

Ontario Gay Men's Sexual Health Summit 2008

***Strengthening Our Response: Understanding HIV
Stigma and other Sexual Health Issues***

Summary Report

**DA Falconer & Associates Inc.
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- Devan Nambiar (Committee Co-Chair)
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- Clemon George
- Paul McCarty-Johnston
- Rob MacKay
- Vaughn Fitzpatrick

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Glossary of Acronyms

AIDS – Acquired Immune Deficiency Syndrome

ASO – AIDS service organization

CAS – Canadian AIDS Society

GBM – Gay, Black man/men

GIPA – Greater Involvement of People Living with HIV/AIDS

GLBTTQ – Gays, lesbians, bisexuals, transgendered, two-spirited, queer

HIV – Human Immunodeficiency Virus

MSM – Men who have sex with men

OHTN – Ontario HIV Treatment Network

PHA – Person with HIV or AIDS

PHAC – Public Health Agency of Canada

POZ – HIV-positive

STI – Sexually transmitted infection

Introduction

The Ontario Gay Men's Sexual Health Summit 2008 took place from February 20-22, 2008 at the Westin Harbour Castle Hotel in Toronto. It was sponsored by the AIDS Bureau, Ontario Ministry of Health and Long-Term Care. The Summit has been an annual event since 2004 and it was formerly known as the Ontario Gay Men's HIV Prevention Summit.

The Summit provides an opportunity to talk about important issues relevant to the work of the participants to improve the sexual health of gay, bisexual and other men who have sex with men. The primary goal of the 2008 Summit was to get the participants thinking about HIV stigma and the relationship between HIV stigma and the ability of gay men to practice safer sex. This work fits within an overall goal of reducing HIV stigma to improve the quality of life for HIV positive gay men, support the sexual health of all gay men and reduce the number of new HIV infections in the gay community.

For the second year in a row, both HIV prevention and support workers in community-based organizations were brought together as well as social workers, researchers, policy makers and colleagues in public health.

This report contains a summary of the proceedings of the Summit (see Appendix A for Summit Programme). The PowerPoint presentations made throughout the Summit were distributed electronically to the participants after the Summit and can be obtained upon request from the AIDS Bureau. This report was prepared by DA Falconer & Associates Inc.

Participants

There were 180 participants from different geographic regions and from AIDS service organizations, universities, government, public health and the private sector (see Appendix B for a breakdown and Appendix C for contact information).

Day 1: Ontario Gay Men's HIV Prevention Strategy

1.0 Welcome

Frank McGee, AIDS Bureau, Ontario Ministry of Health and Long-Term Care welcomed the participants and provided an introduction to the Summit.

1.1 Ontario Gay Men's HIV Prevention Strategy

James Murray and Chris Lau, AIDS Bureau, Ontario Ministry of Health and Long-Term Care presented an update on the Strategy along with different members of the various Strategy Working Groups. The key highlights were:

- Completion of a Strategy process evaluation that focussed on getting feedback on communication, inclusion, decision-making and the value of participation for front-line work.
- Completion of a strategic planning process that resulted in identifying four priorities for the next few years.
- Completion of a process and outcome evaluation on the Be Real campaign.
- Work is underway for a new prevention campaign that will be launched in Fall of 2008. The goal of the campaign is to raise awareness about HIV stigma in the gay community and the relationship between HIV stigma and HIV transmission.
- Other gay men's health work continues including supporting the development of various resources, establishing an anal dysplasia working group and M-Track.
- **Alex Adams and Nik Redman**, Gay, Bi, Queer Trans Men's Working Group:
 - Accomplishments – publication and promotion of *Primed: The Back Pocket Guide For Trans Men & The Men Who Dig Them*; creation of website (www.queertransmen.org) and conference presentations.
 - Upcoming – training of ASOs and service providers; education with non-transmen; research; and conference presentation.
- **Rob MacKay**, POZ Prevention Working Group:
 - Accomplishments – development and dissemination of poz prevention definition, values and principles; delivery of various poz prevention workshops and trainings across the province; support and guidance in planning for upcoming social marketing campaign; input into PHAC national social marketing campaign; and input into CAS national poz prevention initiative.
 - Upcoming – development of poz prevention strategies; further workshops and trainings; and support in development of projects to create various resources for service providers and gay men, including a legal guidebook, poz prevention sexual health guidebook and poz prevention service provider resource.
- **Vijay Saravanamuthu**, Ethno-racial MSM Research Working Group:
 - Accomplishments – ethno-racial MSM capacity-building research project and poster presentation and workshop at OHTN conference.
 - Upcoming – currently looking at broadening mandate of Working Group to not just be focused on research but on all ethno-racial MSM sexual health and HIV prevention issues.

- **Christiane Bouchard**, Francophone Working Group:
 - Accomplishments – establishment of the Working Group and involvement in Positive Places, Healthy Places research.
 - Upcoming – strengthening the Working Group and conducting an environmental scan and literature review of services and needs around sexual health and HIV prevention for Francophone populations with HIV and for gay, bisexual and other men who have sex with men in Ontario. A final report will be ready in the Spring/Summer of 2009.

Day 2: Understanding HIV Stigma and Other Sexual Health Issues

2.0 Welcome

Frank McGee, AIDS Bureau, Ontario Ministry of Health and Long-Term Care welcomed and thanked the participants and provided an introduction to the Summit. He also introduced and thanked the Summit Planning Committee, AIDS Bureau staff and guests from outside the province of Ontario.

2.1 Interpreting HIV Stigma

Winston Husbands, African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) made a presentation entitled *Interpreting Stigma*. Based on the HIV Stigma Study of African and Caribbean communities in Toronto, the following key points were made:

- HIV stigma emerges from community norms and moral codes that subordinate specific groups and regulate behaviours.
- Individuals express stigmatizing attitudes and behaviours, but individual actions reference social relations.
- The antecedents of observed stigma are systemic.
- Stigmatizing gestures, attitudes and behaviours are embedded in social relations at a particular time and place.
- Strategies to address stigma should focus on the systemic and institutional structures that sustain stigma.

2.2 Prevalence and Negative Impact of HIV Stigma among Latino Gay Men in the U.S.

Rafael Díaz, César E. Chávez Institute (San Francisco) made a presentation entitled *HIV Stigmatization among Latino Gay Men in the U.S. (its relation to mental health and prevention)*. The following key points were made:

- There is a social/interpersonal cost to knowing and disclosing one's HIV status.
- There is a knowledge gap as very little (close to nothing) is known about HIV stigma within the gay community.
- Oppressive sociocultural factors have a psychosocial impact that manifest in symptoms such as anxiety, depression and suicidal ideation.
- Resiliency factors can mitigate the psychosocial impact of oppression.
- High levels of HIV/AIDS stigma exist among Latino gay men and three tentative hypotheses for this are: (1) safety through seroconcordance; (2) moderating vulnerability through "othering;" and (3) displaced abjection (internalized homophobia).
- Implications for the CDC "Prevention for Positives" Initiative are: (1) cost of knowing; (2) cost of disclosing; (3) cost of "othering;" and (4) prevention for positives must address HIV stigma among HIV-negative men.

