

GAY MEN'S HIV PREVENTION STRATEGY

Environmental Scan for Rural Southwestern Ontario
Elgin-Huron-Lambton-Middlesex-Oxford-Perth

A Final Report

Prepared & Written by Daniel Pugh for The AIDS Committee of London
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I. Executive Summary

The *HIV/AIDS Community Plan of Southwestern Ontario* (2006) recognizes continuing increases in HIV prevalence and incidence within the "men who have sex with men" (MSM) demographic. An environmental scan was conducted by the AIDS Committee of London, as a means of researching what "points of access" exist in rural southwestern Ontario.

"Many gay and bi men in southwestern Ontario tend to be 'invisible' and difficult to reach. The 'community' is not cohesive or organized. With the decline in the membership and general interest from the community, subsequent closing of Homophile Association of London Ontario (HALO) Club, the gay community has lost one of the longstanding organizations that used to be a base from where people could connect individually or collectively or call to get their questions answered". (*Pozitive Living. Pozitive Lives: HIV/AIDS Community Plan for Elgin, Huron, Lambton, London-Middlesex, Oxford, Perth*, 2006)

Theoretically, this environmental scan intended to investigate the potential need to expand services to rural locations considering several local statistics:

- Gay men and MSM account for 69% of all HIV diagnoses in Ontario, 73% of diagnoses in London-Middlesex, and 92% in Oxford County (Remis et al, 2004).
- Ontario: 690 new MSM infections in 2003 (Remis et al, 2004).
- Estimated prevalence rate amongst MSM in southwestern Ontario is 13.4%, after Toronto (19%) and Ottawa (18%) (Remis et al, 2004).
- 2003: MSM account for 41% of all HIV diagnoses in southwestern Ontario (Remis et al, 2004).

In addition to these statistics, results from the Ontario Men's Survey of 2002 indicated that of the positive test samples, prevalence was 12.7% in Toronto, 7.7% in Southern Ontario, 4.9% in Ottawa and 3.7% in Northern Ontario (*HIV/AIDS Epi Update*, 2005).

This project reviewed existing support, social groups or community services and programs that exist to serve MSM in the rural counties that surround London. Contact was made through public health nurses, county health services, community centres, public secondary schools, organizations,

and counsellors. The research revealed there is an extremely limited amount of services offered to the MSM populations.

II. Introduction & Background

With respect to the Gay Men's HIV Prevention Strategy-an initiative by the AIDS Bureau of Ontario-this environmental scan attempted to identify what strategies other communities are using to reach rural MSM. This goal would help the AIDS Committee of London (ACOL) formulate a strategy that will increase knowledge regarding HIV transmission and related issues and will promote the adoption of harm-reduction skills and strategies amongst MSM. It is important to investigate concerns such as factors that contribute to increased rates, while assessing how we may become more inclusive as an AIDS Service Organization (ASO) to meet the needs of those in rural communities. Southwestern Ontario may have a higher prevalence of HIV in Ontario because it covers a large proportion of rural communities that are characteristically isolated and offer very limited services. In rural areas or small towns, there is perhaps less likelihood of a geographic gay community to "breathe" in, usually less privacy available for those gay men trying to hide their sexual orientation, and fewer gay-specific services (Ryan, Brotman, & Rowe, 2000). As such, it is important to determine what exists and doesn't exist in order to identify what needs to be done. Research was primarily conducted in six surrounding counties. Targeted rural centres included (but were not restricted to) Elgin (*St. Thomas, Port Stanley, Aylmer*), Middlesex (*Strathroy, Parkhill*), Oxford (*Ingersoll, Woodstock, Tillsonburg, Tavistock*), Huron (*Grand Bend, Exeter, Goderich, Wingham*), Lambton (*Sarnia*), and Perth (*Stratford, Listowel, St. Marys*). Action items within the environmental scan included:

- Identify communities in the geographic area ACOL serves that may have a community group that serves MSM.
- Identify community leaders, potential contacts, etc., to develop a master list of stakeholders (see appendices).
- Contact local organizations and youth agencies regarding resources.
- Contact schools (guidance, teachers, school nurses, Gay-Straight Alliances) to determine the existence of support groups, community leaders or interested parties/ organizations.

