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# Improving the Access to And Quality of Public Health Services For Lesbians and Gay Men

## A Position Paper for the Ontario Public Health Association

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## **Definitions of Terms Related to Sexual Orientation** (Chesley et al, 1999)

**Homophobia:** Fear and hatred of lesbians, gays and bisexuals (homosexuals), often exhibited as prejudice, discrimination, harassment, and acts of violence.

**Internalized Homophobia:** The inner feelings of fear or shame felt by lesbian, gay or bisexual people about their sexuality. These are often caused by negative attitudes and/or personal prejudices.

**Heterosexual:** Someone who is physically and emotionally attracted to people of the opposite sex.

**Homosexual:** Someone who is physically and emotionally attracted to people of the same sex. Because the term is associated historically with a medical model of homosexuality, most homosexual people encourage the use of the terms lesbian, gay and bisexual.

**Gay:** A term for “homosexual”. This can refer to both males and females, but is increasingly used to refer to men only.

**Lesbian:** A female “homosexual”.

**Bisexual:** Someone who is attracted physically and emotionally to persons of the same and opposite sex.

**Sexual Orientation:** The physical and emotional attraction of someone to persons of the opposite sex, same sex, or both sexes – a state of being attracted to anybody. Three forms of sexual orientation are labeled heterosexual, gay/lesbian, and bisexual.

**Sexual Behaviour:** How someone expresses himself or herself sexually.

**Sexual Identity:** How an individual presents to the world, i.e. heterosexual identity, gay/lesbian, bisexual identity.

**Gender Identity:** Someone’s sense of being male or female.

**Gender Role:** Refers to characteristics attached to culturally defined notions of femininity and masculinity.

**Transsexual/Transgendered:** Someone whose gender identity is different from her or his biological sex. For example, a biological male who would describe himself as a woman trapped in a man’s body.

**Cross Dressing:** The practice of wearing clothes of the opposite sex which is for erotic enjoyment. Many transvestites are heterosexual men. Often referred to as transvestism (noun, transvestite).

**Drag Queen/King:** Someone who dresses up in clothing of the opposite gender for fun and entertainment. For example, a gay man who dresses up as a woman to attend a social function is called a “Drag Queen”, a woman would be a “Drag King”.

**Female Impersonator:** A man who dresses as a woman to perform professionally in public.

**Heterosexism:** The belief that heterosexuality is superior to any other form of sexual orientation, the idea of inherent superiority. The assumption that everyone is heterosexual unless otherwise indicated.

**Coming Out:**

1. The developmental process through which lesbian, gay and bisexual people recognize their sexual orientation and integrate this knowledge into their personal and social lives.
2. It may also be used to mean disclosure to another person. For example, “I just came out to my parents”.

## Preface

A subcommittee of the Access and Equity Standing Committee of the Ontario Public Health Association began meeting to discuss the actions needed to support lesbians, gay men, bisexuals and transsexuals in our communities. Called the Public Health Alliance for Lesbian, Gay, Bisexual, Transsexual Equity (PHA), the subcommittee has as its mission: a world where sexual orientations are not merely tolerated, but are appreciated and celebrated. Our goals are energetic:

1. Heterosexism and homophobia will be eliminated in Ontario health units, community agencies and within the communities we serve.
2. Accessible, inclusive services and environments providing appropriate, quality care for lesbian, gay, bisexual and transsexual persons will exist across Ontario.
3. Healthy communities and organizations will support, appreciate and celebrate sexual orientations and diversity.

This paper is our first action toward achieving these goals. It is intended to provide the Ontario Public Health Association with a framework to improving the quality of care and the accessibility to health services for lesbians and gay men. This is a complex topic with a broad reach of issues impacting lesbians and gay men. The paper is therefore, not an exhaustive exploration of the issues, it attempts to highlight issues, without expanding on each one.

Lesbians, gay men, bisexual, transsexual and transgendered people are sometimes assumed to be a homogeneous population minority. This assumption has been extended to a belief that the health service needs of individuals identifying in these ways are also similar. Papers such as this, that attempt to address a “collective set” of issues, needs and experience, may perpetuate this notion of sameness. But individuals who are marginalized by sexual orientation experience oppression in different ways (e.g., lesbians experience sexism in addition to heterosexism), and it is therefore important that distinctions are made.