2.3 Experiences of HIV Stigma – Panel Presentation

David Lewis, Black Coalition for AIDS Prevention (Black CAP) made the following key points during his presentation:

- Gay men and gay Black men have internalized a link between HIV and sexuality. The rebellion against being branded as other can illicit an intense reaction and create divides that foster stigma.
- Pre-existing, internalized feelings of negative self-worth, deviance, disease in queer communities allow us to move in stigmatizing and discriminatory ways with one another – the dirty from the clean. For Black men, this has resulted in behaviours such as not testing, using ineffective serosorting techniques, gossiping, labelling and naming of those thought to be HIV-positive.
- While there has been some research, there are still huge gaps in our understanding of how HIV and HIV stigma play out in local Black MSM communities. We know that Black MSM account for a significant number of new infections among racialized MSM.
- HIV and HIV stigma have been a large part of his life, his self-concept, his navigation of relationships both sexual and not, without ever being HIV positive, and beginning with his early learning around being a homosexual. HIV stigma isn't only about and applicable to HIV-positive men.
- Stigma around HIV is about homophobia, especially in the Black community. For Black CAP, this means integrating messages focussed on reducing homophobia and gender-based discrimination into sexual health and HIV prevention campaigns and being inclusive of the needs of those with HIV in the messaging.

Gaston Cotnoir, Access AIDS Network made a presentation entitled *Stigmas and Challenges in North Eastern Ontario* and the following key points were made:

- There is a lack of knowledge about the local ASO, false perceptions about who gets infected, difficulty establishing new programs because of HIV stigma and inherent stigma when working in an ASO which affects both the organization and individuals.
- There are particular challenges when working with the Francophone community, including its size in the north-east (the region represents 20% of all Franco-Ontarians) and the majority of French schools being Catholic institutions. This latter fact means there is a lack of education around sex and HIV; intolerance and lack of support for people who are lesbian, gay, bisexual, transgendered or 2-Spirited; and high risk behaviours due to lack of knowledge.

Alan Li, Committee for Accessible AIDS Treatment made a presentation entitled *Stigma and Discrimination faced by Immigrant, Refugee, Non-status MSM/PHAs* and the following key points were made:

- Immigrants and refugees face multiple stressors. Stigma and discrimination combined with identity, self-esteem, relationships, support and access to services inform risk behaviours.
- MSM, newcomers and PHAs each have particular forms of stigma they deal with and when each identity comes together in one person, there is a compounding impact which increases one's vulnerability to HIV and risk behaviour.
- A new initiative is underway to mobilize leaders in ethno-racial communities in 5 sectors (faith-based, media, health services, social justice and settlement) against HIV/AIDS

stigma. The first phase of the project is disclosure skills development amongst PHAs to support them to take the lead in the campaign.

David Hoe, Community Member and Person with HIV spoke about stigma from a personal perspective of living with HIV for over 20 years. The following key points were made:

- Stigma is held deep in the body where emotional and sexual energy come from. It is a state of fear. Often we think about stigma as something we witness, hear about or know of. Stigma over his 20 odd years of being HIV-positive has been witnessed, lived and fought. The fight has been internal and external: internal in his stigmatizing of others and himself and external in that glass wall we all push against to create the empowered reality of values, oppression free and dignity. Over the years, he has had to back off from people and himself. He has developed a bargaining psyche.
- During the time of personal negotiation, he was also involved in federal work where hierarchies at an organization do not like the personal, particularly the personal of HIV.
- Gay PHAs in large part have a very close relation with their asses and pleasuring their asses. A massage teacher once told him the opposite of anal retentive is anal radiance and he imagines a goal of anal radiance for all gay PHAs as a way to promote dialogue on stigma. But stigma about sex, bums and ecstasy still abounds and until language is developed, we will continue to talk in euphemisms.
- Only now does he believe with the added emphasis on “lived experience” as a guide to change within and without in programs and policy, does he foresee the replacement of fear with love; the replacement of discriminatory acts with “oh that’s no problem;” the replacement of fear with programs/policies to continue to build this new vision.
- He has seen change over the 20 years of living with HIV – governments invite gay men to the policy table; people like him embrace and demand diversity as a principle; gay PHAs create alternatives to protect sexual integrity; and above all, over the years since we all began the fight is the ever expanding welcome into community which sees a future without shame and the dissolution of fear thus allowing love to take its natural place.

2.4 HIV Stigma – Small Group Discussion

The participants engaged in facilitated small group discussions at their table. The information in this section is the key points made based on the notes of the facilitators.

1. *What one thing sticks with you from the presentations you heard so far this morning?*

- **Stigma** is a powerful, complex and diverse issue, with many layers that intersect with and are amplified by other factors such as homophobia, racism and general mental health. Stigma remains strong, even after 20 years, and must be addressed openly.
- The prevalence of **internalized homophobia** throughout the gay community which idealizes and perpetuates masculine or straight image role models. Internalized homophobia is dangerous as it accentuates stigma which in turn leads to isolation and risky behaviour. Self-hate and internalized homophobia must be addressed through the factors that give rise to them, such as ignorance and fear (internal factors) as well as social aspects and religion/spirituality (external factors).

- The concept of **othering**, its prevalence within the queer community and how complicated it is to intervene on.
- There is a **myth of cohesion** within communities, e.g. Latino and Black communities.
- The issue of **disclosure** and how it is complicated by criminalization and its impact on families.
- There was a lack of content regarding white gay men and a need for discussion around the issue of **white privilege**.
- There was not enough discussion surrounding **resiliency** which skews the emphasis of our work on struggles and not strengths.
- Some felt that David Hoe's tone was too emotional and inhibited discussion while others liked his candid presentation.
- The research and presentation by Rafael Díaz were excellent and Winston Husbands provided a great framework.

2. *Was there anything that you heard so far this morning that surprised you?*

- The **extent and persistence of stigma**, its existence both within and outside the gay community and its many layers existing at the individual (as manifested in the language of online ads) and institutional levels.
- The existence of **internalized homophobia** which means that stigma must be addressed both from inside (as well as outside) the gay community.
- The **vast infection rates** among American Black/Hispanic gay men, the lack of knowledge among Latino men of their serostatus, and the **role of racism** in fuelling the spread of HIV in large, urban US areas.
- There is a sense that the gay community is **diversifying itself out of community**.
- The **decline in activism** within gay communities and working in ASOs being motivated by career strategy rather than passion.
- The construction of **PHAs as dangerous**, blaming them for the spread of HIV and placing the responsibility on PHAs for protecting themselves and others.
- Other dimensions of stigma, including complications posed by **culture and location**.
- The concept of **anal radiance**.
- While there are many challenges, there is also a sense of **change, community and resilience**.

3. *What was something you heard this morning that was new information for you?*

- The **complexity of the issue of stigma** – that it occurs even within stigmatized communities themselves such as discrimination against HIV positive men by HIV negative men; that it is higher among gay men than in the general population; and the way in which it is manifested differently in various and diverse communities such as newcomers. It also has an impact on people not getting tested.
- The **lack of access to sex education** in Catholic schools.
- **Information about the US** such as the statistics regarding Black and Latino MSM, as well as the link between crystal meth and HIV risk.

4. *Are there other priorities or issues related to HIV stigma you feel should be highlighted?*

- A variety of approaches is needed to **address the causes of stigma**, including ones that target HIV negative people; promote shared responsibility for prevention; interrogate

internalized stigma and its impacts; dismantle institutional barriers, encourage new language and promote resiliency.