- Connect with fellow AIDS service organizations (ASO's) for information on services and programs to support, inform and educate non-urban clientele.
- Identify current or potential HIV/AIDS prevention campaigns used in other communities/ ASO's.
- Survey online chat rooms for contacts at dances, bars, clubs, and social events in rural areas.
- Connect with London partners to investigate networking opportunities and pre-existing services.

III. Methodology

Contact was initiated with chosen agencies and community partners through phone calls and emails. A standard set of questions was asked to each contact. For example:

- “Do you have any information regarding services/ programs for gay youth, gay men, or MSM in your area?”
- “Are there any notable contacts for further information?”
- “Do you feel there is a need for MSM services in your community?”
- “What are some of the challenges working against the existence of MSM services?”
- “If possible, would you or your agency be interested in working partnerships?”

Sourcing for information or “calls for action” were also shared within several key community meetings: Middlesex London Health Unit (MLHU), Community Planning members, Family Services London, “The Village News”, Port Stanley web news, and www.thehealthline.ca.

IV. Results & Findings

Unfortunately, MSM services in rural southwestern Ontario are few and far between. Searches were categorized as: 1) youth groups 2) secondary schools 3) community centres 4) support groups 5) public health nurses 6) fellow ASO's and 7) other. The following lists very minimal MSM-affiliated services located in all of the six regions.

- Bluewater Volunteer Youth Centre (Sarnia) has an on-site social worker that occasionally attends to the needs of any identifying GLBTIQ2S (Gay, Lesbian, Bisexual, Transgendered, Transexual, Intersexed, Queer, Questioning, 2-Spirited). Rick Graff & Associates of Stratford also has an on-site psychologist that has taken many referrals from St. Marys, Stratford, and Woodstock for struggling youth identifying as gay.
- Of the 22 public secondary schools contacted, only Strathroy District Collegiate Institute hosts an active Gay-Straight Alliance (GSA) group. The number of participants varies, but sits around ten. Several students from Glendale High School in Tillsonburg initiated the establishment of a GSA. The school approved the request, however, the students changed their minds at the last minute for fear of being harassed by their peers.
- For community centres and groups; the only MSM affiliated memberships consisted of PFLAG Sarnia-Bluewater and Sarnia-Lambton Pride which operate events throughout the year, including social gatherings and dances.
- Many fellow ASO's (HIV/ AIDS Regional Services, Kingston, ON; Peterborough AIDS Resource Network, AIDS Committee of North Bay and area, AIDS Thunder Bay) programming for non-urban clientele (MSM in particular) also suffer. Northern Ontario areas such as North Bay have support clients traveling to Sudbury or Toronto for services. Localized ad campaigns do not specifically target MSM. Instead mainstream condom-use messages are used. Many of the ASO's in smaller areas have no visible queer communities. Therefore events such as film screenings, condom-outreach at dances, GLBTIQ2S youth group facilitation, and workshops are scheduled only sporadically. However, several ASO's have on-site programming for youth that identify as GLBTIQ2S. For example, AIDS Action Perth (Stratford) hosts a "safe spaces" youth group for queer persons. The participation has decreased over the last six months, and programming runs on a limited time basis. Furthermore, most of the centres contacted throughout Perth County made referrals to AIDS Action Perth and their respective services. Stratford Central Secondary School posts information promoting the "Safe Spaces" youth group at AIDS Action Perth.
- Information has been gathered concerning the implementation of an AIDS service website for Sarnia that will require partnership with ACOL (details are pending). It will most likely involve the facilitation of MSM participants.

