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INTRODUCTION

This submission broaches the discussion on the social policies and programs relating to the needs of gays, lesbians and transgendered people, also known as LGBTQ, in Canada. However, since this group is not a homogenous group, I will attempt to focus on a subgroup of the LGBTQ community: African homosexual immigrant men in Toronto, Ontario. My intention to research the lived experiences of members of this social group in relation to tailored government policies and programs is informed by the fact that I am also an African homosexual immigrant male. In this paper, African or Black homosexual men refers to Sub-Saharan African-born or Caribbean-born immigrant men who have sex with other men (MSM) in Canada. The study of Black MSM is important because this cohort seems to have the principal need of preventing high rates of HIV/AIDS.

However, the exploration of this group is limited in two main areas: African Canadians, 2.5% of the total Canadian population (PHAC, 2009, p5), in general are a new influx of immigrants, most of them arrived between 1982 to 1991 (PHAC, 2009, p9), and as a result there is a dearth of research and literature on their lived experience in their new adopted country, Canada; in these burgeoning ethno-racial communities, homosexuality is regarded as a social taboo. Hence, African Canadian men who have sex with men do not always self identify as homosexuals. Crichlow, researcher at the University Of Toronto, has noted that: “Black men in Canada demonstrate that self-expressed sexual identity and orientation do not necessarily match sexual behavior in a straightforward way. For example, some of his informants during his research refused to claim a specific identity or orientation, or appeared to be both “gay” and “straight” (Husbands, 2010, p11). Therefore, not only is this social group incipient in the country, but it is also difficult to identify them as a distinct group. In addition, since the vast majority, 62%, of African Canadians live in urban Ontario, the chose of Toronto captures a broader population sample (Statistic Canada, 2006 and PHAC, 2009, p6).

Nevertheless, by the end of this research, I hope to have explained in-depth the demography and social location of this social group; the legal jurisdiction and organization responsible for service delivery to African-Canadian homosexuals; crucial government initiatives that address the needs of this group; and evaluate the efficacy of social services available to them. Above all, while research conducted by a member of this fledging sexual minority group builds on existing knowledge, it also, helps highlight some of the multilayered issues faced by this marginalized group.

DEMOGRAPHIC PORTRAIT OF SOCIAL GROUP

Statistics Canada reported in 2006 that 0.6% of Canadians self-reported as a sexual minority (Census Canada, 2006). This data was largely castigated as not being detailed because same-sex people of color were homogeneously labelled as nonwhite - ignoring the heterogeneity of ethnic homosexuals in multicultural Canada. In 2009, a pioneering research conducted by the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) entitled *MaBwana*: *Health, Community and Vulnerability HIV among African, Caribbean and Black Gay and Bisexual Men in Toronto,* had the objective to document the lived experiences of this cohort. This study exclusively explored the social needs and lived experiences of African men self-identifing as homosexuals in the greater Toronto area. Since it looks like there is no reliable data from Statistics Canada, in order to present a comprehensive portrait of the socio-economic location of African Canadian Homosexual men, I deferred to the community-based research by ACCHO entitled *MaBwana*.

SOCIOECONOMIC DATA ON BLACK MSM

In the *MaBwana* report, 157 Black men who ascribe to an avowed homosexual identity participated. Though the number of the participants in this ground breaking inquiry appears to be small, compared to 178,200 Black people in Toronto and 8.4% of the city's total population (PHAC,10 and Husband, 4), it is reasonable to say that the personal information divulged in this study can offer a glimpse into the realities of this stigmatized sexual minority subgroup. The median average age of the participants of this report was 31, 18 was the minimum age and 61 was the maximum age (ibid). In terms of education, less than (45.3%) of the participants had a University degree and 16.1% do not have a High School diploma (ibid). According to this survey, 40% of Black homosexual men claimed that they earned less than $20,000 and only 14.4% made more than $60,000 or more a year. Most of *MaBwana* respondents (58.6%) owned, rented an apartment or a house (ibid). However, 11% did not have an address (ibid). Also, this investigation noted that the vast majority of African Homosexual men described themselves as single with only 11% married or in common-law arrangements (ibid). Given the lack of applicable data on this fledging social group, the *MaBwana* survey, to some extent, informs our thinking about the socioeconomic demographic profile of Black homosexual men in the greater Toronto area.

