Sexual health determinants in black men-who-have-sex-with-men living in Toronto, Canada

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Abstract

Purpose – *The purpose of this paper is to develop a profile of the sexual behavioural characteristics of black men who have sex with men (MSM) in the Greater Toronto Area (GTA), Canada who constitute a unique mixture in terms of background, race, ethnicity, and culture. Having a profile of the sexual health and risk taking behaviours of these men is important since it provides information on these black Canadian men in comparison other black MSM.*

Design/methodology/approach – *Data were collected as part of a cross-sectional study of black MSM in GTA. Survey participants completed a questionnaire requesting information on socio-demographic characteristics, sexual behaviour, general and mental health, and awareness of social marketing strategies for gay men. The study was conducted in 2007-2008, through convenience sampling. Based on the data collected, the authors characterized the profile of black MSM with respect to sexual risk behaviours.*

Findings – *The authors collected data on 168 black MSM. These men perceived their general health to be good. However, a large proportion of them practiced inconsistent condom use but this varied according to the ethnicity of the partner. Inconsistent condom use also varied by place of birth with Canadian-born men and Caribbean-born men less likely to consistently use condoms than African-born men. In multiple regression analysis, being born in Africa favoured condom use. Men were also more likely to practice inconsistent condoms use when the sexual partner was non-black. Further, when sex with other black men was examined, those who were older (⩾30 years) and had not disclosed their sexuality were more likely to stop using condoms. Other variables which were expected to have associations with inconsistent condom use, based on studies in other jurisdictions – such as previous sexually transmitted infections, sex with women, sex while travelling, and drug use were not related to inconsistent condom use.*

Research limitations/implications – *While the survey data were based on a relatively small sample size and may not be representative of the entire black MSM population in the GTA, it provides a basis for ongoing and targeted support for black MSM particularly those born in Canada. Older men who are not open with their sexuality may be at a risk of acquiring or transmitting HIV. Future research should focus on these men.*

Originality/value – *This report provides a perspective on the sexual health and risk taking behaviours of black MSM in Canada. This is particularly important since their social history and health determinants are different from those of US African Americans. The results will stimulate further research targeting this group, and support HIV programmes and services for these men.*

Keywords *Ethnicity, Health, Race, Sexuality*

Paper type *Research paper*

Introduction

There is a paucity of research on the sexual health and risk taking behaviours of black men who have sex with men (MSM) in Canada. As a result, assumptions about black MSM are often made based on data from white MSM in Canada or black MSM in the USA. Yet, black MSM in

Canada have historical and social profiles that differ from those in the USA, and they experience life through a different social prism than the white MSM population.

People of African descent have lived in Canada since the early days of the British and French empires. In the 1700s, black Loyalists from the USA resettled in Nova Scotia and Ontario and were later joined by former slaves through the "underground railroad" (Milan and Tran, 2004; Nelson, 2008). Since the 1960s, Canada's black population increased steadily due to immigration from the Caribbean and sub-Sahara Africa (Milan and Tran, 2004). In the Greater Toronto Area (GTA), black people make up 7.2 per cent of the population, and 2.9 per cent of the Canadian population overall (Statistics Canada, 2013). Further, 42 per cent of black people in Canada live in Toronto and more than 8.9 per cent are at least third generation Canadian (Statistics Canada, 2013).

Undeniably, black people in North America face racial discrimination (Reed *et al.*, 2013). Black people in the USA may experience and deal with discrimination differently than black people who are Canadian born or who have recently immigrated to Canada. The legacy of colonialism has had a negative impact on African and Caribbean countries, leading to racial discrimination in countries such as South Africa and to racial cleansing in Rwanda (Baynes, 1997; Hintjens, 2001). Various forms of racism continue against black Canadians (Nelson, 2008), but many immigrants migrate for economic purposes. However, racial discrimination, largely formed on principles of slavery, has always been part of the cultural fabric for black Americans (Bobb, 2001).

With regards to health outcomes, little research has compared the experience of black people born in Canada, or those who migrate from the Caribbean or Africa, with the experience of black Americans, although the latter is often used as a benchmark for Canada. Within the USA, some research indicates that there are differential health outcomes, particularly among black immigrants compared to black Americans, in regard to HIV risk behaviour and testing (Johnson *et al.*, 2010; Villanueva *et al.*, 2010), often with better outcomes in the immigrant groups. Like the USA, heterogeneity in health outcome will exist among black Canadians due to the various factors impacting their health (Rothenberg *et al.*, 2007; Hoffman *et al.*, 2008).

