceived by others and how this reflects upon one's family, is equally as important as family honour for South Asians. Family honour is inextricably linked to an individual's social status in the community. One participant gave the example of an MSM who, choosing to disclose his sexual identity to immediate family, is expected not to tell extended family members, in order to spare family members of public scrutiny and ridicule. As one participant explained: "What will people think?".

■ Fear of Recognition ■

Participants spoke of the fear many South Asian MSM have of being recognized by other community members (Indo-Caribbean and new immigrant MSM tend to be less afraid of being recognized by other South Asians). In bathhouses, ASAP's MSM Outreach worker noted that some first-generation MSM are particularly afraid of being recognized, given the small size of the gay South Asian community. For similar reasons, MSM who are worried about being recognized, or who have internalized racist and homophobic attitudes, may fear accessing South Asian services such as ASAP, preferring the anonymity of mainstream service organizations. MSM who have resided in Canada for many years are perhaps better known in their communities, thus are at greater risk of being recognized in gay-identified venues. Thus, participants believed at times it should be easier to reach new immigrant MSM for outreach initiatives rather than those who have been living in Canada for several years, since the latter have a stronger fear of being recognized.

■ Low Priority of Sexual Health ■

Participants perceived sexual health (including safer sex education) as a low priority for some new immigrant South Asian MSM, who may be occupied by more basic settlement needs such as finding employment, adequate housing and learning English.

■ HIV/AIDS Knowledge ■

Lack of HIV/AIDS information (particularly information specific to risk behaviours) is a major barrier to HIV prevention for South Asian MSM, especially those who are new immigrants. First-generation MSM, especially those who self-identify as gay or bisexual, are regarded as more knowledgeable about HIV/AIDS. As well, Indo-Caribbean MSM, who tend to integrate more easily into western society, are exposed to western cultural values in their countries of origin. They speak English as a first language and have greater access to HIV/AIDS information.

New immigrant South Asian MSM hold a number of misperceptions about HIV/AIDS, including the commonly-held belief that HIV/AIDS is a "white gay man's disease". One dangerous implication of this belief is that HIV risk is heightened for those who believe it is unnecessary to practice safer sex with non-Caucasian men. Moreover, non-gay-identified MSM may believe that safer sex is only to be practiced by gay men. Contradicting this is the belief that Caucasian men are more knowledgeable about HIV/AIDS, and are therefore assumed to be HIV-negative or "clean".

Another misperception is that a healthy person who is not visibly ill cannot be HIV-positive. Thus, infection risk is exclusively associated with those who look noticeably ill. New immigrant MSM often do not understand the difference between being HIV-positive and having full-blown AIDS.

Misperceptions surrounding HIV/AIDS leave many South Asian MSM at elevated risk for HIV infection. They can create paranoia and fear, hampering prevention efforts, as well as the ostracization of South Asians living with HIV.

■ Racism & Power Dynamics ■

Participants described the impact of racism on the lives of South Asian MSM. One explained that while some new immigrant South Asian MSM hold overtly racist attitudes, they are also victimized by racism. Ironically, they are not initially cognizant of their own victimization. First-generation South Asian MSM tend to be more aware of racism, of its societal manifestations, and how it effects individuals. This may result from direct personal experience of racial discrimination and harassment and/or self-reflection.

In South Asia, conflicts tend to revolve more around control of the commons (such as conflicts over territory), religion, ethnic background, class and/or gender. Racial conflict is uncommon and therefore people are generally unaware of racism. Participants noted some South Asian MSM may perpetuate racist attitudes and behaviours when they refuse to go to sex venues frequented by Asian men. Further, many South Asian MSM are vulnerable to racist attitudes and behaviours because they are unable to identify racism when it occurs.

> The prior Canadian government practice of collapsing all South Asians into one category for census purposes was viewed as problematic by participants. No distinctions were made between Indians, Pakistanis, Sri Lankans, etc., and, consequently, few demographic data related to specific South Asian communities in Canada are available. Participants acknowledged that the government is currently attempting to differentiate between various South Asian communities in census data.

■ Internalized Racism ■

Internalized racism was seen as an important factor related to HIV/AIDS among some new immigrant and first-generation South Asian MSM. Internalized racism may be manifest in the preference that some South Asian MSM have for Caucasian men for sexual and intimate relationships (this was regarded as more an issue for new immigrant rather than first-generation MSM). It was presented that an imbalance in power may exist in these relationships, most often to the disadvantage of South Asian MSM.