The Public Health Alliance for Lesbian, Gay, Bisexual, Transsexual Equity recommends that bisexual, transsexual/transgendered people be represented as population groups who have a significantly different set of circumstances, experiences and barriers to health and social services than the lesbian and gay populations. For example, there is a complexity to the issues bisexual and transsexual people must deal with to live openly. Bisexuals must not only deal with social homophobia, but also the view that sexual orientation is a simple dichotomy (<http://www.biresource.org/>). Transsexual/transgendered people face discriminatory complexities that arise from gender identity, sexual identity, and sexual orientation (Namaste, 1995).

The Public Health Alliance does not feel that we can adequately represent the issues of bisexual, transsexual and transgendered people in this paper and have therefore chosen to speak specifically to the issues of lesbian and gay male populations. By taking a position that respects these differences, two separate position papers on the quality of and access to public health services for bisexuals and for transsexual/transgendered people require development in the next year.

The paper is presented in four parts. The issues of access facing many lesbians and gay men arise as a result of a social context in which there is oppression and discrimination. The first part of this paper reviews the social context and names the issues that perpetuate the experiences of discrimination and oppression. How the oppression becomes manifest within our communities and institutions is then described in such a way as to make clear where change can be directed.

Part two of the paper presents the evidence of how oppression impacts the health and well-being of gay men and lesbians. It does not offer an exhaustive review of the literature, partly because there are many basic health issues that have not been researched, and partly because an exhaustive review would unduly lengthen the paper.

The relevance of the health impacts, the social context, and the role of public health becomes clearer in the third part of the paper. This section illustrates and develops the position that sexual identity is not only linked to social and organizational constructs, but should also be considered as a determinant of health.

Finally part four, presents an action plan. Since public health services are legally, professionally and ethically obligated and mandated to understand the diversity of the population to whom service is provided, our role is to become well informed so that we can be inclusive and can work toward eliminating oppression at all levels (individual, community, organizational and societal). Our role is to identify potential health risks, educate our communities with the goal to change attitudes, while consistently providing insight and remaining sensitive to the issues.

There are six main actions referred to throughout this paper. Each is necessary to influence and change the conditions lesbians and gay men face when they engage health services. All actions are within the network of influence of the Ontario Public Health Association. They are:

1. The development of position papers that review and make explicit the issues that bisexual and transsexual people are faced with in terms of their access to health services. The PHA is committed to this task.
2. The development of a collaboration to facilitate and advocate for changes to the Ontario Mandatory Core Guidelines, Program Standards. The recognition of special populations such as lesbians and gay men must be part of programming for Healthy Children, Parenting, Reproductive Health, Family Health, Cancer Detection, Chronic Disease. Currently, sexual orientation is included with and limited to Sexual Health. This is insufficient to meet the needs of lesbians and gay men.
3. Support the development of a collaborative network of community and other sector partners working toward the development of accessible and inclusive services.
4. Advocate for a national long-term research strategy. This is needed to support an evidence-based practice.
5. Advocate for health professional education that includes issues of oppression, diversity, discrimination, and the health impacts that are concomitant with the social determinants of health.
6. Work toward the elimination of discrimination, a long-term goal that will impact on social attitudes and perceptions. To begin this work, a Multi-sector, Provincial Advisory Panel made up of health advocates from the lesbian and gay community, organizational decision-makers and ministry officials must be established. The committee would act to plan, recommend and ensure the provision of accessible services. A complaint procedure is also a necessary standard.

## **Introduction**

Mainstream discussions about sexual orientation often refer to the notion that about 10 percent of the population are gay or lesbian. More recent work on sexuality actually describes a fluid and changing range of expression for sexual identity throughout the lifespan and expresses the difficulty of determining actual percentages. This newer work, (Klein et al, 1990; Keppe & Hamilton, 2000), remains outside the “common knowledge” of many people, including many health professionals. Numbers are important to health professionals, because we try to determine the prevalence of an issue in order to inform our practice. However, discernment is difficult when people describe themselves in a variety of ways. And numbers become unimportant when we consider the impact of homophobia and heterosexism as forms of social control that affect all of us.

Kinsey (1953) described a range of attraction protocols, (from which the 10% number emerged), but his estimates were based on the premise that a gay or lesbian identity was solely a result of having sex with someone of the same sex. The assumption does not differentiate between sexual behaviour, sexual identity, and sexual orientation (see definitions). Many of the myths and stereotypes about gay men and lesbians were founded on the assumption that sexual identity is about sexual behaviours.