Most of the health literature on MSM is tied to the HIV epidemic. A recent meta-analysis of data from black MSM in the UK, USA, and Canada found similar sexual risk factors, substance use, and combination antiretroviral use (Millett *et al.*, 2012). While parallels can be drawn with black MSM in other regions, it is important to recognize that the social and historical context of black MSM in the USA and the UK differs from that of black MSM in Canada.

Several factors contribute to healthy sexuality, including good physical and mental health, self-perception and self-esteem, socialization and acceptance, perception of risk, housing security, and substance use (World Health Organization, 2006). Among MSM, unprotected anal intercourse is often used as a proxy measure of sexual health since it is the most important risk factor for HIV transmission (Koblin *et al.*, 2006). MSM continue to have a high frequency of anal sex without condoms, despite their knowledge of HIV transmission (Phillips *et al.*, 2013). Various reasons have been put forward to explain this, including condom fatigue, erectile difficulties, momentary lapses and trade-offs, personal turmoil and depression, and the advent of combination antiretroviral therapy (Adam *et al.*, 2005; Mustanski *et al.*, 2011). This study examines the sexual health of black MSM in Toronto, Canada as indicated through sexual risk factors such as inconsistent condom use.

Methods

This study utilized quantitative data from the MaBwana study, a mixed-method study of black MSM in the GTA carried out in 2007-2008 (George *et al.*, 2012). Participants in the MaBwana study self-identified as black men, were 18 years of age or older, were living in, or regularly socializing in the GTA, and self-identified as gay, bisexual, trans, or as straight MSM. The current study examines the proportion of the MaBwana study participants who reported having anal sex with another man within the previous 12 months. The study was administered in English. Research Ethics Board approval was obtained from the University of Toronto, University of Windsor, and the University Of Ontario Institute Of Technology.

A community advisory committee (CAC) was formed to ensure that the study remained relevant to black MSM communities. The CAC was composed of eight men knowledgeable about African, Caribbean and black lesbian, gay, bisexual, trans, and queer (LGBTQ) communities in the GTA through voluntary and professional affiliation. The CAC advised the research team on recruitment, data analysis and interpretation (George *et al.*, 2012).

A biostatistician helped determine the appropriate sample size, as no sampling frame existed. The sample size was 168. The MaBwana study began in June 2007 during the weekend of Toronto Pride Week. Volunteers of various genders, ages, and ethnicities, equipped with a poster of the study, invited men to participate. After verifying eligibility, men were given additional information about the study and their questions were addressed. Eligible men completed the survey in a private polling station, which took approximately 30 minutes. Participants received an honorarium of $20 and materials on sexual health services in the GTA. About 50 per cent of the target sample was recruited at Toronto Pride Weekend and outreach continued until January 2008, with recruiters reaching out to "hidden" black MSM, who may not patronize public LGBTQ events (as described in the description of the sample, below).

Measures

The questionnaire collected information on socio-demographics, relationship status, substance use (including anti psychotic/anti-anxiety prescription medication), sexual practices, and affiliation with both LGBTQ networks and black community networks. We also asked participants whether they had disclosed their sexuality to anyone. As religion has been shown to be important in the lives of black people (Woodyard *et al.*, 2000; Valera and Taylor, 2011), we asked about attendance at religious services and involvement in religious organizations. For the purposes of the study, "inconsistent condom use" was defined as any response other than "all of the time" when asked about condom use during anal sex.

We used a single item measure of general health (Simon *et al.*, 2005; Bowling, 2005). To assess psychological wellbeing, participants completed the Centre for Epidemiologic Studies Depression Scale, short version 10 (CES-D10) (Lee and Chokkanathan, 2008), and we report on a cut-off value of 10 (Lee and Chokkanathan, 2008; Akena *et al.*, 2012). Before and during the study, there were several HIV awareness campaigns in the GTA. Participants were shown snapshots of the campaign slogans and asked whether they had seen or knew about these campaigns and whether the campaigns were personally meaningful. Examples include "Do you remember seeing [snapshot of campaign]?" "How useful was [it] to you?".