PRINCIPAL CONCERN AND NEED

Moreover, the health status of this nascent demographic group is a cause for reflection especially in the field of Social Work and Health Care. For example, *Public Health Agency of Canada,* the National Health Agency*,* reported in 2009 that: "the infection rate among individuals from HIV-endemic countries, Sub-Saharan African and Caribbean, was estimated to be at least 12.6 times higher than among other Canadians in 2005" (PHAC,2009, p17). Moreover, the *MaBwana* study noted that African and Caribbean immigrants in Ontario are disproportionally represented by HIV (p3). In 2006, Ontario's African and Caribbean population represented 4% of the province's total population; yet they accounted for 16% of newly infected HIV diagnosis (Remis et al., 2008). Black men who have sex with men (MSM) in Ontario represented 8% of the reported AIDS infections, second only to white men (70%), among the

eight major ethnoracial groups in 2000-2004 (Remis and Lui, 2007). The experience of HIV-AIDS in the Black communities on a provincial level is very similar on the municipal level of Toronto. In 2006, The Black population comprised 8.4% of Canada's largest city population, Toronto, and accounted for 14% of HIV cases in the Toronto Health Region (Remis et al., 2008) - it increased to 15.9% in 2007 (Cunningham, 2010,p5).

According to experts, Black men who have sex with men are vulnerable in this context of high preponderance of HIV-AIDS. They composed 5.3% of all new HIV infections 1983-2004, but declined from 12% in from 1983-1984 to about 7% in 2000-2004 (Remis and Liu, 2007). Unfortunately, the preponderance of HIV-AIDS in the subgroup of Black homosexual men is not unique to Canada. Early this year, the *New England Journal of Medicine,* in March 2010, observed that HIV rates among Black MSM in some major cities in the United States is higher than in some countries in continental Africa:

> "One in 16 Black males living in Washington D.C. is infected with HIV, so are one in 40 Black males living in New York City - that is more than reported in African countries like Senegal, Ethiopia and Rwanda. This study also found out that in several urban areas in the United States, the HIV prevalence among men who have sex with men is as high as 30% - as compared with a general-population prevalence of 7.8% in Kenya and 16.9% in South Africa" (Wafaa M. El-Sadr et al., 2010)

Clearly, addressing the high rates of HIV-AIDS among Black men who have sex with men and other related social problems can be said to be a principal need of this social group.

A combination of factors explain the dangerous rates of HIV cases among Black MSM in Toronto. Some factors, such as pervasive poverty remains high in this cohort: "Even though levels of schooling were comparable in 2000, the incidence of low income was substantially higher among Black families (33%), than among the nation's families as a whole (13%)"(PHAC, 2009, p29). Ronald Walcot, a professor at the University of Toronto, claims that most Black homosexual men are in the lower income brackets in Toronto and this observation was confirmed by the *MaBwana* report, which stated that: "40% of respondent earned less than $20,000 annually" (Husband, 2009, p22).

A third principal need underpinning the spread of HIV-AIDS among this social group is homophobia in the Afro-Caribbean communities. In other words, this ethno-racial group, decries homosexuality as a form of pathology and denounces those infected with HIV - " a gay disease" - as deserving their illness. As a result, some Black men who have sex with men also have sex with the opposite sex, to avoid the reproach of homosexuality in the community (Gardezi, 2006, p30). The last, but not least factor influencing the transmission of this virus is the experience of double effect of stress, stemming from racism and homophobia in the mainstream Canadian society, which can lead to high-risk sexual behavior correlating with the spread of this disease. Experts point out that:"social oppression and marginalization related to sexuality and race do influence gay men's health outcome and vulnerability to HIV" (Caceres et al.,2008; Diaz et al., 2004; Li et al.,2008). It seems the high rate of HIV-AIDS is a symptom of a bigger problem in the African Canadian Community.

JURISDICTION AND ORGANIZATION FOR SERVICE DELIVERY

PUBLIC HEALTH AGENCY OF CANADA

Given that many factors affect the proliferation of HIV-AIDS, African homosexual men in Canada require a combination of legal jurisdictions, such as federal, provincial and municipal governments to address this social pathology from many angles. To this end, the jurisdiction of the federal government of Canada announced its policy on combatting HIV-AIDS in Canada - entitled *Leading Together: Canada Takes Action on HIV/AIDS (2005 - 2010)*: "Prevent the acquisition and transmission of new infections; slow the progression of the disease and improve quality of life" were some of the goals of this federal initiative (PHAC, 2005). To effectively administer its policies on health, Ottawa established the Public Health Agency of Canada in 2006, a national health institution. This four-year federal agency was given the mandate to implement federal government's initiative on fighting HIV-AIDS in Canada: "The Government of Canada increased ongoing funding for HIV/AIDS over the next five years, from $42.2 million to $84.4 million annually by 2008-2009. The Public Health Agency of Canada will lead this renewed *Federal Initiative to Address HIV/AIDS in Canada,*" explained by the then Health Minister, Ujjal Dosanjh (PHAC, 2005).