- Other factors that intersect with HIV stigma must be recognised in order to address their role in HIV transmission. These include **age, race, culture, gender, homophobia, newcomer status, health and issues around disability**.
- **Negative attitudes** and other influencing factors around testing must be addressed such as internalized stigma, criminalization, fear and ignorance.
- Factors that impact upon **sexual behaviour** in general should be examined, such as violence, self-esteem, condom fatigue and lack of knowledge regarding continued relevance of safer behaviours.
- There should be some examination of **what has been tried and worked** before, both in local communities and at the global level. As well, **strategies that have failed** should be examined. The impact of **criminalization** on disclosure and testing requires attention.

5. *What do you see as the links between HIV stigma and sexual health?*

- **HIV stigma encourages high-risk behaviour.** Stigma leads to low self-esteem, inhibits disclosure and discussion, and contributes to negative attitudes towards sex. This in turn discourages people from getting tested, encourages sero-sorting, leads to disassociation from the community and perpetuates high-risk behaviour such as barebacking.
- **Stigma is worsened by other factors** such as poverty, criminalization, internal attitudes (morality) and social constraints surrounding sexual relationships which in turn impacts negatively on health.
- The **need for education** of the general population and **raising awareness of sexual practices** which includes information surrounding unsafe behaviour, the influence of porn and how attitudes inhibit constructive discussion of sexual practices.

6. *What is one thing you will take away from this morning's presentations that you think will be helpful in your work?*

- **Discussions must be broadened** to include other belief systems, communities that have been ignored, such as MSM and Francophones, and relevant issues such as those surrounding agency, intergenerational dialogue and stigma in other settings.
- Prevention cannot be addressed without **dealing with the underlying factors of stigma**, its causes and effects.
- **Strategies and approaches must be broadened**, incorporating other formats and media, such as the internet, and involving not only individuals but groups and institutions. There must be recognition that sexual behaviour is dependant on individual experiences and other considerations that transcend issues of health and touch upon personal situations and natural human desires.

7. *Have you done any work in your community to address HIV stigma with gay/bi/MSM?*

- **Raising awareness** of issues such as HIV stigma, self-hate and the importance of HIV prevention during counselling sessions, through campaigns and at public fora, social groups, community discussions, workshops and focus groups/research.
- **Mobilizing for behaviour change** by promoting testing and general health awareness.

8. *What more can you do in your work to address HIV stigma with gay/bi/MSM?*

- **Cast the net wider** to include families, community, HIV negative people, schools, youth, newcomers, refugees, Francophones and women.
- **Question existing approaches** that may perpetuate stigma or fail to address the marginalization of other groups.
- **Enhance techniques** by using more appropriate or inclusive language, recording or remembering history, promoting awareness of the existence and damaging effects of stigma, through education and monitoring effectiveness of campaigns.
- **Target other dimensions of health** such as spirituality, mental health, psychosocial well-being and general health.

2.5 Lunch 'N Learn Sessions

2.5.1 MSM Epidemiological Update

Robert Remis, University of Toronto made a presentation entitled *Epidemiological trends in HIV infection among men who have sex with men in Ontario: The situation in 2007*. He noted the following conclusions in the presentation:

- Gay men in Ontario continue to be severely affected by the HIV epidemic.
- HIV prevalence: 16% (regional variation: 6 -21%).
- HIV incidence (i.e. new infections) not decreasing and likely increasing.
- By detuned assay, incidence appears stable 2001-06, but repeat tester data and PHAC statistical model indicate significant increase 1996-2005.
- 800 new HIV infections annually.
- If sustained, HIV prevalence >20% by age 50 years.
- Trends in HIV incidence consistent with trends in risky sexual behaviour.
- Reasons for persisting high HIV incidence unclear:
 - Treatment optimism?
 - Safer sex fatigue?
 - Increased substance use?
- Need to implement and evaluate effective primary and secondary preventive interventions in MSM.

2.5.2 Trans 201

Alex Adams, Matt Lundie, Nik Redman, Ayden Scheim, Syrus Ware, Gay/Bisexual/Queer Transmen's Working Group made a presentation entitled *Getting Primed: GBQ Trans Men and Sexual Health*. They reported on the Working Group's accomplishments and future work.

2.5.3 Strengthening our Response with Younger Gay Men

Alex Dow, Griffin Centre; **Alex Kennedy**, Youth Services Bureau of Ottawa; **Doe O'Brien-Teengs**, Ontario Aboriginal HIV/AIDS Strategy; and **Jordan Tarini**, Youth Services Bureau of Ottawa each presented on how to better address the sexual health needs of younger gay men in Ontario. Sharing personal stories, the speakers focussed on youth who were 2-Spirited, trans men, gay and living with HIV, and LGBT in some of the diverse communities of Toronto's inner suburbs. The session concluded with a call for a young men's working group to inform and drive youth issues in the Strategy.

2.6 Sexual Health Update

Irving Salit, Toronto General Hospital made a presentation entitled *Anal Cancer: A Sexually Transmitted Disease*. He noted the following key points and conclusions in the presentation:

- Anal cancer is very similar to cervical cancer.
- The Toronto Research for Anal Cancer Evaluation (TRACE Study) with HIV+ men found anal human papillomavirus (HPV) in about 95% of the men in the study; anal pap smears were abnormal in 66%; and biopsy revealed high-grade pre-cancers in 25%. The outcomes were the same for laser and acid treatment of anal pre-cancers.
- Screening for anal cancer should be implemented for gay men once adequate experience has been gained from studies such as this.

Paul MacPherson, Ottawa Hospital, University of Ottawa made a presentation entitled *HIV Transmission*. He noted the following conclusions in the presentation:

- HIV transmission is highly complex.
- Estimates of risk involve a number of behavioural and biological variables interacting at once.
- “Low risk” activity can become high risk depending on certain modifiers.
- “High risk” can be lowered depending on certain modifiers.

The participants engaged in facilitated small group discussions at their table based on a case scenario. The information in this section is the key points made based on the notes of the facilitators.

1. *What are three main messages you would relay to each client about his level of risk for HIV transmission or STIs?*

Peter:

- Be diligent about condom use and cultivate harm reduction strategies such as being attentive to oral hygiene and health; engage in non-penetrative sex; access follow-up treatment; monitor blood.
- Test regularly for STIs (especially as relationship is open) and HIV.
- Communicate – do not make assumptions about status and trust, and be understanding of individual positions regarding risk.
- Clarify if viral load in blood versus semen and be aware that each has different viral loads.
- Abstain from sex until Lewis treated.
- Identify support systems, including for accident situations (such as condom breaking).
- Affirm right to personal decisions.

Lewis:

- Be diligent about condom use. Explore options regarding condom use where sensitivity is not compromised in order to encourage safer sexual practices.
- Disclose in certain circumstances.
- Communicate.
- Be aware that undetectable viral load does not mean no HIV so that the risk of transmission still exists.

- Be aware that the possibility of re-infection and superinfection exists.
- Get treated for syphilis.
- Identify support systems.
- Affirm right to personal decisions.

2.7 Wrap Up

Frank McGee, AIDS Bureau, Ministry of Health and Long-Term Care thanked the participants and encouraged them to complete their evaluation forms. He also made various announcements.