Social engagement with black communities was measured by the item "Do you spend most of your free time with other Black/African/Caribbean people?".

Data analyses

Data analyses were conducted using SPSS. Standard descriptive statistics were examined using frequency distribution. Bivariate relationships were examined using χ^2 and Fisher exact tests as well as Pearson correlation and ANOVA for continuous variables. Age, a continuous variable, was later categorized to best fit the data.

We constructed multivariable analyses to test for the association between inconsistent condom use and other variables. As we had no a priori hypothesis, we first checked for associations in bivariate analyses, checked for Pearson correlation, then entered variables through stepwise logistic regression. Multivariable analyses were conducted using binary logistic regression with reported odds ratios and 95 per cent confidence intervals with inconsistent condom use as the dependent variable.

We also examined the relationship between inconsistent condom use by type of partnership (regular, casual) and by sexual positioning (bottoming-receptive, topping-insertive). A logistic regression analysis was conducted to assess the relationship between age, education, place of birth, circumcision status, religious service attendance, HIV testing, and having friends/family who died from HIV, in stepwise logistic regression model based on a $p \leqslant 0.05$.

In a further logistic regression analysis, we looked at those who used condoms inconsistently with men of other ethnicities excluding white men (Latino, Asians, etc.).

Results

We recruited 168 men; 88 (52.4 per cent) at Toronto Pride, 20 (11.9 per cent) at dance clubs in the GTA, 12 (7.1 per cent) at bathhouses, 35 (20.8 per cent) through voluntary calls to the study coordinator and 13 (7.7 per cent) at LGBTQ community agencies in the GTA. One-third of participants (33.7 per cent) were Caribbean-born, with the remainder born in Canada, Africa and elsewhere (see Table I). Caribbean-born participants ($n = 53$) had longer residency in the GTA compared to men from Africa ($n = 40$) ($p < 0.0001$). Participants ranged in age from 16 to 61, with a mean age of 33 and a median age of 31. Most participants reported living in stable housing (89 per cent) defined as living in an apartment, house or condominium, and 49 per cent

Table I Demographic and social characteristics of the participants

Characteristics	*Frequency*	*%*
Sexual orientation		
Gay or homosexual	90	58.4
Bisexual	43	27.9
Straight/heterosexual	13	8.4
Queer/other	8	5.2
Residence in GTA (years)		
<2	30	18.8
2-4	21	13.1
5-9	17	10.6
10+	73	45.6
Live outside GTA	19	11.9
Geographical birth place		
Canada	49	30.1
Africa	40	24.5
Caribbean	55	33.7
Other	19	11.7
Education		
<High school	28	16.7
Completed high school	14	8.3
Some college/university	50	29.8
Completed college/university	50	29.8
Graduate/professional	26	15.4
Income (individual)		
<10,000	38	23.8
$10,000-19,999	26	16.3
$20,000-29,999	19	11.9
$30,000-39,999	23	14.4
$40,000-49,999	17	10.6
$50,000-59,999	14	8.8
$60,000 or more	23	14.4
Relationship status		
Single	125	77.6
Married or common law	18	11.2
Divorced or separated	7	4.4
Other	11	6.8
Attends religious services		
Never	47	30.5
Once or twice/year	51	33.1
Weekly/monthly	56	36.4
Housing		
Unstable	18	11.1
Stable	144	88.9

Note: $n = 168$

lived alone. While many participants were raised in a religious faith, almost one-third no longer attended religious services ($n = 47$; 30.5 per cent).

Two-thirds of the participants rated their health as "excellent" or "very good" (see Table II). However, those who reported being HIV-positive ($n = 34$) rated their health as "excellent" least often and opted for "fair" (data not shown). The distribution of substance use in the entire sample is shown in Table III, with high rates of alcohol use (78.4 per cent) and marijuana use (43.5 per cent). Crack use was also high, with almost 20 per cent reporting occasional or frequent use. In bivariate analyses (not shown), substance use was not associated with inconsistent condom use.

Most participants (58.4 per cent) identified as gay or homosexual, 27.9 per cent identified as bisexual, 8.4 per cent identified as straight or heterosexual, and 5.1 per cent reported alternative descriptions (e.g. pansexual). There was no difference in reported sexual identity according to place of birth. Three participants identified as trans men in addition to identifying as gay, bisexual or queer. Most participants (59.5 per cent) reported that they had disclosed their sexual orientation to close friends and 11.3 per cent had not disclosed to anyone.