Participants traced internalized racism to a history of imperialism in South Asia and a conscious/unconscious re-creation of the power imbalance between South Asians and Caucasians. The appreciation of lighter skin colour in most South Asian cultures was seen as proof of this. Whiter skin is desirable and regarded as powerful, whereas darker skin is devalued. South Asians may collectively internalize these unequal power dynamics, and its underlying racism. The value of lighter skin colour is thought to be historically linked to colonization and to the division between lighter-skinned Aryans and darker-skinned Dravidians within the Indian sub-continent, and continually reinforced in contemporary South Asian culture through the present-day influx of western culture and media. Despite the fact that internalized

racism was viewed as less of a concern for Indo-Caribbean MSM, they also tend to value lighter skin colour. According to participants, Indo-Caribbean MSM value Caucasian men; "picking up", or being "picked up" by, Caucasian men enhances their self-esteem.

Participants also attributed this preference to the excitement and novelty of being with Caucasian men (this would apply to recent immigrant MSM, rather than first-generation MSM). Similar interest for Black or Asian partners is not evident, thus reinforcing a cultural preference for lighter skin. Exceptions to the rule exist; some South Asian MSM prefer relationships with other South Asian men or those from other racial groups.

Preference for Caucasian men could impact HIV prevention efforts among South Asian MSM who may take undue sexual risks if requested by their Caucasian partners. If they perceive Caucasian partners as better educated about HIV/AIDS, they may perceive them as more trustworthy, making them less likely to question the risk of sexual behaviours.

■ Sexual Freedom ■

North America presents an opportunity for greater sexual freedom for new immigrant South Asian MSM who come from societies where sexuality typically is not freely expressed, and where sex is not as readily available. This suppression of sexuality in South Asia varies with social class, economic position, religion, gender, etc.

Many South Asians will not discuss sexual practices with older people, authority or religious figures, or members of the opposite sex. Discussion is more likely to occur with same-sex peers. Sex is not openly discussed in the family context.

Some South Asians also view oral sex as degrading. One participant explained that many believe only "prostitutes perform oral sex". Fearing it may be disrespectful to ask their wives to perform oral sex, some turn to other men. Many South Asians do not like condoms; they prefer their sex to be "natural". Many South Asian women believe it is not their right to ask male partners to use condoms. In addition, if women believe they are in monogamous relationships, they will not perceive themselves to be at risk for HIV infection. These factors heighten risk for HIV among South Asian women.

Sexual abstinence until marriage is a strong norm in countries of origin; even dating is often culturally prohibited. These values may encourage same-sex sexual activity. In Pakistan and India, many heterosexual men have sex with men until marriage since dating women is not allowed. However, this is not viewed as a gay/bisexual activity or lifestyle because there is no concept of sexual identity. For many, it merely is regarded as a recreational activity.

Upon arrival in Canada, South Asian MSM tend to seek out more sex than they would in their countries of origin. Bathhouses are new and exciting venues. When approached by ASAP's MSM Outreach worker, many new immigrant MSM are more concerned about where to find sex than they are about safer sex practices. As participants summarized, there seems to be a "kids-in-a-candy-store" attitude regarding sex for some new immigrant MSM. This is also further evidence of the low priority of sexual health for these men.

In contrast, some first-generation South Asian MSM, who tend to be more comfortable with their sexuality and with open discussion about sexual behaviour, are more likely to look for intimate relationships with men as opposed to looking solely for sex.

■ Issues concerning Identity ■

An individual's sense of self (sexual identity and one's perceived sexual role as active or passive) is an important factor affecting HIV risk among South Asian MSM.

The concept of a community of MSM does not exist among South Asians; MSM are viewed as merely engaging in recreational activity. The concept of sexual identity equally does not exist: homosexuality, bisexuality and heterosexuality are perceived as western concepts, to which some South Asians (usually those born or raised in the West) adhere. According to one participant, the concept of sexual identity exists for Indo-Caribbean communities, since they have greater exposure to Western norms.

Further, overt sexual images, pornography, or sex for individual pleasure are not well regarded. Sex is restricted to married men and women, and regarded solely as a necessity for the purpose of procreation. Other forms of sex are forced underground. According to one participant, in Indo-Caribbean communities in the countries of origin, many MSM meet in "rum shops" (bars) to meet other men.

The social invisibility of alternative sexualities perpetuates heterosexual dominance. With only this norm to adhere to, the development of a personal sexual identity is impossible. According to participants, defining oneself in relation to one's sexuality or gender may result in one being shunned, such as the Hijras (a community of transgenders in India and Pakistan), prostitutes and gays.

The lack of open discussion about sex and sexuality in South Asian cultures may deter HIV testing. Because South Asian MSM do not identify as gay or bisexual (or with any other form of sexual identity) and since AIDS is still perceived to be a gay disease, HIV testing is uncommon. Those who self-identify as gay or bisexual, however, tend to realize the importance of testing.