As a result, the Public Health Agency of Canada, in collaboration with other government institutions, has funded knowledge development through research projects on HIV-AIDS. In 2009, this agency gathered leading experts to investigate the rate of HIV-AIDS, among people from countries where HIV is endemic, which resulted in the publication of *Population-Specific HIV/AIDS Status Report*. This study is an important policy guide because it demonstrates that Black people of African and Caribbean descent living in Canada have high rates of AIDS, so government policies should reflect the determinants of health that contribute to this health quandary. The federal government's role in financially supporting in-depth research is one way of addressing the principal needs of this social group, because they represent a new Canadian demography that require further exploration.

ONTARIO MINISTRY OF HEALTH

The government of Ontario through the Ontario Ministry of Health and Long-Term Care delivers crucial services to stated group. In 2006, the ministry had a budget of $54 million per a year, which increased to $55 million in 2008, for HIV-AIDS related programs. The provincial Ministry of Health is over hundred years old and, as part of its aim of confronting the menace of HIV in the province, it has funded over 80 organizations, providing tangible support and education to specific communities with high HIV rates. This agency offers over $1 million in scholarship to more than 400 Ontarians living with this expensive disease. This program is beneficial to Black MSM who are infected with the disease, because there is a link between this illness and poverty (Anderson and Brown, 2003). Apart from this initiative the Ministry has also earmark money for: "supporting the work of the Ethno-racial men who have sex with men (MSM) Research Working Group, a committee of researchers and community organizations who are developing ways to strengthen research in Ontario, specific to MSM from diverse ethnic and racial communities" (HIV In Ontario, 2008).

AFRICAN AND CARIBBEAN COUNCIL ON HIV/AIDS IN ONTARIO

African and Caribbean Council on HIV/AIDS in Ontario (ACCHO), as already mentioned, is a non governmental organization, funded by Canadian Institute of Health Research (CIHR) and Ontario's Ministry of Health (ACCHO, 2008). Its objective is to develop community-based and culturally sensitive programs that illuminate, as well as provoke, the discussion of the high-rates of HIV-AIDS in the Black Community (ibid). It has been in existence for almost six years and during, this period, ACCHO has been responsible for launching an HIV prevention campaign entitled *Keep it Alive.* This outreach awareness program exclusively targets members of the African and Caribbean community, with the objective of de-stigmatizing AIDS, breaking the yoke of the silence around homosexuality and encouraging HIV testing. *Keep it Alive* released of posters of two Black men in an affectionate pose designed to stimulate discussion of homophobia in Black conservative culture (ibid). It is hoped that this AIDS awareness program will sensitize Black MSM to embrace their homosexual identity, practice safer sex, and use appropriate social and health services, equipped to handle homosexual behavioral complications.

In addition, ACCHO has organized conferences and summit for members of the community, as part of its strategy of HIV-AIDS prevention program. For example, in 2008, ACCHO convened *People Living with AIDS Summit* to "improve access to care, treatment and support for Black people living with AIDS" against the backdrop of despondency among these cohorts (ibid). In 2010, *Cultures of Sexuality and Black Men's Health* was organized to engage in themes of health, well-being, community, and social justice. The Summit featured a number of plenaries and workshops relating to employment, spirituality, and self-care. The later summit, which I attended, also served as a psychosocial program to build social networks and affirm the visibility of an African homosexual shared experience. This space of making new like-minded friends can be said to reduce the cyclical effect of isolation, loneliness, and depression, an underlying factor of risky sexual behavior among people who face multiply layers of discrimination. Invariably, the gatherings provided the platform to convey the relevant community and provide general resources for those who needed them. ACCHO is one salient community organization that delivers culturally informed services to Black homosexual men in Southern Ontario.