Of those who reported receiving an HIV test ($n = 144$), 22 per cent ($n = 34/144$) reported being HIV-positive. Of these men, 25 (74 per cent) had disclosed their HIV status to close friends or relatives and three (8.8 per cent) had not disclosed to anyone. Almost half (47.9 per cent) of the participants reported having lost a family member, friend, or sexual partner to AIDS, and 60 per cent were close to someone currently living with HIV. Men who were born in Africa (70; 60 per cent) or the Caribbean (68; 54.8 per cent) were more likely to have experienced a loss due to HIV/AIDS, or to know of someone living with HIV, compared to those born in Canada (50 per cent; 28 per cent) ($p = 0.015$; $p = 0.05$, respectively).

Table II General and psychological well-being of participants

Variable	*Frequency*	*%*
General health		
Excellent	53	32.9
Very good	56	34.8
Good	42	26.1
Fair	9	5.6
Uncertain	1	0.6
Gonorrhea		
No	114	67.9
Yes-past 12 months	4	2.4
Yes- >12 months	15	8.9
Syphilis		
No	119	70.8
Yes-past 12 months	2	1.2
Yes- >12 months	6	3.2
Chlamydia		
No	107	63.7
Yes-past 12 months	6	3.6
Yes- >12 months	16	9.5
Hepatitis A vaccinated		
No	52	31.0
Yes	75	44.6
Unknown	33	19.6
Hepatitis B vaccinated		
No	31	18.5
Yes	116	69.0
Unknown	18	10.7
Prescribed anti-depressive medications		
No	143	85.1
Yes	18	10.7
Unknown	2	1.2

Notes: $n = 168$. n may not add up to 168 due to missing values

Table III Alcohol and recreational drug use among participants, past 12 months

Variable	*Frequency*	*%*
Alcohol		
Never	18	10.7
Occasionally	99	58.9
Often	34	20.2
Marijuana		
Never	69	41.1
Occasionally	47	28.0
Often	31	18.5
Poppers		
Never	108	64.3
Occasionally	24	14.3
Often	6	3.6
Special K/Ketamine		
Never	129	90.2
Occasionally	14	9.8
Often	–	
Ecstasy/MDNA		
Never	124	73.8
Occasionally	16	9.5
Often	2	1.2
Crystal Meth		
Never	133	93.7
Occasionally	9	3.3
Often	–	
Erectile stimulants (Viagra, Levitra, Cialis)		
Never	129	76.8
Occasionally	12	7.1
Often	3	1.8
Cocaine/crack/freebase		
Never	114	67.9
Occasionally	16	9.5
Often	17	10.1
Tranquilizers (Valium, Rivotril, etc.)		
Never	134	93.1
Occasionally	10	6.9
Often	–	

Notes: $n = 168$. n may not add up to 168 due to missing values

Among those who had seen any of the HIV awareness campaigns, 55 per cent reported seeing Keep it Alive, and 43 per cent reported seeing Be Real (both of which featured black men), but fewer reported seeing the other campaigns (Condom. Unwrapped; Cruising; Getting Together; Are You Negative About Positives?). Based on our bivariate analyses, knowledge and awareness of most local campaigns were limited. We observed no associations between campaign awareness and inconsistent condom use.

The following analyses focus on the 134 participants (79.8 per cent of the total sample) who reported having anal sex with another man in the past year. The 19.2 per cent who reported not having anal sex in the previous year did not differ in socio-demographic characteristics from the overall group of participants, and were not included in further analysis. Of those included in the analysis, more than three-quarters (76.9 per cent) were sexually active in the month preceding the survey; 17.9 per cent had been sexually active between one and six months and 5.2 per cent were sexually active between six months and one year preceding the survey. In total, 17 per cent reported only one past-year partner, 40 per cent reported two to five partners and 43 per cent reported more than six. The most popular places men sought sexual partners were the internet (56 per cent), gay bars and clubs (40 per cent), and bathhouses (34 per cent).