Among both new immigrant and first-generation South Asian MSM, the passive sexual role is degrading, akin to being "womanly", whereas the active sexual role is considered "manly", reflecting the view of men's superiority over women. This view of the active role is not affected by the sex of one's partner since the sexual act is merely understood as an act. In fact, some MSM who do not identify as gay or bisexual often engage in talk about being the active sexual partner with other men as if it were an accepted experience. However, being the passive partner is not acceptable and rarely discussed openly. Finally, some MSM who frequent bathhouses say they do not actively seek out sex, but wait to be approached. This is acceptable as long as these men are in the active sexual role.

■ Self-esteem ■

Participants agreed that for some new immigrant South Asian MSM, low self-esteem may have an important impact on safer sex behaviours. New immigrant MSM must cope with their limited understanding of English, often lowered socio-economic status, difficulty finding employment, limited support networks, conflict between religious beliefs and sexuality, and cultural expectations and family norms related to marriage. According to ASAP's MSM Outreach worker, these pressures negatively affect the self-esteem of MSM, which subsequently can lead to high-risk sexual practices.

First-generation MSM may also suffer from low self-esteem associated with the pressures of trying to fit into mainstream North American gay culture. In so doing, some may feel alienated and dis-empowered, leading to difficulties negotiating safer sex.

Use of ASAP Services

Participants were concerned with the limited use of ASAP's services by South Asian MSM, and questioned how access could be enhanced. Many MSM use ASAP services simply because they are able to communicate in their own South Asian languages, while others perceive it as an opportunity to socialize with other men. As one participant explained: "some MSM view ASAP as a dating service", evidence of the lack of more suitable and accessible socializing venues. Some more western-identified South Asian MSM, might also feel more comfortable approaching mainstream agencies for services.

Mainstream South Asian communities tend to view ASAP as geared towards South Asian MSM, making it difficult to serve the general South Asian populations.

Use of services is affected by limited funding ASAP receives to offer services towards South Asian populations. ASAP is only able to offer limited services, as opposed to other agencies who receive greater support from funders. Financial support from the South Asian communities is limited since AIDS is simply not a priority in these communities.

RECOMMENDATIONS

Developing Strategic Education & Prevention Initiatives

1. Program Priorities

- Continue to do culturally-appropriate education at the secondary and post-secondary level to young South Asian MSM to increase awareness about HIV/AIDS issues, with the added objective of addressing homophobia, racism and classism.
- Gear HIV educational materials for South Asian MSM in bathhouses:
    - Language used for HIV educational materials should be community-specific.
    - Employ visually-appealing educational materials in bathhouses.
- Support outreach in bathhouses and other places to reach South Asian MSM:
    - Utilize outreach workers fluent in various South Asian languages.
    - Extend ASAP's outreach mandate into the Halton and Peel regions.
    - Recruit more outreach workers to cover the Halton and Peel regions and to implement diverse forms of outreach.
- Make existing HIV educational materials available in South Asian languages, especially in Tamil.
- Develop new HIV educational materials in South Asian languages, especially in Tamil, as well as in English.
- Initiate an anonymous and confidential hotline to educate community members.
- Conduct HIV education at religious classes in local community centers or via phone lines (interviews) to reach women as a target group.

2. Core Prevention Principles

- Recognize the diversity within South Asian MSM populations.
- Address "self-esteem" issues in relation to homophobia, racism and classism.
- Translate HIV educational materials to appropriate literacy levels.
- Emphasize the need to protect oneself and one's partner (both male and female) in HIV prevention messages.

3. Community Development

South Asian Community Development workers are needed to:

- Increase awareness of the existence of South Asian MSM, especially among South Asian women;
- Continue outreach and education through South Asian media to increase awareness of HIV/AIDS and to encourage support for South Asian PHAs.
- Collaborate with faith leaders, political leaders, cultural leaders and role models (in sports, academia, government, entertainment, etc.) to increase awareness of HIV/AIDS in the community and to encourage support for South Asian PHAs.
- Develop an anonymous HIV/AIDS information telephone hotline to provide services in various South Asian languages.

4. Increase Capacity in Outreach and Education

- Target gay bars, bathhouses, the internet, South Asian social support groups such as Khush, Al-Fatiha (queer Muslim group), and ethno-specific and mainstream ASOs (ASAP, ACT, etc.) to reach South Asian MSM who identify as gay or bisexual.
- Target South Asian women when doing outreach to South Asian MSM. This way, wives/girlfriends of South Asian MSM will be targeted as a group.
- Build outreach capacity by recruiting workers and volunteers.
- Raise awareness among policy makers (including boards of education, ASAP funders, Health Canada, Ontario Ministry of Health and local health departments) of the needs and issues faced by South Asian populations.

5. Program Needs

- Build capacity towards community-based health research by working in partnership with other ASOs and other HIV-related research units/universities:
    - Establish an Education Committee at ASAP, comprised of South Asian individuals experienced community-based health education.
    - Establish a Research Committee at ASAP, comprised of South Asian individuals experienced in community-based health research.
    - Train ASAP staff members about health research methods.