For most of the identified community support programs, the only potential access to services for MSM would be in the event there was a support worker on staff. One centre operating out of Tavistock indicated that referrals to Stratford are likely to occur. Finally, all public health nurses contacted throughout the environmental scan agreed upon the lack of, but definite need for, organized services for MSM.

When asked for information on MSM services in southwestern Ontario, the following represent the *most* common challenges and reasons for lack of programs in rural locations:

- Issues of confidentiality and disclosure (particularly for youth). This results in fear of discrimination and potential for physical harm from peers and community members.
- Lack of family support, particularly for younger MSM. Referrals are insufficient for under age youth with no money or access to transportation. There is also significant long-term emotional and psychological stress that accumulates as a result of no support.
- No regular venue/ location at information, brochures, pamphlets, contact and emergency numbers, etc can be accessed.
- In secondary school settings there are few staff trained for, or committed to, GSA supervision. Active parental resistance to these services is another factor.
- MSM in rural and farming communities are often isolated or secluded from social gatherings/ venues.
- Inaccurate messages and information retrieved on the Internet.

V. Recommendations

With respect to the data collected on rural MSM services in southwestern Ontario, several key issues need to be addressed before implementing a working plan or logic model. The long-term outcome of increased programming and services would be; declining infection rates, community awareness, and decreased discrimination and stigmatization. By increasing our prevention campaigns through education and support, harm-reduction practices may become more adequately achievable. Core suggestions include an increase in general health programming

directed towards MSM, expand working partnerships with pre-existing community members, selecting committed delegates within each target area and extending outreach opportunities. The following is a breakdown of recommendations pertaining to each of the aforementioned "challenges".

- Assist with the implementation of GSA groups in appropriate secondary schools. Collect adequate resources available to key guidance counsellors who may support MSM or GLBTTIQQ2S students; promote on-call public health nurses for those schools without; discuss the advantages with willing school officials in having a "safe spaces" location at schools; workshop presentations by ACOL.
- Develop partnerships (and/ or) connect with pre-existing GSA's for training opportunities to staff, recruit volunteers. It may also be suitable for ACOL to develop a GSA training package that can be made readily available to those of potential interest.
- Determine key locations whereby information may be obtained, and the 1-800 Youthline number is retrievable; ACOL to reinstate a hotline for phone support and education to anonymous and disadvantaged; connect with local PFLAG chapter for affected support and information services.
- Take advantage of key localized venues (i.e.; local health clinic, office, walk-in clinic, youth centre, library) for MSM information distribution.
- ACOL to expand outreach services so that the facilitation of MSM groups, information sessions, workshops, etc. can be made available to local health services on a quarterly basis (providing space is located).
- Within identifiable key locations post ACOL (MSM) website, and address regular, active presence on Gay.com and Squirr.org to accommodate anonymity and confidentiality while addressing questions or concerns about safer sex and HIV. Web sites, internet-based

chat rooms and bulletin boards can have an impact on the health of gay men, as well as working to reduce the isolation for MSM of rural regions.

- As per recommendations stemming from the Gay Men's HIV Prevention Strategy and the *HIV/AIDS Community Plan for Southwestern Ontario*, ACOL should continue its commitment to the opportunity for sharing information with other ASO's and community partners. Exchanging ideas about programming, policy and procedures will inform participants about what does or does not work for MSM within different communities.
- Promoting the inclusion of same sex relationships into sexual health education programs allows for open and frank discussions about human sexuality while respecting informed choices and encouraging the healthy development of self-esteem.
- Full support for the new Gay Men's HIV Prevention Strategy that will involve the release and distribution of a new advertising campaign directed specifically towards MSM. Public media spaces have already been confirmed within London, Sarnia and Stratford.

It should be noted that, in compliance with the *HIV/AIDS Community Plan*, it is essential to abide by the GIPA (*Greater Involvement of People Living with or Affected by HIV/AIDS*) principles established by UNAIDS in 1999. Collaborating with the direct experience of those PHA's (specifically from rural counties) will allow us to better understand how and what action items need to be accomplished with respect to MSM programs and services.