Day 3: Strengthening Our Response

3.0 Welcome

Frank McGee, AIDS Bureau, Ontario Ministry of Health and Long-Term Care welcomed the participants to the third and final day of the Summit.

3.1 Ethno-racial MSM and Aboriginal/2-Spirit Men – Panel Presentation

Lydia Makoroka & Winston Husbands, MaBwana Black Men's Study made a presentation entitled *Towards HIV Prevention for African/Caribbean/Black MSM in Toronto*. They noted the following conclusions in the presentation:

- HIV is a serious problem among Black/African/Caribbean communities in Ontario, including among gay and bisexual men and MSM.
- Black/African/Caribbean men are not an entirely homogeneous group.
- Black/African/Caribbean men care about their health.
- There is evidence that those who work on HIV prevention programming for Black/African/Caribbean men should be optimistic about our efforts.
- There is a need for continued targeted HIV prevention, but perhaps from a community engagement perspective.
- We should adopt some approaches or tools that haven't been exploited sufficiently in the past (e.g., engaging the communities online).
- Research is helping to improve the knowledge base for HIV prevention among Black/African/Caribbean MSM.

Devan Nambiar, Ethno-Racial MSM Capacity-Building Project made a presentation entitled *Improving the Capacity of the HIV Sector to Respond to the Ethno-Racial MSM: Tapping Front-Line Expertise and Wisdom*. He noted the following conclusions in the presentation:

- To improve HIV prevention and education for the ethno-racial MSM:
 - Focus on the whole cultural and religious community inclusive of families and move beyond urban cores.
 - Make HIV information accessible in different languages and different mediums, e.g. the internet, interactive web-based messages.
 - Integrate HIV information in broader social and cultural programs and services in the ethno-racial communities in a culturally sensitive manner.
 - Provide information on the correct use of condoms.
 - Fund programs that target ethno-racial MSM communities.

Percy Lezard, 2-Spirited People of the 1st Nations made a presentation entitled *Stigma and Discrimination: How are 2-Spirit Men Experiencing Discrimination and Being Stigmatized*. She noted the following recommendations in the presentation:

- Foster a culturally competent model of delivery of social services.
- For ASOs and non-Aboriginal agencies, partner with agencies that are doing work with Aboriginal and 2-Spirit community members.

- Provide continued funding for agencies that are supporting 2-Spirit men.
- Be critical of the Indian Act which institutionalized heterosexual marriage and heterosexuality as it was the only way a status Indian could pass on Indian status right and title.
- Rekindle teachings of what the traditional roles of 2-Spirited people had and have.
- Recognize the diversity within Aboriginal communities.

3.2 Ethno-racial MSM and Aboriginal/2-Spirit Men – Round Table Conversation

Antoney Bacchus, Black Coalition for AIDS Prevention; **Jose Cedano**, Centre for Spanish-Speaking Peoples; **Andre Ceranto**, AIDS Committee of Toronto; **Daniel Le**, Asian Community AIDS Services; **Terrence Sands**, Ontario Aboriginal HIV/AIDS Strategy; and **Vijay Saravanamuthu**, Alliance for South Asian AIDS Prevention made the following key points during the conversation:

- There is diversity within each community, including languages and cultures.
- Each organization has its strengths and challenges in the varied needs of the communities they serve. Elasticity is an essential quality to do the work.
- Approaches that work well for one community may not work for another, e.g. bar outreach.
- Doing AIDS work means being stigmatized and workers have to find ways to move through this.
- Different approaches are needed to work with newcomer MSM than MSM who are Canadian born or have lived in Canada for a long time.
- The need to address prejudice, discrimination and racism is common across communities as is internalized oppression.
- The importance of family, community and supports cannot be understated.
- New and better ways are needed to increase access to services and meet people's needs once they get through the door. People need to feel they matter and belong.
- Resiliency exists – recognize people's history and draw strength from that.
- Nurture and support leadership of PHAs.
- Build relationships and partnership across issues and sectors.

3.3 Ethno-racial MSM and Aboriginal/2-Spirit Men – Small Group Discussion

The participants engaged in facilitated small group discussions at their table. The information in this section is the key points made based on the notes of the facilitators.

1. *What one thing sticks with you from the presentations you heard so far this morning?*
 - **Layers of isolation** exist within communities. In every community, there is a multiplicity of cultures. Groups such as ethnoracial, newcomer/immigrant and migrant worker MSM face added discrimination from within and outside the gay community.
 - The existence of a **multiplicity of cultures** requires specific initiatives to deal with the multiplicity of issues. For example, there is a need for ethnospecific workers, for an understanding of the complex dynamics between and among minority/racialized groups, for cultural competency in ASOs, for dealing with the determinants of health and for an

appreciation of the differing needs of specific groups. The specific concerns or issues faced by newcomers would remain inadequately addressed if they are lumped together with ethno-racial or MSM communities.

- Certain communities are consistently sidelined, such as **Aboriginals and Francophones** – even at this summit where the latter were totally unrepresented. However, Francophone organizations need to take more responsibility by addressing racism, stigma and discrimination against PHAs and GLBTTQ from within.
- Small groups face particular challenges which are accentuated in **small towns or rural/remote communities** where ASOs have to fulfill multiple roles and are stigmatized. **Toronto as an immigration centre** has special challenges.

2. *Was there anything that you heard so far this morning that surprised you?*

- That **segregation and oppression** exists within cultures, perpetrated by the gay community itself and internalized by some groups such as MSM. This leads to other issues such as greater isolation and lack of participation in community.
- The difficulties faced by **ethnospecific ASOs** which are understaffed, overworked and lacking the necessary resources to deal with the wide range of communities and needs targeted.
- The disturbing **HIV/AIDS statistics** for the African and Caribbean community.
- The **internet** is seen as an effective, confidential and underused resource with limitations such as not being accessible to all, especially older people; being impersonal; and providing information that may not always be sufficient or even accurate.
- **Migrant workers** face specific problems such as greater prejudice and discrimination and a lack of access to information and services.
- Issues around **condoms** such as condom fatigue and lack of availability.

3. *What was something you heard this morning that was new information for you?*

- The impacts of **drug use and sexual violence** within the gay community.
- The **lack of research** or information with regard to certain communities, such as ethnoracial communities, trans communities and youth. The diversity of agencies dealing with ethnoracial communities points to the initiative of immigrants in addressing these problems.
- The problems faced by **migrant workers**, including the size of this group, the vast distances they have to deal with and the problems posed by competing values related to family and religion on the one hand and sexual freedom on the other.
- The **Buddy program for newcomers** is an interesting program with potential.
- The impact of the **Indian Act** on Aboriginal culture.

4. *Are there other priorities or issues related to ethno-racial gay/bi/MSM and Aboriginal 2-Spirit men you feel should be highlighted?*

- **Removing language barriers**, including the removal of offensive language found in online ads.
- The **isolation of certain communities** such as migrant workers, immigrants and ethnoracial groups. Their vulnerability is heightened after an HIV diagnosis and it is important to provide services to them and address their isolation.