■ SUGGESTED RESEARCH QUESTIONS ■

■ Culture ■

Sexuality

- How do South Asian communities understand sexuality?

■ HIV/AIDS Knowledge & Attitudes ■

INDIVIDUAL
Knowledge & Attitudes
- What is the level of HIV/AIDS knowledge amongst South Asian MSM?
- What are common misperceptions held by South Asian MSM regarding HIV/AIDS?

Access to Information
- Where do South Asian MSM access HIV/AIDS information?

■ Behaviour ■

Sexual Behaviours
- What are the patterns of HIV risk-taking behaviours among South Asian MSM who:
    a) self-identify as gay?
    b) self-identify as bisexual?
    c) do not label themselves?

■ Identity ■

Concept of Sexual Identity
- How do South Asian MSM identify themselves sexually?
- How does South Asian understanding of sexuality impact on gay and bisexual South Asian men's sexual identity formation?

■ Interpersonal Factors ■

Self-esteem
- What factors impact self-esteem for first-generation South Asian MSM?
- How does self-esteem affect HIV risk-taking behaviours for new immigrant South Asian MSM?
- How does self-esteem affect HIV risk-taking behaviours for first-generation South Asian MSM?

■ Immigration ■

Status
- How does the process of immigration affect self-esteem for new immigrant South Asian MSM?

■ Marginalization / Inequity ■

Oppression
- How do South Asian MSM understand and experience oppression?
- How do South Asian cultural values (e.g. religion, family, gender roles, etc.) impact these understandings and experiences of oppression?
- How does South Asian MSM understanding and experience of oppression affect HIV risk-taking behaviour?

■ Support Systems ■

Service Accessibility

- In what circumstances do South Asian MSM turn to health and social services for support?
- What barriers do South Asian MSM encounter in mainstream and ethno-specific ASOs?
- What would reduce barriers for South Asian MSM in mainstream and ethno-specific ASOs?

Family

- In what circumstances do South Asian MSM turn to their families for support?

Faith / Religion

- In what circumstances do South Asian MSM turn to faith groups for support?

■ HIV Prevention Strategies ■

- What are the most effective HIV prevention strategies for targeting South Asian MSM (e.g. those which enhance self-esteem, etc.)?

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■ SPANISH-SPEAKING COMMUNITIES ■

■ SUMMARY ■

In addition to the anti-homosexual influences of the Church and family, MSM from Spanish-speaking countries continue to experience machismo, repression, persecution, homophobia, discrimination and rejection. As a result, these men can lead "double lives" where their public selves are heterosexually-identified, yet their private selves may be homosexually-active. In this context, protection from HIV and other STDs may not be a priority due to health information and education which does not target this duality.

In many cases, MSM who solicit refugee status or who immigrate via other means, do so because of the repression and persecution they suffer as a result of their sexual activity and orientations. Some of these men immigrate on their own, leaving the confines and traditions of the family or experience a new and liberated sexual identity in a new culture and society. This can lead to problems of adaptation and assimilation.

Other Spanish-speaking MSM immigrate with their families, and continue to live with them once they arrive in Canada. These men often remain in the closet and continue to live the same "double lives" they did in their countries of origin. Thus the original contexts which facilitated inadequate protection from HIV is replicated in Canada.

Regardless of the relationship these men have to their family, most will experience culture shock when they begin to adapt to Canadian culture. Many experience significant changes with regard to Canada' s comparatively liberal attitudes towards sexuality, sexual identity and sexual freedom.

Some Spanish-speaking MSM will use alcohol and drugs as a means of integrating themselves in the new culture. Others will experience fear, discrimination, racism, shame and alienation. Even though they will live in a free and open society, many will be unable to negotiate safe sexual activity. This is because historically, Spanish-speaking communities have immigrated to Canada with many of their traditional cultural taboos intact. These taboos often discriminate against MSM. The result is that Spanish-speaking MSM tend to separate or move away from their communities of origin.

MSM from Spanish-speaking countries have varying levels of education and experience. Not all have the same fluency in English as a second language and not all have the same understanding of Canadian society. As a result, many are unable to secure the same type and level of professional employment that they had in their countries of origin.

In Spanish-speaking communities, HIV is often synonymous with MSM. The myths, fears, lack of education and the non-acceptance of AIDS as a community-wide problem influence the rejection of MSM who are HIV-positive. Cultural taboos evolving from the association of HIV with MSM do much to reinforce the inability of men who are HIV-positive to disclose their serostatus to their families or communities.

The ignorance and the inability to accept that all MSM are at risk for HIV also influences discrimination. As a result of the lack of support to openly and honestly discuss HIV, Spanish-speaking MSM who are HIV-positive may not disclose their serostatus to their sexual partners.