Of the 134 men who had sex within the previous year, 115 (85.8 per cent) reported on condom use. In total, 66 (57.4 per cent) black MSM reported having inconsistent condom use whereas 49 (42.6 per cent) reported using condoms consistently. In the bivariate analysis (see Table IV), unstable housing ($p = 0.02$), higher depressive scores on the CES-D10 ($p = 0.06$), and being born in either Canada or the Caribbean ($p = 0.04$), were significantly associated with inconsistent condom use.

Nearly a third of men (32 per cent) were classified as having symptoms of depression based on the CES-D10 scale. Yet, only 13 per cent indicated that they were prescribed medication for psychological distress.

Participants were asked about the ethnic background of their sexual partners (white, black, other). Some participants reported having sex with men of more than one ethnicity and are included in more than one "sex by ethnicity preference group". There was a significant association between inconsistent condom use and having sex with a man of another ethnicity as opposed to having sex with black men only ($p = 0.02$). In a sub-analysis, men who did not use a condom for anal sex with other black men, as opposed to those who used condoms consistently with other black man, were less likely to have disclosed their sexuality, were older and displayed higher levels of depression.

Place of birth played a significant role in inconsistent condom use: Men who were born in Africa or the Caribbean were less likely to have unprotected sex ($p = 0.02$) compared to those born in Canada.

In logistic regression analyses, inconsistent condom use while topping with a regular partner was more likely when the partner was not black (OR 4.08; 95 per cent CI 1.11-14.9), adjusting for the interaction between "having friends with HIV" and "having multiple partners". Inconsistent condom use among men who reported topping with a casual partner was associated with being born in Canada vs outside Canada (OR 3.37; 95 per cent CI 1.04-10.95); having low depression scores (OR 0.38; 95 per cent CI 0.12-1.20) did not reach statistical significance. Inconsistent condom use among men who reported performing as bottom with a regular partner approached statistical significance with having partners who were of other ethnicity (OR 3.05; 95 per cent CI 0.79. Consistent condom use when bottoming with a casual partner was associated to having friends with HIV (OR 9.09; 95 per cent CI 1.22-50). Black MSM who used condoms inconsistently with other black men were more likely to have undisclosed sexual identity (OR 7.69; 95 per cent CI 1.30-50).

Black MSM who were not socially engaged within black communities practiced more inconsistent condom use than those who were socially engaged. Moreover, there is evidence to

Table IV Factors associated with unprotected intercourse among black MSM irrespective of the HIV serostatus – the past 12 months

	Unprotected intercourse any partner			*Logistic regression adjusted model*		
Variable	*Yes (%)*	*No (%)*	*p-value*	*OR*	*95% CI*	*p-value*
Sex with black men						
No	64.0	36.0	0.02			
Yes	37.2	62.0				
Housing						
Stable	37.1	62.9				
Unstable	71.4	28.6	0.02	0.34	0.09-1.27	0.11
Birth origin						
Canada	57.6	42.4				
Africa	25.0	75.0		Afr. vs Carib 0.41	0.14-1.23	0.02
Caribbean	41.9	58.1	0.04	Can vs. Carib 1.85	0.73-4.7	0.02
Depression score						
Low	34.8	65.6				
High	54.6	45.5	0.06			

Notes: $n = 115$. Afr., born in Africa; Carib, born in the Caribbean; Can, born in Canada

suggest that social support could impact sexual risk behaviour (Kegeles *et al.*, 1996; Peterson *et al.*, 1992). Men who were born in Canada were more likely to practice inconsistent condom use compared to foreign-born men. When the data for Caribbean and Canadian men were separated, men born in Africa had higher consistent condom use than Caribbean and Canadian born men. While the reason for inconsistent condom use cannot be explained from the data, other studies suggest that condom use is stigmatized for reasons of religion or masculinity (Kocken *et al.*, 2006; McKeown *et al.*, 2010; Jayakody *et al.*, 2011; Doyal *et al.*, 2008).

Discussion

The major factors approaching significance associated with inconsistent condom use were sex with a non-black man; being born in Canada or the Caribbean; having unstable housing; and having high depression scores. Almost 60 per cent of men in our study reported inconsistent or no condom use during anal sex with men in the previous year. This is an important outcome since unprotected anal intercourse is the most important risk factor for HIV infection in MSM (Baggaley *et al.*, 2010; Vittinghoff *et al.*, 1999). This may partially explain the high HIV prevalence among black MSM in Canada. However, unprotected anal sex among monogamous couples who are known to be HIV negative cannot be a risk factor – a fact that our study could not discern.