Most recommendations will require active participation with community partners. Some endorsements will likely require the assistance of volunteers.

VI. Conclusions

Gay men, their communities and informal networks in Canada have long demonstrated courageous initiative and incisive analyses in addressing conditions for their health and wellness. A convergence of recently changing contexts, including gay communities, their changing experience of HIV and their relation to it, as well as the context of federal health policy, has shifted the ground

of HIV prevention among gay men in Canada (*Valuing Gay Men's Lives*, 2000). Today, when most health experts talk about prevention for gay men, they focus on groups that have traditionally been hard(er) to reach with safer-sex information: young gay men and gay men of colour. However, recent statistics suggest dramatic increases in 'high risk' sex (and other kinds of risky behaviour) among older, white, and relatively affluent gay men in major cities -- traditionally the group for whom prevention efforts were most effective (Cox, Winter 2005/2006). However, with little resources available to a high-risk (MSM) community, HIV is just as likely in rural Ontario as it is in our major urban centres. It is this very fact that needs to be considered when we realize that there is very little being done in isolation to reach out and educate people about HIV.

There are many theories that exist as to why we have been seeing a recent increase in the amount of infections in the gay community given its 20 plus year anniversary. From "condom fatigue" to low self-esteem, we need to effectively address each issue as a potential contributor to HIV infection. In addition, we need to ensure this is being discussed in all our communities whether urban or rural. It has always been hard to get a clear picture of where the epidemic is headed. The long asymptomatic period after infection and spotty surveillance efforts have usually meant that data reflect the epidemic of five to ten years ago. However, a variety of "secondary" markers suggest a resurgence of high-risk behaviour (Cox, Winter 2005/ 2006). These secondary markers may consist of the introduction of crystal methamphetamine within urban gay communities leading to more casual partners and more episodes of unprotected anal intercourse. In a study published by the AIDS Committee of Toronto in 2004 on party drugs in the gay dance club scene, participants reported that drugs are "seductive in many ways". Drugs (Crystal Meth, Ecstasy, Poppers, etc.) diminish sexual inhibitions, heighten sexual desire, increase the intensity of sex, and lengthen (sexual) encounters. Some participants concluded that drugs impair their ability to practice or negotiate safer sex (Husbands, W. et al, 2004). It should be noted that although most data on these drugs stems from urban centres (i.e.; Toronto and Vancouver), I am proposing that the likelihood for a "ripple effect of influence" into the rural community is possible. Isolated MSM who are secluded from accurate information about drugs and safer sex practices may find themselves in a position of compromise. Essentially, those that do not have the appropriate skills to negotiate safer sex practices are at risk for infection.

Another fundamental contributor to the spread of HIV in the MSM population is depression. It is estimated that approximately 20% of gay men show symptoms of depression, as compared to

about 7% of all men (Cox, Winter 2005/ 2006). Depression can be linked with unsafe sex because prevention messages that speak to self-esteem are ineffectively perceived in terms of harm reduction. By not providing prevention services to this neglected group we are also sending a message that they are of little importance within a greater community. Considering these issues, how then, should health departments and AIDS service organizations go about preventing the virus from further spreading amongst MSM in remote and rural communities where support is non-existent? Developing program consistency and sustainability will promote the development of meaningful health services while taking into consideration the disadvantages of rural seclusion and isolation. This may be achieved by providing HIV education and topic-specific safer sex methodology, promoting awareness of recreational drugs (i.e.; crystal meth and ecstasy) and alcohol, creating access to treatment for addictions, developing ongoing outreach initiatives, supporting community partnerships and networking opportunities, and establishing social group membership to foster a better sense of MSM community in rural areas. If we neglect to establish, promote and support programs and information to isolated MSM, we are perpetuating the likelihood for marginalization. Essentially we are refusing to acknowledge that the health and well being of a particular margin of society is their human right.

The establishment of such programs will promote harm reduction for those stigmatized southwestern rural MSM who are more susceptible to HIV and STI infections.