The key informants interviewed for this study indicated that while they may have a technical understanding of how to prevent HIV/STD transmission and infection, Spanish-speaking MSM continue to have unprotected anal sex. These men do not frequently test for HIV or other STDs and MSM who are HIV-positive do not believe they can become re-infected.

Not all Spanish-speaking MSM who are HIV-positive have access to dental care, only those who have dental insurance or those on social assistance. This can cause health problems.

Spanish-speaking MSM who are HIV-positive who are also illegal immigrants do not have access to HIV medications in Canada and this can cause them to be careless or to be unable to continue with the medication they may have had previously.

PROJECT PROCESS

Initiation of Project Partnership

In the Fall of 1999, project staff from the HIV Studies Unit worked collaboratively with Jose Cedano and Consuelo Llanos, from the AIDS Program of the Center for Spanish-Speaking Peoples (CSSP), to develop a partnership initiative for identifying research issues and questions related to MSM and HIV in the Spanish-speaking communities in Toronto. A Terms of Reference document (Appendix A) was developed, outlining roles, responsibilities and expectations based on the skill sets each organization had to offer. CSSP formed an ad-hoc Working Group, consisting of the following members:

Jose Cedano (MSM Outreach Worker - CSSP)
Consuelo Llanos (HIV/AIDS Program Coordinator - CSSP)

The role of the Working Group was to develop and implement a work plan to meet the goals of the project.

Method

The Working Group decided to conduct key informant interviews with Spanish-speaking MSM. A questionnaire guide was developed in Spanish by Working Group members and presented to their HIV/AIDS Program Advisory Committee. This questionnaire was developed for use with community members with varying socio-economic status and from different cultural backgrounds.

Ten interviews were carried out in Spanish by Jose Cedano over the telephone or in person, at people's homes or in coffee shops. Each interview was approximately two hours in duration. Information from the interviews was compiled by Jose Cedano, based on his own personal notes. Participants were from all parts of the city of Toronto, were between the ages of 25 and 54, and had varied educational levels. Half were from South America and the others from Mexico and Central America. Most were Canadian citizens, and many were living below the poverty line. Participants were recruited as key informants because of their involvement in HIV education, their experiences as CSSP clients and their community involvement as drag queens.

AGENCY PROFILE

Mission Statement

Founded in 1973, the Centre for Spanish-Speaking Peoples (CSSP), responds to the needs of new immigrants from 22 countries and other members of a greatly diverse Spanish-speaking community.

CSSP meets their community's needs by making their own, and the services of other agencies and governments, accessible through the elimination of physical and linguistic barriers as well as barriers of gender, race, age and sexual orientation.

In providing inclusive and accountable services, the Centre promotes the overall development of the community and its members with a view to achieving equality and social justice through the full participation and representation of its community.

Programs

For more than 26 years, the main goal of CSSP has been to strengthen the diverse Spanish-speaking communities in Toronto. CSSP works extremely hard to be able and ready to respond to the changing needs of their many different clients, whether they are women who have suffered domestic abuse, new immigrants, low-income families, youth, seniors or members of the gay and lesbian community.

The programs and services of CSSP facilitate community development, and integration and participation for Hispanic Canadians and newcomers. The work is carried out in an atmosphere of respect and appreciation for cultural and racial differences, a commitment to gender equity and opposition to homophobia.

Current programs and services include the following:

1. Settlement Program
The Settlement Program makes the settlement experience a positive one for Spanish-speaking newcomers. It assists with a wide range of services such as translation, interpretation, supportive counselling, preparation of documents, and escorting and accompaniment to appointments. The program also provides referrals and advocacy in areas of employment, housing, immigration, citizenship, child tax benefits, day care, pensions, social assistance, health, and education and training.

2. HIV/AIDS Program
This program focuses on prevention initiatives and support for people with HIV/AIDS. Its principal work is to promote healthy sexual behavior through the provision of information, counselling and support groups.

3. Language and Training Program
Through English as Second Language (ESL) classes, this program offers a support network and enables the Hispanic community -- especially newcomers and older adults -- to acquire basic language skills that will accelerate their settlement and facilitate their contribution to Canadian society.

4. Women's Program
The Women's Program carries out activities designed to provoke changes in the Hispanic community and to give support to women who live with abuse. Among these have been workshops on legal rights, health and self-esteem.

5. Legal Clinic
The Clinic program offers legal help for the welfare and protection of members of the Hispanic community and low-income people throughout Ontario.

■ F u n d i n g ■

CSSP is funded by various institutions from the municipal, provincial and federal governments, such as: Human Resource Development Canada, Employment and Immigration Canada, Health Canada, Canadian Heritage, Legal Aid Ontario, Ontario Ministry of Community and Social Services, Ontario Ministry of Health, Ontario Ministry of Citizenship, **U**nited Way of Greater Toronto, City of Toronto, Trillium Foundation, Rainbow Foundation and by individual donors and supporters.