KEY POLICIES AND PROGRAMS FOR BLACK MSM IN ONTARIO

One key policy - entitled *Say Yes To Knowing HIV/AIDS in Ontario* - addresses the needs of the aforementioned group. $58 million per year, since 2008, has been committed to HIV related programs in the province, with the second highest rate of the disease in the country (HIV in Ontario, 2008). Instead of 80 organizations being financially sponsored in 2006, the money now reaches over 90 organizations, from various ethnic, sexual and aboriginal groups developing tailored service and support projects (ibid). Moreover, this initiative does not include the Ontario Health Insurance Program (OHIP), which already covers visit to physicians for HIV consultation and treatment and the Ontario Drug Benefit (ODB) formulary for HIV/AIDS - which pays for the cost of HIV-AIDS medication after infection(ibid). The government initiative is poignant to Black MSM, because it is a multilayered approach: preventive, treatment and care.

In line with the government stated objective, it has set up numerous health facilities and sites for free and private HIV tests. "This includes 50 province-wide anonymous HIV testing and rapid point-of-care (called *POC*) testing sites with 20 minutes test results and pre-test and post-test counseling. Information on risk reduction, partner notification, and referral is also provided by this program" (HIV in Ontario, 2008). Further, the Health Ministry is committed to supporting a province-wide AIDS and Sexual Health telephone service, combined with an interactive web-based forum, offered in 16 languages, providing anonymous counseling, referrals and information about harm reduction in intravenous drug use (HIV in Ontario, 2008). These existing programs are beneficial to Black MSM because it respects their privacy and does not stigmatize them. Ben Kin Moon, the United Nations General Secretary, affirms this approach of service delivery when he said: "stigma remains the single most important barrier for why people are afraid to see a doctor" (Cunningham, 2010, p13). The awareness that these services are accessible - 24-hours/7 days a week - and requires no financial obligations from its users is definitely beneficial to this demography.

EFFICACY OF PROGRAMS

Programs supported by government initiatives on HIV are highly recommendable, as it is designed from a multi-prong approach to address this insidious problem facing the communities I belong to. Both federal and provincial agencies have supported community-based projects and other Non-governmental organizations' programs to confront this epidemic. However, it is difficult to evaluate the efficacy of these services because HIV among the cohort of African Ontarians has not decreased, but rather increased: it also increased from 14% in 2006 to 15.9% in 2007 (HIV in Ontario, 2008). In this regard, I will concede that the allocation of more government funds does not "always" correlate with HIV-reduction rates among this social group. Social behavior is the primary reason for the proliferation of AIDS, therefore government policy should reflect social determinants of health, such as racialized unemployment, poverty and incarceration in Ontario, which influences risky social behavior. Blacks are more likely to account for 56% of all incarceration in the province, this context of mass incarceration influences social behavior and the spread of AIDS and should be addressed in relations to HIV-prevention (PHAC, 2009, p32). In supporting my claim for an HIV policies and programs, which incorporate solutions to other social problems, poverty reduction, in tackling HIV, research has noted that health care facilities that assist Black people living with HIV-AIDS and at the same time providing access to opportunities for employment, received high-quality rating by its users. (Gardezi, 2006, p43). In other words, though government programs are praise worthy, more should be done to address underlying social stresses.

CONCLUSION

As an African homosexual, I explored social policies and programs for African MSM, whose principal need was confronting the spread of HIV/AIDS. Statistically, we have comparable educational achievements with mainstream society, still, *MaBwana* report maintains that we are predominantly impoverished. While we represent a small percent of the total population, we are over represented by HIV/AIDS cases; stigma, homophobia, poverty and stress

are some of the factors influencing this phenomenon. All the jurisdictions of government have participated in outlining policies and programs to fight HIV in Canada. Examples include, *Leading Together: Canada Takes Action on HIV/AIDS (2005 - 2010)*, a $84.4 million federal response, compliments *Say Yes to Knowing HIV in Ontario,* a laudable provincial initiative, which spends $58 million annually for HIV/AIDS related programs. Free drug program, scholarships, community-based research, free, accessible and anonymous tests along with culturally sensitive awareness campaign, such as *Keep It Alive,* and educational projects are all salient examples of beneficial programs to this cohort. Nevertheless, the disease has not shown any significant sign of abating, but rather soared. In my evaluation of the efficacy of the programs, I suggested an inclusive holistic plan to curb this social pathology by taking on social determinants of health. Social determinants of health have not been adequately included in HIV/AIDS prevention programs. Above all, hope remains that a more comprehensive method will stem the tide of this sad reality in Black Canada.

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