VII.I Appendix: References

Cox, Spencer. "Risky Business" AIDS Community Research Initiative of America. New York, New York: Winter 2005/ 2006.

Framing Gay Men's Health in a Population Health Discourse: A Discussion Paper. Canadian Strategy on HIV/AIDS. October 23, 2000.

From Principle to Practice: Greater Involvement of People Living with or Affected by HIV/AIDS (GIPA). UNAIDS Geneva, Switzerland. 1999.

HIV/AIDS Epi Update. Centre for Infectious Disease Prevention and Control. Public Health Agency of Canada. May 2005.

Husbands, W. [et al], *Party Drugs in Toronto's Gay Dance Club Scene: Issues for HIV Prevention for Gay Men*. AIDS Committee of Toronto. Toronto, 2004.

Pozitive Living. Pozitive Lives: HIV/AIDS Community Plan southwestern Ontario (Elgin, Huron, Lambton, London-Middlesex, Oxford, Perth). Final Report. Quorum Communications, Inc. February 2006

Remis, R,S. [et al], *Report on HIV/AIDS in Ontario 2003*. University of Toronto. December 2004.

Ryan, B., Brotman, S., & Rowe, B. *Access to care: Exploring the health and well being of gay, lesbian, bisexual and Two-Spirit people in Canada*. McGill Centre for Applied Family Studies, Montreal, 2000.

Valuing Gay Men's Lives: Reinvigorating HIV Prevention in the Context of our Health and Wellness. Canadian Strategy on HIV/AIDS. 2000.

VII.II Appendix: Contacted sources

Include lists of contact (see over).

Public Secondary Schools for Environmental Scan (2006):

School	Address	Phone	PH Nurse, et al.
Alexander Mackenzie S.S	1257 Michigan Ave. Sarnia	519-542-5505	Rhonda Galler
Annandale School	60 Tillson Ave. Tillsonburg	519-688-3498	Ms. Scheider (Guidance)
Arthur Voaden S.S	41 Flora St. St. Thomas	519-631-3770	Elaine McMillan
Bluewater S.S— Corrections Fac.	Hwy 21 S Exeter	519-524-2107	
Central Elgin Coll. Inst.	201 Chestnut St. St. Thomas	519-631-4460	Ann Gare
College Ave. S.S	700 College Ave. Woodstock	519-539-0020	Marianne Condruk
FE Madill S.S	231 Madill Dr. Wingham	519-357-1800	Shelly Spencer
Glendale H.S	37 Glendale Tillsonburg	519-842-4207	Marianne Condruk
Goderich Dist. Coll. Inst.	260 South St.	519-524-7353	Ms. Senn (Principal)
Huron Park S.S	900 Cromwell St. Woodstock	519-537-2347	Justine DeLuca
Ingersoll Dist. Coll. Inst.	37 Alma St.	519-485-1200	Justine DeLuca
Listowel Dist. S.S.	155 Maitland Ave.	519-291-1880	
North Middlesex Dist. H.S	100 Main St. Parkhill	519-294-1128	Maureen Mouritzen
Northern Coll. Inst. & Voc. School	940 Michigan Ave. Sarnia	519-542-5545	
Parkside Coll. Inst.	241 Sunset Dr. St. Thomas	519-633-0090	Ann Gare
Sarnia Coll. Inst. & Tech.	275 Wellington St.	519-336-6131	Rhonda Galler
South Huron Dist. H.S	92 Gidley St. Exeter	519-235-0880	Michelle Carter
St. Clair S.S	340 Murphy Rd. Sarnia	519-332-1140	Rhonda Galler
Stratford Central S.S.	60 St. Andrew St.	519-291-4500	
Stratford Northwest S.S.	428 Forman Ave	519-291-9740	
Strathroy Dist. Coll. Inst.	361 Second St.	519-245-2680	Joanne Lubansky, Hank Bervoets (Gdnc)
Woodstock Coll. Inst.	35 Riddell St.	519-537-1050	Justine DeLuca