- Recognising the strengths and weaknesses of the **internet**: the internet lacks a vital human element and is restricted to sex-centred services. On the other hand, it facilitates connections between people, including people with varying language needs.
 - The need for **innovative solutions** that address multiple issues of culture, language, spirituality, sexual orientation, HIV and health, as well as highlight the resilience of communities.
 - **Capacity building** in small cities and ASOs, including the need for ethnoracial workers, greater cultural competency, expertise in providing a wide range of services as opposed to making referrals and developing links between agencies.
5. *What is one thing you will take away from this morning's presentations that you think will be helpful in your work?*
- **Networking** (personally and among agencies), **collaboration**, and **building alliances** to better serve understaffed or underrepresented communities.
 - **Innovative ways to address systemic barriers** within our own agencies such as alleviating the effects of lack of resources through collaboration with and the support of other organisations, the use of volunteers and students, online resources and being mindful of individual strengths and capacities.
 - The **role of other risk factors**, such as eating disorders and childhood sexual abuse.
 - The **invisibility of certain populations** such as migrant workers.
 - Being **conscious of diversity** and how cultural differences may dictate the provision of services to clients.
 - The need to move beyond dealing with incidents and towards **empowerment** of individuals.
6. *Have you done any work in your community to work with gay/bi/MSM from ethno-racial and Aboriginal communities?*
- Diversify **volunteer base**.
 - Work with and create **linkages** with various community groups, ethnoracial populations, Aboriginal communities and migrant workers.
 - Raise **awareness** about issues such as diversity, inclusivity, role of language, queer community and partnering.
 - Provide **information** through various media such as online and by telephone, and in languages other than English.
 - Provide **referrals**.
7. *What more can you do to better serve gay/bi/MSM from ethno-racial and Aboriginal communities in your work?*
- Diversify **staff** and improve **capacity** to respond to concerns and issues.
 - Adjust **programs** and incorporate the **GIPA principles** into the work.
 - Ensure greater **collaboration** between and among established networks, service organisations, universities, volunteers, ethnoracial groups and public health workers in general.
 - Improve **service delivery** by extending hours and creating other means of contact such as through the internet or telephone.

- Improve **service delivery to and participation of ethnoracial communities** by use of appropriate language, culturally sensitive advertisements and providing services accessible to the disabled.
- Expand the **type and range of services**, e.g. by providing mentorship programs, family support group programs, intergenerational-focused groups and targeting children of GLBTTQ.
- Raise **visibility and awareness** of ASOs among the general population.
- Create a provincial **forum for Francophone service providers**.
- Provide more extensive **anti-racism/anti-oppression training**.
- AIDS Bureau to provide **funding** grants for small ASOs.

3.4 Criminalization of HIV – Panel Presentation

Richard Elliot, Canadian HIV/AIDS Legal Network made a presentation entitled *HIV (Non)-Disclosure and the Criminal Law*. He noted the following key points in the presentation:

- To date, the vast majority of charges and convictions in Canada have been against HIV+ men who have had sex with women. There are a few cases against HIV+ men who have had sex with men and HIV+ women who have had sex with men.
- It is *exposure without disclosure* that is the offence. Lack of valid consent is the issue. Lying about, or not disclosing, HIV+ status can amount to “fraud” in some cases.
- The duty under the criminal law to disclose HIV-positive status arises when there is a “significant risk of serious bodily harm” to another person. “Serious bodily harm” includes HIV infection. “Significant risk” includes unprotected vaginal sex (and, presumably, unprotected anal sex).

Ryan Peck, HIV/AIDS Legal Clinic (Ontario) made a presentation entitled *Public Health Section 22 Orders & Some Disclosure Issues for Service Providers*. He noted the following key points in the presentation:

- Under the Health Protection and Promotion Act, where a health unit reasonably believes a person with HIV is putting others at risk, they can issue a “section 22 order.” In order to issue an order, the health unit must have reasonable grounds to believe that the order is necessary to decrease or eliminate the risk. Under a section 22 order, public health can order “a person to take or to refrain from taking any action.”
- Section 22 orders are not common. Usually they are only issued when someone who is HIV+ is diagnosed with another sexually transmitted disease, like syphilis or gonorrhea, because that is considered proof of unsafe sexual activity. In addition, if someone refuses to disclose the names of their past sexual partners, or refuses to tell their current partner they are HIV+, public health can issue an order forcing them to.
- Public health law is different from the criminal law. The criminal law is all about disclosing your HIV+ status to others. For public health purposes, disclosing HIV+ status is not the issue – making sure a PHA does not transmit HIV to others is.
- In Canada, there is no common law obligation, outside of a specific statute, that imposes a legal “duty to warn,” e.g. call the police when one believes a crime has been committed.
- The Supreme Court stated there is a common law discretion to disclose confidential information. At common law, the discretion to release privileged information exists if all of the following conditions are met: (1) there is a risk of harm to an identifiable person or

Group; (2) the risk is imminent (urgent); (3) the harm threatened is serious; (4) the disclosure is made in a manner designed to least impact on the rights of the patient.

- Unregulated professionals should take care not to promise 100% confidentiality as that may not be deliverable in all circumstances. There really are no cases where a service provider has been found negligent for not breaching confidentiality.

Murray Jose, Toronto PWA Foundation made the following key points during his presentation:

- Service providers need up-to-date information, tools, support and discussion as doing the work has emotional/ethical/moral challenges for each person.
- Delivering services means that providers do not get to choose clients and as such, have to serve whoever comes forward.
- It is important to be conscious of the language being used as the issue is not criminalization of HIV but rather criminalization of HIV non-disclosure. I am not a criminal nor is my virus.
- Often assumptions are made about clients (in challenging HIV disclosure situations) that impact a provider's ability to provide services effectively. Criminalization validates existing biases and makes them seem more credible – including to service providers.
- Dealing with these issues warrant certain agency considerations: (a) media response preparedness; (b) policies and procedures; (c) support for staff; (d) open discussions with staff around ethical/moral/emotional responses; (e) shared communication provincially/nationally; and (f) information and tools.
- The Criminalization and HIV Committee of the AIDS Bureau will be focussing on: (a) education materials; (b) training; (c) media; (d) policy/advocacy.

3.5 Wrap Up

Frank McGee, AIDS Bureau, Ontario Ministry of Health and Long-Term Care thanked the participants, presenters and organizers. He encouraged everyone to complete and submit their evaluation forms.

4.0 Evaluation Results

Throughout the Summit, participants were requested to complete an evaluation form which assessed each component of the event. From the 180 participants, 87 completed evaluation forms were returned for a response rate of 48.3%.

This section presents the quantitative data collected from the completed evaluation forms. The qualitative data collected will be reviewed and used by the Summit Planning Committee to enhance future Summits.

4.1 Strategy

How helpful did you find the Strategy updates?

- | | |
|----------------------|-----|
| 1. Not valuable | 0% |
| 2. Somewhat valuable | 19% |
| 3. Very valuable | 65% |
| 4. I loved it! | 16% |

How clear are you on the role and purpose of the Strategy in your work?

- | | |
|--|-----|
| 1. I have no clue | 0% |
| 2. I have a basic understanding | 21% |
| 3. I see the role, but have some questions | 33% |
| 4. It is crystal clear | 45% |

4.2 Interpreting HIV Stigma

How valuable did you find this presentation?

- | | |
|----------------------|-----|
| 1. Not valuable | 0% |
| 2. Somewhat valuable | 18% |
| 3. Very valuable | 64% |
| 4. I loved it! | 18% |

4.3 Prevalence & Negative Impact of HIV Stigma among Latino Gay Men in the U.S.

How valuable did you find this presentation?