Men in our sample were more likely to use condoms consistently with other back MSM compared to men of other ethnicities. Our questionnaire was not designed to probe reasons for this, as it was an unexpected finding. We speculate that black MSM may assume that there is more risk of contracting HIV from other black men or perhaps they may have a sense of responsibility towards other black MSM. Social power differentials between black and white MSM and men of other ethnicities may influence their decision to have sex without a condom. Brennan *et al.* (2013) suggests that black men may be intrigued that their bodies are desired by non-black men and are willing to discard safety for such an encounter (Brennan *et al.*, 2013). We were not able to test if black men "trade-off" safe sex in interracial encounters, as suggested by Adam *et al.* (2005). Our findings contrast with studies in which black men use condoms less with other black men but more with white men (Clerkin *et al.*, 2011). Clerkin *et al.* (2011) argue that it may be easier to negotiate safer sex when both members of the sexual partnership are black. Our results suggest a continued need for sexual health and HIV prevention programmes for black MSM, particularly interventions that increase skills to negotiate and practice safer sex.

Determining the reasons behind inconsistent condom use as a function of the ethnicity of sexual partner(s) could have important public health implications. In a sub-analysis, men who did not use a condom for anal sex with other black men, as opposed to those who used condoms consistently with other black man, were less likely to have disclosed their sexuality, were older and displayed higher levels of depression. Based on the evidence that depression and sexual orientation non-disclosure increase the risk of HIV transmission, some men in our study may be at high risk for HIV acquisition or transmission (Jimenez, 2003; Berry *et al.*, 2007).

We found high rates of depression symptoms based on the CES-D10 scale (32 per cent), yet relatively few men (13 per cent) report being prescribed medication for psychological distress. This is in keeping with Williams *et al.* (2007), who found high rates of major depressive disorders among African Americans and Caribbean blacks, and noted that such depression was usually untreated. Reisner *et al.* (2009) observed similar findings with MSM and evaluated depression as a risk factor for HIV. Carefully planned studies in this area are warranted.

A large proportion of men in our sample identified as gay or bisexual but many maintained a heterosexual identity, similar to study findings in the USA (Siegel *et al.*, 2008). It has been said that identity is constructed by many factors, including culture and the impact of the media (Gomillion and Giuliano, 2011; Icard, 1986). In bivariate analyses, there was no association between inconsistent condom use and sexual identity.

Drug use is a risk factor for condomless sex and HIV (Campsmith *et al.*, 2000). The percentage of black MSM reporting crack use in our study (20 per cent) was higher than in a US study among black MSM where past-month crack/coke use varied from 1.5 to 15.7 per cent

(Mimiaga *et al.*, 2010). This may be an important area for public health intervention in reducing overall sexual risk in black MSM.

Our recruitment of black MSM was successful due to our community-based research approach, a strategy that has been successful in other research with black MSM (Anderson *et al.*, 2009). Using this approach, many of the men were willing to complete the study and verbally indicated that a study focusing on black MSM was long overdue. While the sample size was small, we were able to recruit men with a wide range of socio-demographic characteristics.

Conclusion

The study indicates that black MSM have varied sexual behaviours, with some men engaging in inconsistent condom use, depending on the ethnicity of the partner. To promote sexual health, it is important to examine why men practice inconsistent condom use (e.g. seroadapting, thrill seeking, stigma and isolation, depression). At issue for many is acknowledging their sexuality and recognizing it as positive. LGBTQ organizations need to support men to be open about their sexuality and help them take positive action to enhance their health.

Limitations

Several methodological limitations must be noted in interpreting our study. First, this is a cross-sectional study and, due to the recruitment strategy, is not representative of all black MSM in the GTA. We did not measure levels of acculturation and this may have an impact on the lived experiences of men (e.g. labeling, sexual practices). The study is also based on data collected to assess HIV risk, so some data regarding sexual health were not collected. Men who completed the study were motivated to participate and volunteer bias could affect the results. Finally, the sample size was small and not based on a statistical strategy, further reducing its generalizability. We could not disaggregate data for further statistical analyses particularly with regard to inconsistent condom use by ethnicity of partners. Despite these limitations, the study provides primary data that add to the much-needed sexual health information and provides direction for future studies.

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