Some health professionals have distinguished between behaviour and identity in the sexual health literature for some time. Sexual health programs work from a base understanding that sexual behaviours may or may not be related to a person’s sexual identity, or their sexual orientation. What is not recognized in the current Mandatory Guidelines (1997) and current health professional education is that lesbians and gay men experience additional service needs that are not related to their sexual health. Service needs such as depression, suicide, and lack of social support remain unmet because of barriers associated with societal and systemic heterosexism, and with professional lack of knowledge (CLGRO, 1997).

Lesbians and gay men represent a diverse group in race, ethnicity, education, age, ability and sexual practice. They are impacted by the general social attitudes that perpetuate oppression from early childhood. This makes the issues that are important to health care providers far more broad than those traditionally considered. It is our obligation to understand the diversity of the population to whom we provide service, and we are required to attend to the social and political forces producing the inequities, and describe, theorize and explain the phenomena (Love, 1999, Raphael & Bryant, 2000).

## **Part 1 – Oppression as a Determinant of Health**

### **Societal Context**

As public health practitioners, it is important for us to understand the social-structural and political contexts that impact the health of the public (Raeburn & Rootman, 1998). We must also subscribe to an expanded view of health that is able to name and understand all the factors that impact upon health and well-being. When referring to a determinant of health, one supposes there are elements of control, otherwise it would not be named as a determinant. Like all forms of oppression, homophobia and heterosexism are forms of social control that are complex and multidimensional, occurring at the individual, community, organizational and societal levels. Each level of oppression is distinct, yet interrelated and serve to reinforce the oppression inherent in all levels (Onken, 1998). Discrimination and prejudice against gay men and lesbians is still an accepted and practiced form of prejudice in our current social environment (O'Brien et al, 1993; Simpson, 1994) requiring our attention.

The invisibility of gays and lesbians in our everyday lives contributes to the ongoing persecution. The social and political aspects of oppression are rooted in a belief that promotes the superiority of heterosexuality. It implies that heterosexuality is healthier, and makes the assumption that heterosexuality is all-inclusive (everyone is a heterosexual) and that other forms of expression are therefore deviant. The majority of health issues that lesbian and gay men face do not stem from sexual orientation but rather from rejection by society, which for many people leads to profound problems, (Clermont, et al 1997) and has been described by O'Hanlan (1998) as homophobic fallout. The invisibility of lesbians and gay men, and the nature of homophobia and heterosexism, results in the exclusion of relevant analyses in academic literature, which tends to be heteronormative (written always within the assumption of heterosexuality). For example, the Social Determinants of Health course at the University of Toronto, Department of Community Health, names gender, class, race and ethnicity as determinants. Missing from this analysis is homophobia and heterosexism as powerful forms of social control.

Recently, there have been many policy and legislative gains, such as same-sex workplace benefits, survivor benefits, and a change in the definition of spouse, that will go far in improving the lives of gay and lesbian people. The issues become complicated because the notion of "homosexuality" is still at the centre of a public debate that often evokes great emotional and moral fervor. Changing public policy is but a single strategy that contributes to social change. It is insufficient on its own to benefit the public health. Public health professionals have an obligation to be conduits that support and facilitate the development of supportive environments, and to eliminate discriminatory practices.

Contributing to the ongoing oppression of lesbians and gays are the myths and stereotypes that exist. These include the notion that there is "a gay lifestyle", that "its just a phase, she'll/he'll grow out of it," and that the "recruitment" of youth to the "lifestyle" is possible. There are many more. Stereotypes that assign personality traits such as 'butch', 'femme' or 'sissy boy' contribute to a climate of fear, hatred and social oppression. The multidimensional nature of homophobia leads to individual responses of self-hate and internalized oppression (Thompson et al, 1990). People in our culture, starting at very young ages, understand the social stigma for lesbians and gay men. The overt

expression of a response to social stigma and stereotypes may precipitate schoolyard incidences of bullying, harassment and name-calling.

Myths and stereotypes contribute to an oppressive environment through the devaluation of social roles and negative labeling of gays and lesbians. In addition, myths and stereotypes are structurally and culturally pervasive as “common knowledge”. All these individual influences result in social stigmatization. Stigma arises because in society it is predetermined that categorizing and assigning attributes to people is an ordinary and natural thing to do (Goffman, 1963). Children learn what constitutes stigma and that stigmatization hurts because it discredits and marks individuals as outside or marginal. In order to avoid such stigma, human beings learn it is necessary to hide their differences. Stigmatization decreases the life chances of people who are stigmatized (Onken, 1998). Social attitudes and understandings must be given a priority in this analysis. Homophobia is a form of social control that profoundly affects all people.