- | | |
|----------------------|-----|
| 1. Not valuable | 1% |
| 2. Somewhat valuable | 1% |
| 3. Very valuable | 20% |
| 4. I loved it! | 78% |

4.4 Experience of HIV Stigma – Panel

How valuable did you find this presentation?

- | | |
|----------------------|-----|
| 1. Not valuable | 0% |
| 2. Somewhat valuable | 20% |
| 3. Very valuable | 39% |
| 4. I loved it! | 41% |

4.5 Sexual Health Update – Anal Cancer

How valuable did you find this presentation?

- | | |
|----------------------|-----|
| 1. Not valuable | 0% |
| 2. Somewhat valuable | 7% |
| 3. Very valuable | 57% |
| 4. I loved it! | 36% |

4.6 Sexual Health Update – Physiology of HIV Transmission and STIs

How valuable did you find this presentation?

- | | |
|----------------------|-----|
| 1. Not valuable | 0% |
| 2. Somewhat valuable | 14% |
| 3. Very valuable | 48% |
| 4. I loved it! | 38% |

4.7 MaBwana Black Men’s Study

How valuable did you find this presentation?

- | | |
|----------------------|-----|
| 1. Not valuable | 1% |
| 2. Somewhat valuable | 26% |
| 3. Very valuable | 61% |
| 4. I loved it! | 12% |

4.8 Ethno-Racial MSM Capacity-Building Project

How valuable did you find this presentation?

- | | |
|----------------------|-----|
| 1. Not valuable | 2% |
| 2. Somewhat valuable | 28% |
| 3. Very valuable | 58% |
| 4. I loved it! | 12% |

4.9 2-Spirit People of the 1st Nations

How valuable did you find this presentation?

- | | |
|----------------------|-----|
| 1. Not valuable | 0% |
| 2. Somewhat valuable | 35% |
| 3. Very valuable | 43% |
| 4. I loved it! | 22% |

4.10 Ethno-Racial MSM and Aboriginal/2-Spirit Men – Round Table Discussion

How valuable did you find this presentation?

- | | |
|----------------------|-----|
| 1. Not valuable | 4% |
| 2. Somewhat valuable | 22% |
| 3. Very valuable | 49% |
| 4. I loved it! | 24% |

4.11 Criminalization of HIV

How valuable did you find this presentation?

- | | |
|----------------------|-----|
| 1. Not valuable | 0% |
| 2. Somewhat valuable | 5% |
| 3. Very valuable | 52% |
| 4. I loved it! | 44% |

4.12 Small Group Discussions (Days 2 and 3)

How relevant do you feel the small group discussions were to your work?

- | | |
|-----------------------|-----|
| 1. Totally irrelevant | 0% |
| 2. Somewhat relevant | 13% |
| 3. Good enough | 32% |
| 4. Totally relevant | 55% |

Were you able to participate in the discussion to a level you would have liked?

- | | |
|-----------------------|-----|
| 1. Not at all | 0% |
| 2. Somewhat | 8% |
| 3. For the most part | 36% |
| 4. Participated fully | 56% |

Were you able to express your concerns with the ideas presented?

- | | |
|-----|-----|
| Yes | 97% |
| No | 3% |

How would you rate the facilitation of the small group discussions?

- | | |
|--------------|-----|
| 1. Not good | 0% |
| 2. Average | 7% |
| 3. Very good | 37% |
| 4. Excellent | 56% |

4.13 General Feedback

Were you satisfied with the hotel and meetings rooms?

- | | |
|----------|-----|
| Yes | 91% |
| Somewhat | 9% |
| No | 0% |

Were you satisfied with the food provided?

- | | |
|----------|-----|
| Yes | 95% |
| Somewhat | 4% |
| No | 1% |

How would you rate the facilities overall?

1. Poor	0%
2. Somewhat acceptable	1%
3. Good enough	27%
4. Excellent	72%

Did you receive a pre-Summit package in the mail?

Yes	65%
No	35%

Did you find the materials helpful in preparing you for the Summit?

1. Not helpful	1%
2. Somewhat helpful	20%
3. Very helpful	61%
4. I loved it!	18%

Did you have all the information you needed to register, get a hotel room, and find your way around Toronto?

Yes	94%
No	6%

How would you rate the on-line registration process?

1. Poor	0%
2. Somewhat acceptable	0%
3. Good enough	40%
4. Excellent	60%

How would you rate the on-site registration process?

1. Poor	0%
2. Somewhat acceptable	0%
3. Good enough	35%
4. Excellent	75%

Please rate how well the Summit was organized this year, based on the following statements:

(A) I thought that was the right amount of time devoted to small group discussions.

1. Not even close	1%
2. I somewhat agree	15%
3. I would say it's pretty close	59%
4. Perfect	25%

(B) I had enough opportunity to think about and discuss the information that was being presented to me.

- | | |
|---|-----|
| 1. Nope | 0% |
| 2. I could have used more time | 14% |
| 3. On balance, it was pretty good | 55% |
| 4. It was the perfect balance of information provision and discussion | 31% |

(C) Do you feel you had enough of an opportunity to talk with your peers at this Summit?

- | | |
|-------------------------------------|-----|
| 1. Not even close | 3% |
| 2. Somewhat | 10% |
| 3. Pretty much, but could be better | 40% |
| 4. Totally | 47% |

(D) This year, we pre-assigned tables to all Summit participants. How would you rate the effectiveness of this in ensuring that participants hear a diversity of experiences and in encouraging greater networking?

- | | |
|--------------------------|-----|
| 1. It didn't work at all | 1% |
| 2. Somewhat effective | 11% |
| 3. Very effective | 49% |
| 4. I loved it | 39% |

(E) Do you think we should pre-assign tables for future Summits?

- | | |
|-----|-----|
| Yes | 92% |
| No | 8% |

The Gay Men's HIV Prevention Strategy strives to create working environments that are inclusive and respectful of the diversity that exists within our communities. There have been particular efforts at this Summit to integrate this principle into the delivery of the Summit.

How would you rate how well the Summit has been in creating an inclusive and equitable environment through the planning, as well as through the presentations?

- | | |
|-------------------------|-----|
| 1. Not inclusive at all | 0% |
| 2. Somewhat inclusive | 14% |
| 3. Very inclusive | 57% |
| 4. Extremely inclusive | 29% |

4.14 Lunch 'N Learn Sessions

MSM Epi Update

Did you find this presentation useful for your work?

- | | |
|--------------------|-----|
| 1. Totally useless | 0% |
| 2. Somewhat useful | 20% |
| 3. Very useful | 65% |
| 4. I loved it! | 15% |

How clear was the presentation?

- | | |
|-------------------|-----|
| 1. I'm lost | 0% |
| 2. Somewhat clear | 35% |
| 3. Very clear | 55% |
| 4. Crystal clear | 10% |

How well do you feel you understand the HIV epi data for Ontario after this presentation?

- | | |
|-------------------|-----|
| 1. I'm lost | 0% |
| 2. Somewhat clear | 15% |
| 3. Very clear | 60% |
| 4. Crystal clear | 25% |

Trans 201

Did you find this presentation useful for your work?

- | | |
|--------------------|-----|
| 1. Totally useless | 0% |
| 2. Somewhat useful | 15% |
| 3. Very useful | 45% |
| 4. I loved it! | 40% |

How clear was the presentation?