■ C O M M U N I T Y P R O F I L E ■

Toronto's Spanish-speaking communities are comprised of individuals from over twenty different countries including Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, Spain, Uruguay and Venezuela.

Immigration from Spanish-speaking countries to Canada has significantly increased since the early 1960s, especially from Mexico, Argentina, Chile, Uruguay, Columbia and Peru. Immigration for many Spanish-speaking people is often a reaction to political and economic instability in their countries of origin. Many Spanish-speaking people possess professional training but have had their licenses annulled due to professional regulating organizations. Thus, although education levels tend to be high in Spanish-speaking communities, income levels rarely correlate with this reality.

Although Spanish-speaking people reside throughout the newly amalgamated Toronto, there are higher concentrations in the inner core and North York.

According to Statistics Canada (1996), there are 213,000 Spanish-speaking people in Canada; 101,000 living in Ontario, and 73,000 residing in Toronto. According to the Hispanic Development Council report "Feasibility Study: Credit Union for the Spanish-speaking Community in Metropolitan Toronto" (1995), it is projected there will be 173,000 Spanish-speaking people in the newly amalgamated Toronto in 2001. Estimating that between 4 and 6% of men over the age of 15 are MSM (Remis, 2000, personal communication), up to 4,300 Spanish-speaking MSM will reside in Toronto in 2001.

■ IDENTIFIED THEMES & ISSUES ■

Spanish-speaking MSM experience rejection, shame, discrimination and alienation within their own ethno-cultural communities and from the mainstream community in general. In addition, they experience racism from the mainstream gay community. The desire for respect from the Hispanic community, and the importance of family, church and friends, have a significant impact on their well-being. Furthermore, family values and cultural norms are important factors influencing whether Spanish-speaking MSM disclose their sexual orientation.

Spanish-speaking MSM report barriers to services and lack adequate and culturally-specific information on HIV and other sexually transmitted diseases. Moreover, they report difficulties associated with immigration to a new country and challenges adapting to a new country with different norms and values (Ilda, you will have to ask for clarification about what some of these difficulties and challenges are – it would be nice to give some examples). Moreover, experiences of discrimination within the Spanish-speaking community are common when these men disclose their sexual orientation or HIV status. These factors have a cumulative effect on the ability of Spanish-speaking MSM to access information and services, and their safer sex behaviours.

■ Sexual Identity ■

Interviewees identified as gay (55%), homosexual (30%) or bisexual (15%). None identified as a "straight" man who has sex with other men. Of the 10 participants, half (50%) said their families in their country of origin knew of their sexual orientation.

Coming Out

In the Spanish-speaking communities, family, church and the acceptance of community are important determinants of whether MSM will disclose their sexual orientation. Half the interviewees (50%) received support from their families when they disclosed their sexual orientation, while the others remained in the closet or were not impacted by their family's attitudes. When disclosing their sexual orientation within their community, 70% experienced discrimination, 20% received support and 10% claimed their community attitudes had no impact on their lives. Half of the men had been rejected by the church because of their sexual orientation, while the other half were unaffected by the church's position on homosexuality.

In Spanish-speaking countries, machismo is persistent. Marsiglia (1998: p.118) defines machismo as:

> "… a socially constructed, learned, and reinforced set of behaviors… linked with sexual potency, physical courage… [and] the belief that men are innately superior to women. Machismo suggests a protective attitude toward women, which also encourages promiscuity. The macho is the ideal personality for which men strive."

Moreover, Spanish-speaking MSM face repression, persecution, homophobia, discrimination, and rejection. They must also contend with family expectations, community attitudes towards homosexuality, and the church's position on homosexuality. For example, the majority of men who are not married are expected to live with their family, living double lives, and having little access to HIV information. Some gain independence when they immigrate and are able to accept themselves and live more open lives.

Community, Family & Peer Responses to HIV/AIDS

For HIV+ Spanish-speaking MSM, community, family and peer responses to HIV affects their ability and desire to disclose their HIV status. Myths and fears about HIV are commonplace among community members. This can lead to marginalization of those who are HIV+. Almost all (80%) of those interviewed had been rejected by other community members.

The stigma associated with infection results in serious isolation for HIV+ MSM. Cultural taboos and the association of HIV with homosexuality forces many to hide their sexual orientation from their families in their countries of origin. Most (60%) had not disclosed their HIV status to their families because they found open discussions difficult as a result of cultural taboos (40% however, found their families supportive in relation to heir HIV status). Most (70%) felt comfortable disclosing their HIV status to friends and had found them supportive; however (30%) had not told their friends they were HIV+. When disclosing their HIV status to romantic and sexual partners, 30% had been rejected. Ten percent of interviewees had not disclosed their HIV status with their current partner and 20% claimed they would notify their partner of their HIV status in the near future.