Community Centres, Groups and Social Services for Environmental Scan (2006):

Bluewater Volunteer Youth Centre	519-524-2107 (ext. 279)
Child & Family Counselling Centre of Elgin	519-637-2673
Family Services Thames Valley (London)	519-433-0183
Goderich Social Services	519-482-8505
Goderich Victim Services	519-524-4108
Grand Bend Area Health Centre	519-238-2362
Grand Bend Big Brothers/Big Sisters	519-235-3307
Grand Bend Community Health Centre	519-238-1556
Huron/Perth Children's Aid Services	519-271-5290
Huron/Perth County Child-Youth Services	519-291-1088
Ingersoll Youth Centre	519-425-1181
Oxford Health, Ann Gare (RN)	519-539-9800
Rick Graff & Associates	519-273-2522
Sarnia Community Directory	519-332-0330 (ext. 200)
St. Mary's Community Services	519-284-3272
St. Mary's YMCA	519-284-2500
St. Mary's Youth Centre	519-284-9965
St.Thomas Memorial Community Centre	519-633-7112
Strathroy/ Alvinston Resource Centre	519-898-5252
Stratford Community Services	519-271-0250
Stratford Social Services	519-271-3773 (ext. 252)
Stratford YMCA	519-271-0480
Strathroy Youth Centre	519-245-4272
Talbot Teen Centre (St.Thomas)	519-631-8820
Tavistock Community Health	519-655-2322
Tillsonburg Community Centre	519-688-9011
Upper Deck Youth Centre (Listowel)	519-291-9296
Woodstock City Hall	519-539-1291
Woodstock General Hospital	519-421-4211

PFLAG Canada, Focused southwestern Ontario Chapters

London, ON. (pflaglondon@hotmail.com)

Andrew

King, Joanne

Sarnia-Bluewater, ON. (sarniabwon@pflagcanada.ca)

Lambert, Ruth

Learn, Betty & Richard

Port Huron, MI

Coulter, John & Roberta

Public Health Departments and Clinics for Environmental Scan (2006):

Chatham-Kent Public Health Services, Chatham, ON.

<http://www.chatham-kent.ca/>

519-352-7270

County of Lambton Community Health Services Dept., Point Edward, ON.

<http://www.lambtonhealth.on.ca/>

519-383-8331

County of Oxford-Dept. of Public Health & Emergency Services, Woodstock, ON.

<http://www.county.oxford.on.ca/healthservices/ocbh/>

519-539-9800

Elgin-St.Thomas Health Unit, St.Thomas, ON.

<http://www.elginhealth.on.ca/>

519-631-9900

Huron County Health Unit, Clinton, ON.

<http://www.huroncounty.ca>

519-482-3416

Perth District Health Unit: Listowel Clinic

519-291-4200

Middlesex-London Health Unit, London & Strathroy, ON.

<http://www.healthunit.com>

519-663-5317

Murray, Brenda, RN, Pt.Stanley, ON.

(Sexuality consultant, private practice)

1-888-582-7326

Perth District Health Unit, Stratford & Listowel, ON.

<http://www.pdhu.on.ca>

519-271-7600 (ext. 267)

Stratford Sexual Health Clinic

519-271-0375 (ext. 704)

Strathroy General Hospital

519-245-3935

Key AIDS Service Organizations (ASO) Targeted for Environmental Scan (2006):

AIDS Action Perth http://www.aidsperth.ca	519-272-2437
AIDS Committee of North Bay and Area http://www.aidsnorthbay.com	705-497-3560
AIDS Committee of Windsor http://www.aidswindsor.com	519-973-0222
AIDS Thunder Bay http://www.tbaytel.net/actb	1-800-488-5840
HIV/AIDS Regional Services, Kingston, ON. http://www1.kingston.net/~hars/	613-545-3698
Peterborough AIDS Resource Network (PARN) http://www.parn.ca	1-800-361-2895