- | | |
|-------------------|-----|
| 1. I'm lost | 0% |
| 2. Somewhat clear | 10% |
| 3. Very clear | 80% |
| 4. Crystal clear | 10% |

How useful have you found the information contained in the Primed sexual health resource for your work?

- | | |
|-----------------------------|-----|
| 1. Have not read or seen it | 26% |
| 2. Somewhat useful | 0% |
| 3. Very useful | 47% |
| 4. Incredibly useful | 26% |

Younger Gay Men

Did you find this presentation useful for your work?

- | | |
|--------------------|-----|
| 1. Totally useless | 0% |
| 2. Somewhat useful | 15% |
| 3. Very useful | 33% |
| 4. I loved it! | 51% |

How clear was the presentation?

- | | |
|-------------------|-----|
| 1. I'm lost | 0% |
| 2. Somewhat clear | 11% |
| 3. Very clear | 31% |
| 4. Crystal clear | 58% |

Ontario Gay Men's Sexual Health Summit 2008

Day 1: February 20, 2008

- 4:00 – 6:00* **Registration**
- 6:00 – 7:00* **Dinner and Welcome**
Frank McGee, AIDS Bureau
- 7:00 – 8:25* **Ontario Gay Men's HIV Prevention Strategy**

An overview and update on the work of the Ontario Gay Men's HIV Prevention Strategy.
- 8:25– 8:30* **Wrap Up**

Day 2: February 21, 2008

- 8:00 – 8:45* **Registration & Breakfast**
- 8:45 – 8:55* **Welcome**

Frank McGee, AIDS Bureau
- 8:55 – 9:05* **Interpreting HIV Stigma**

Winston Husbands, African and Caribbean Council on HIV/AIDS in Ontario (ACCHO)

Presentation illustrating the comparison between definition and interpretation of HIV stigma, based on the HIV Stigma Study of African and Caribbean communities in Toronto.
- 9:05 – 10:15* **Strengthening our Response: The Prevalence and Negative Impact of HIV Stigma among Latino Gay Men in the U.S.**

Rafael Díaz, César Chávez Institute (San Francisco)

Presentation on qualitative and quantitative data revealing strong negative attitudes towards HIV-positive individuals among Latino gay men in the U.S. Evidence will be presented on the impact of those attitudes on the health and well-being of HIV-positive Latino gay men who must often be silent about their HIV serostatus in a hostile and stigmatizing environment. The discussion will be framed in the context of the relationship between social oppression, social discrimination, and HIV risk in ethnic minority communities.
- 10:15 – 10:30* **BREAK**
- 10:30 – 11:30* **Strengthening our Response: Experiences of HIV Stigma**

PANEL

David Lewis, Black Coalition for AIDS Prevention
Gaston Cotnoir, Access AIDS Network
Alan Li, Committee for Accessible AIDS Treatment
David Hoe, Community Member and Person with HIV

Panelists speak of experiences of HIV stigma from various perspectives as service providers but also from personal experiences living as community members.

11:30 – 12:30 **Strengthening our Response: HIV Stigma**

SMALL GROUP DISCUSSION

Small group discussion on themes raised during Plenary and Panel presentation.

12:30 – 1:00 **LUNCH**

Grab your lunch and join one of the following three Lunch & Learns.

1:00 – 2:15 **LUNCH & LEARNS**

LUNCH & LEARN 1: MSM Epidemiological Update

Robert Remis, University of Toronto

Presentation and discussion on the most recent HIV rates and trends among men who have sex with men (MSM) in Ontario.

LUNCH & LEARN 2: Trans 201

Alex Adams, Matt Lundie, Nik Redman, Ayden Scheim, Syrus Ware – Gay/Bi/Queer Trans Men Working Group

Presentation of findings from the gay/bi/queer trans men needs assessment research project and discussion of particular sexual health issues affecting gay/bi/queer trans men.

LUNCH & LEARN 3: Strengthening Our Response with Younger Gay Men

Alex Dow, Griffin Centre
Alex Kennedy, Youth Services Bureau of Ottawa
Doe O'Brien-Teengs - Ontario Aboriginal HIV/AIDS Strategy
Jordan Tarini, Youth Services Bureau of Ottawa

Hear from front-line workers and gay youth on how we can better address the sexual health needs of younger gay men in Ontario.

2:15 – 2:45 **NETWORKING BREAK**

2:45 – 4:55 **Strengthening our Response: Sexual Health Update**

Irving Salit, Toronto General Hospital
Paul MacPherson, Ottawa Hospital - University of Ottawa

Presentations focus on anal cancer, sexually transmitted infections, the physiology of HIV transmission and their particular impact on HIV-positive men.

4:55 – 5:00 **Wrap Up**

Day 3: February 22, 2008

8:00 – 8:55 **Breakfast**

8:55 – 9:00 **Welcome**

9:00 – 10:30 **Strengthening our Response: Ethno-racial MSM and Aboriginal/2-Spirit Men**

PANEL

Lydia Makoroka & Winston Husbands, MaBwana Black Men's Study
Devan Nambiar, Ethno-Racial MSM Capacity-Building Project
Percy Lezard, 2-Spirited People of the 1st Nations

Two presentations focus on community-based research focused on Black men, as well as on ethno-racial MSM. A third presentation will address issues affecting Aboriginal/2-Spirit men.

10:30 – 10:45 **BREAK**

10:45 – 11:30 **Strengthening our Response: Ethno-racial MSM and Aboriginal/2-Spirit Men**

ROUND-TABLE

Antoney Bacchus, Jose Cedano, Andre Ceranto, Daniel Le, Terrence Sands, Vijay Saravanamuthu

An intimate conversation with front-line educators and outreach workers specifically targeting ethno-racial MSM and Aboriginal/2-Spirit men in Ontario.

11:30 – 12:30 **Strengthening our Response: Ethno-racial MSM and Aboriginal/2-Spirit Men**

SMALL GROUP DISCUSSION

Small group discussion on themes raised during Plenary and Round Table.

12:30 – 1:30 **LUNCH**

1:30 – 3:45 **Strengthening our Response: Criminalization of HIV**

PANEL

Richard Elliot, Canadian HIV/AIDS Legal Network
Ryan Peck, HIV/AIDS Legal Clinic (Ontario)
Murray Jose, Toronto PWA Foundation

This plenary focuses on the criminalization of HIV and its impact on service provision, as well as on HIV-positive gay men.

3:45 – 3:50 **Wrap Up**

Appendix B: Summit Participants by Geographic Region & Type

Participant breakdown by geographic region

Region	Number of participants	%
Toronto	83	46.1
Ottawa	29	16.1
Provincial *	14	7.8
South west	12	6.7
National **	12	6.7
Northern	10	5.6
Sudbury	3	1.7
Hamilton	3	1.7
Central east	3	1.7
Central west	3	1.7
Waterloo	2	1.1
South east	2	1.1
British Columbia	2	1.1
Windsor	1	0.6
USA	1	0.6
Total	180	100.0

* Participants who work for organizations/agencies with a provincial mandate

** Participants who work for organizations/agencies with a national mandate

Participant breakdown by type

Participant type	Number of participants	%
Educators	62	34.4
Agency Management / Executive Director	33	18.3
Support worker	21	11.7
Researchers	21	11.7
Community	21	11.7
Government	11	6.1
Public health	8	4.4
Private sector/business	3	1.7
Total	180	100.0

Appendix C: Participant Contact List

The following Summit participants consented to having their names, agency affiliations and email addresses listed in this report as a way to encourage networking.