Knowledge of HIV/AIDS

Sixty percent of the men interviewed feel they have a great deal of information, while 40% feel they have sufficient information about HIV. Moreover, 30% said they knew a lot about other STDs, while the other 70% felt their information levels were sufficient. Participants were also asked whether they were aware of the CSSP outreach and prevention initiatives offered at saunas, parks and bars. Of those who visit these venues, half said they were aware of these services and had accessed information. Twenty percent claimed they had no knowledge of park outreach. All had read Spanish-language HIV prevention materials, and while 40% had found them adequate, 60% believed the availability of these materials should be increased and their content modified.

Participants spoke of the importance of making resources and supports that exist in both the mainstream and Spanish-speaking communities known to recent immigrant MSM. One suggested an information package listing services for MSM and sources of HIV/AIDS information be distributed at the airport information centre and in train and bus stations.

Access to Medical Services

Most participants (80%) have access to medical services but 20% say these services are limited. All interviewees have access to medications through insurance plans or the province's Trillium drug plan; 40% access them through social assistance and half (50%) rely on their own financial resources to purchase them. All interviewees expressed concern for those HIV+ Spanish-speaking people who are in Canada illegally, and who can not get the medication and services they urgently need. Participants identified several other services required by the Spanish-speaking communities including legal aid, newcomer/settlement orientations, and counselling for newcomers to Canada.

Impact of Immigration

Participants were asked how immigrating to Canada has affected their sexual life. Sixty percent responded that immigration had no impact on their sexual life, but 80% noted the freedom they

now have from their families. Forty percent said they felt segregated or marginalized from society because of language barriers, sexual freedom and exposure to new values.

■ Sexual Behaviours ■

Forty percent of participants indicated they had had anal sex without a condom in the past, 40% say they have had unprotected sex some of the time and 40% say they have never had unprotected sex. Ten percent say they do not know if they have had unsafe sex in the past. Many (70%) of participants shared a common fear of HIV infection (or re-infection) and other STIs. Reasons varied and included misinformation about HIV and STIs, inadequate resources and services for both recent and illegal immigrants, and cultural taboos that hinder access to services. Participants attributed HIV infection to alcohol and drugs (30%), inadequate or culturally-inappropriate HIV information (20%), losing control sexually (20%), unsafe sexual practices (20%). Ten percent believes themselves to be at minimal risk for re-infection because of the HIV anti-viral medications they take. Finally, 20% of participants believed themselves to be at no risk for HIV infection if they were in a monogamous relationship.

■ Marginalization / Inequity ■

Participants spoke of the impact of fear, shame and alienation, discrimination, and racism in their lives. Eighty percent said they fear disclosure of their sexual orientation or HIV status to members of their community. Seventy percent of interviewees feel discriminated against by their community, 60% have experienced racism, and 30% have experienced shame and alienation once their sexual orientation was discovered. In mainstream society, all (100%) have experienced discrimination; 40% report experiencing racism in the mainstream gay community.

■ RECOMMENDATIONS ■

The Working Group suggests the following program needs:

1. Provide targetted workshops addressing:
    - Ethnicity, cultural diversity, self-esteem, values;
    - Oppression, discrimination, racism, breaking cultural taboos;
    - Sex education, sexual abuse, homophobia;
    - Re-education on HIV prevention for Spanish-speaking MSM, their families & friends;
    - HIV re-infection prevention;
    - Education about HIV/AIDS for all persons living with HIV/AIDS, their families & friends;
    - Alcohol and drug prevention.

2. Provide cultural activities that value customs, races and origins, and in which persons living with HIV/AIDS can participate.

3. Provide public HIV prevention in Spanish on television, radio and other media

4. Modify and enhance HIV educational materials so that they are culturally-and linguistically appropriate and sensitive to community members with different levels of education.

5. Increase HIV prevention outreach to more parks, public washrooms and adult video stores.

6. Provide more outreach to non-homosexually identified Spanish-speaking MSM.

7. Provide more support groups in Spanish for:
    - Spanish-speaking persons living with HIV/AIDS;
    - Spanish-speaking families and friends of persons living with HIV/AIDS.

8. Ensure increased access for persons living with HIV/AIDS to:
- Natural treatments;
- Dental services;
- Community fund for those who do not have access to Disability, Trillium, or special insurance

9. Advocate for greater access to HIV treatments for persons living with HIV/AIDS who are unofficial residents of Canada.

10. The modifications to services should be done in consideration of the information provided by respondents.

■ SUGGESTED RESEARCH QUESTIONS ■

■ Immigration ■

1. How does immigration affect Spanish-speaking MSM?
2. Does immigration impact self-esteem among Spanish-speaking MSM? If so, how?
3. How might exposure to North American values related to sexuality affect the sexual behaviour of immigrant Spanish-speaking MSM?