Last name	First name	Agency/Affiliation	Job title	Email
Abulsamad	Suhail	Sherbourne Health Centre	Program Coordinator	soynewcomer@sherbourne.on.ca
Ackery	Jo-Ann	Toronto Public Health	Manager STI program SW Region	jackery@toronto.ca
Adam	Barry	University of Windsor	University Professor	adam@uwindsor.ca
Adams	Alex	GBQ Transmen Working Group	Working Group member	adamsalex01@gmail.com
Alexander	Stephen	Canadian AIDS Society	Programs Consultant	stephena@cdnaids.ca
Ali	Firdaus	Alliance for South Asian AIDS Prevention	Executive Director	ed@asaap.ca
Babcock	Joseph	HIV/AIDS Regional Services	Positive peer support	josephbdesigns@hotmail.com
Baccas	Antoney	Black Coalition for AIDS Prevention	Men's Outreach Coordinator	men2gether@black-cap.com
Banks	Phillip	H.I.M. - Health Initiative for Men	Consultant	phillipb@shaw.ca
Barnes	Ricky	Pink Triangle Services	Gay Men's Health & Wellness HIV/AIDS Prevention Coordinator	richardlbarnes@gmail.com
Barton	Ian	410 Sherbourne Street Health Centre	Social Worker/HIV Program	bartoni@smh.toronto.on.ca
Baxter	Lori	AIDS Committee of Windsor	Director PHA Support Services & Harm Reduction	lbaxter@aids Windsor.org
Bellavance	Daniel	FrancoQueer	Board member	danbella@rogers.com
Bereket	Tarik	Women's College Hospital	Research Associate	bereket77@gmail.com
Betteridge	Glenn	Toronto People with AIDS Foundation	Legal and Policy Consultant	gbetteridge@pwatoronto.org
Bieth	Richard	Toronto Public Health	Public Health Nurse	rbieith@toronto.ca
Bouchard	Christiane	Ottawa Public Health	Project Officer	christiane.bouchard@ottawa.ca
Boutin	Jean-Rock	FrancoQueer	Vice Chair	jean-rock.boutin@francoqueer.ca

Last name	First name	Agency/Affiliation	Job title	Email
Boyce	Nick	Fife House	Provincial Trainer - Ontario HIV and Substance Use Training Program	nboyce@fifehouse.org
Boyd	Rob	Oasis-Sandy Hill Community Health Centre	Program Director	rboyd@oasischc.on.ca
Brennan	David J.	Faculty of Social Work, University of Toronto	Assistant Professor	david.brennan@utoronto.ca
Burtch	Michael	AIDS Committee of Ottawa	Volunteer	livingproof1982@yahoo.ca
Busch	Adam	AIDS Committee of Toronto	Harm Reduction Coordinator	abusch@actoronto.org
Caldwell	B.J.	AIDS Committee of Guelph & Wellington County	HIV/STI Prevention and Outreach Educator	education@acg.guelph.org
Calzavara	Liviana	HIV Social, Behavioural & Epidemiological Studies Unit	Professor	liviana.calzavara@utoronto.ca
Campbell	Christine	Peterborough AIDS Resource Network	Support Services Coordinator	chris@parn.ca
Campbell	Ryan	AIDS Committee of London	Case Manager/Community Support Liaison	rcampbell@aidslondon.com
Carter	Stephanie	Peterborough AIDS Resource Network	Prevention Services Worker	preventionworker@parn.ca
Cedano-Mellado	José	Centre for Spanish-Speaking Peoples	Educator and Sexual Health Worker	aidsccsp@spanishservices.org
Ceranto	Andre	AIDS Committee of Toronto	Portuguese-speaking Men's Outreach Coordinator	aceranto@actoronto.org
Chen	Brian	AIDS & Sexual Health Info Line, Toronto Public Health	Supervisor	bchen@toronto.ca
Cherian	Mooky	Prisoners' HIV/AIDS Support Action Network	Provincial Program Coordinator	mooky@pasan.org
Cherry	Michele	Ontario AIDS Network	Coordinator of Skills Development	mcherry@ontarioaidsnetwork.on.ca
Clarke	Bruce	Toronto Public Health	Manager, STI Program	bclarke2@toronto.ca
Collins	Evan	Ontario Organizational Development Program	Consultant	ecollins@interlog.com
Corroy	Francisco	Griffin Centre	Outreach Worker - HIV/AIDS	fcorroy-moral@griffin-centre.org

Last name	First name	Agency/Affiliation	Job title	Email
Cotnoir	Gaston	Access AIDS Network	Healthy Sexuality Coordinator	leckyf@hotmail.com
Croteau	Gerry	AIDS Committee of Simcoe County	Executive Director	acscexecutivedirector@rogers.com
Cule	Steve	Public Health Agency of Canada	Surveillance Analyst	Stephen_Cule@phac-aspc.gc.ca
Cullen	Jim	Centre for Addiction and Mental Health	Clinic Head/Manager	jim_cullen@camh.net
Desarmia	Robert	Oasis-Sandy Hill Community Health Centre	OASIS Drop In/Anonymous HIV Testing	rdesarmia@oasischc.on.ca
Dias	Rick	Ottawa Public Health	Outreach Worker	rick.dias@ottawa.ca
Díaz	Rafael M	César E. Chávez Institute	Professor/ Research Scholar	RMDIAZ@sfsu.edu
Dolan	Le-Ann	AIDS Committee of Toronto	Director of Programs and Services	ldolan@actoronto.org
Elliott	Richard	Canadian HIV/AIDS Legal Network	Executive Director	relliott@aidslaw.ca
English	Ken	AIDS Bureau	Senior Policy Analyst	Ken.English@ontario.ca
Falconer	Dionne A.	DA Falconer & Associates Inc.	Consultant	dafalconer@rogers.com
Fenta	Haile	Ontario HIV Treatment Network	Ethnoracial and Ethnocultural Research Capacity Development Consultant	hfenta@ohnt.on.ca
Fergus	Stevenson	Queen's University	Assistant Professor	ferguss@queensu.ca
Fernandez	Paul	Asian Community AIDS Services	Intern	paulf_243@yahoo.ca
Gaylord	John	AIDS Committee of Toronto	Counsellor	jpgaylord@actoronto.org
Gilmore	Mark	Toronto People With AIDS Foundation	Food For Life	mgilmore@pwatoronto.org
Graham	Adam	AIDS Committee of Ottawa	Gay Men's Prevention Coordinator	mens.health.project@aco-cso.ca
Greenspan	Nicole	AIDS Committee of Toronto	Research Coordinator	ngreenspan@actoronto.org
Grimard	Marcel	FrancoQueer	Co-Chair	mgrimard@rocketmail.com
Guimond	Tim	Centre for Addiction and Mental Health	Resident in Psychiatry	tim_guimond@camh.net
Gunaratnam	Sivakaran	Alliance for South Asian AIDS Prevention	Tamil Outreach Coordinator	tamil.outreach@asaap.ca

Last name	First name	Agency/Affiliation	Job title	Email
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