■ Marginalization / Inequity ■

Experiences in Mainstream Gay Communities

4. What do Spanish-speaking MSM who speak minimal English experience in the mainstream gay community?

Experiences in Casual & Intimate Relationships

5. How do Spanish-speaking MSM define power in intimate relationships? How does this differ in relationships where partners are casual versus intimate/more long-term?
6. How does this differ in relationships where the partner is from a different culture?
7. What factors affect the ability of Spanish-speaking MSM to negotiate safer sex?
8. How do cultural and linguistic differences affect their intra-cultural, inter-racial, intimate and casual relationships?

■ HIV/AIDS Knowledge & Attitudes ■

INDIVIDUAL

Knowledge & Attitudes

9. What is the level of HIV/AIDS knowledge among Spanish-speaking MSM?
10. Where do Spanish-speaking MSM get information about HIV/AIDS?
11. What sexual behaviours do Spanish-speaking MSM perceive as risky in relation to HIV?

■ Behaviour ■

Sexual Behaviours

12. How does HIV/AIDS knowledge affect sexual behaviour among Spanish-speaking MSM?

HIV Testing Patterns

13. What are the HIV testing patterns for Spanish-speaking MSM?
14. What encourages HIV testing among Spanish-speaking MSM?
15. What hinders HIV testing among Spanish-speaking MSM?

Alcohol & Drugs

16. How does alcohol affect sexual behaviour among Spanish-speaking MSM?

■ Cultural Values ■

Gender Roles

17. How is machismo understood and experienced by Spanish-speaking MSM?
18. How does machismo affect sexual behaviour among Spanish-speaking MSM?

■ Identity ■

Coming Out / Disclosure

19. How is coming out perceived, understood and experienced by Spanish-speaking MSM?
20. How are these related to sexual behaviour among Spanish-speaking MSM?

■ Support Systems ■

Service Accessibility

21. What health care and social service barriers are experienced by new immigrant Spanish-speaking MSM?
22. What barriers do Spanish-speaking MSM encounter accessing HIV/AIDS services?
23. What factors (example ESL training) would improve access to HIV/AIDS, other health and social services for Spanish-speaking MSM?

■ HIV/AIDS Prevention Strategies ■

24. Which HIV/AIDS prevention strategies are most effective in reaching :
    a) gay or bisexual identified Spanish-speaking men.
    b) non-gay identified Spanish-speaking MSM
    c) married Spanish-speaking MSM

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APPENDIX A

TERMS OF REFERENCE

(Agency) and

HIV Social, Behavioural and Epidemiological Studies Unit

This project has two goals: (1) identify research issues, questions and methods specific to ethno-cultural MSM communities, and (2) to incorporate culturally sensitive questions on MSM and HIV infection into the Ontario Men's Survey.

The following are the terms of reference for a collaborative working relationship between **(Agency)** and the MSM in Ethno-Cultural Communities Project, HIV Social, Behavioural and Epidemiological Studies Unit, University of Toronto (herein referred to as the HIV Studies Unit).

Such collaboration between the above parties is as follows:

HIV STUDIES UNIT:

- to provide staff support to **(Agency)** to establish a Working Group (may include contacting key community informants, organizing key informant interviews, brainstorming sessions and/or focus groups as determined by Working Group)
- to provide $1,000 for activities related to issue identification
- to provide $1,500 towards compensation of key agency contact (as per pending approval by funding agent)
- to provide research support in the identification of community-specific issues and themes where required
- to help formulate research questions from the issues and themes identified by the Working Group
- to lead in discussion of appropriate research methodology with Working Group
- to initiate the development of a literature review relevant to ethno-specific MSM
- to draft a report to the Ministry of Health, AIDS Bureau
- to consult with Working Group in the writing of report to Ministry of Health, AIDS Bureau
- if time permits and collaboration with the HIV Studies Unit is requested, to begin the development of future research proposals

(Agency):

- to establish a Working Group representative of the communities to collaborate with the HIV Studies Unit in this project

- to administer financial support and honorarium offered by the HIV Studies Unit for project activities such as focus groups, interviews, brainstorming sessions and refreshments
- to identify key issues and themes regarding MSM and HIV infection
- to comment on culturally-sensitive issues related to research methodology
- to collaborate with the HIV Studies Unit to formulate research questions from the identified issues and themes
- to provide direction to the HIV Studies Unit on the development of questions related to ethnicity for inclusion in the Ontario Men's Survey
- to provide the HIV Studies Unit with direction regarding the Ontario Men's Survey translation into appropriate targeted languages
- to participate in writing (if so desired), to review and approve the communities' chapter in the final report before submission to Ministry of Health, AIDS Bureau
- if so desired by **(Agency)**, to collaborate with HIV Studies Unit in writing future ethno-specific research proposals on HIV infection and MSM in their communities