Within our social context we learn what is necessary to be acceptable as males or females, we learn our gender role. These too are stereotypes that have generalized acceptance and contribute to heterosexist assumptions. Lesbians and gay men often do not conform to these gender norms, but neither do many other people in the society. Rigid gender roles contribute to the oppression of all people regardless of their sexual orientation, because they leave people who express themselves differently open to violence and discrimination. Anyone who is even perceived as being a lesbian or a gay man is a potential target. Stevens (1992) indicates that “the patterns of civil liberties violation and abuse are similar whether the sexual orientation is assumed, based on rumor and opinion, or known, based on public record or verbal acknowledgement” (p.113). Heterosexism is a form of social control that profoundly affects all people.

As Nosal (1998) states: “The issue of homophobia has traditionally been neglected by health and social service agencies despite the tremendous impact it may have on the health and well-being of youth and other members of the community. Perhaps the most costly aspect of prejudice and discrimination against gays and lesbians, and hardest to quantify, is the limit it puts on human potential – the human potential that exists in every community, including ours” .... (p. 32).

### **Systemic Heterosexism**

The social learning described above exists within an ideology of heterosexism that is perpetuated by our institutions, including the health care system as documented in *Systems Failure* (CLGRO, 1997), *Opening Doors* (Simpson, 1994) and *No Safe Bed* (O’Brien et al, 1993). These three Ontario based reports illustrate the barriers to services experienced by lesbians and gay men. Systemic commitment to heterosexist assumptions ensures that many lesbian and gay people remain invisible. If they are invisible within the system, they will remain invisible within society, and our communities. The individual impacts of being invisible will continue (isolation, depression, high-risk behaviours), and the process of identity formation for gay and lesbian adolescents will therefore continue to be initiated in isolation.

The system discriminates when clients are welcomed by heterosexist assumptions at the time they approach institutions to engage services. Heterosexist assumptions include experiences such as exclusion from hospital visiting, and not having a “boyfriend” being equated with not being sexually active. Health care can only be considered accessible when lesbians and gay men are able to interact with professionals and the system in a manner that results in feelings of value, inclusion, safety and acceptance. A safe environment is one that respects confidentiality, anonymity when requested, and provides optimum care, but also validates and celebrates individual differences. A person must be able to perceive this safety at the moment of their initial contact, and throughout their interactions with the environment (Stevens, 1992; MacDonnell, 2000).

This is far from the experience of many people (CLGRO, 1997; Stermac & Sheridan, 1993; Stevens, 1994; White et al, 1995; Simkin, 1998; Davis et al, 2000 ). Rather, when lesbians and gay men engage the health care system or social services, they face biased, insensitive and inadequate practices with respect to their treatment or assessment. Many of our colleagues practice with inappropriate knowledge or expertise and are uninformed about lesbian and gay people, their issues, experiences, situations and relationships. Many never consider that their client may be more than who they see and what they hear in their offices (White et al, 1995; Simkin, 1998).

The result of systemic heterosexism is that lesbians and gay men receive less than adequate care, such as missed diagnoses and potentially poor treatment outcomes. Feelings of distrust and discomfort can lead to long-term rejection of the system, avoidance of regular examinations, failure to return for follow-up, reluctance to report health issues, and non-disclosure of sexual orientation to service providers (Gentry, 1992; Robertson, 1992; Davis et al, 2000). It is essential to modify services for all marginalized groups – poor people, ethnic minorities, and gays and lesbians (Clermont et al, 1997). Same-sex orientation crosses all social locations of class, race, ethnicity, age, ability, religion and professions and systemic heterosexism therefore cause gaps across all these locations.

The costs associated with such systemic gaps and inadequacies include: 1) personal health issues, 2) financial costs (insurance claims that result from inappropriate treatments) and 3) human resource potentials (CLGRO, 1997). Systems Failure (1997) states “The human costs to society include thousands of individuals who are highly stressed, and damaged in their self-esteem; their opportunity to become productive members of society is diminished” .... (p. xvii).

Public Health was reported as being the second most unwelcoming service within the province of Ontario (CLGRO, 1997). Negative experiences were reported by 16% of lesbians, gay men and bisexuals using public health services. In the same study, lesbians and gay men reported that they need to access health services for coming out issues, self-esteem and self-confidence, loneliness and isolation, family problems related to sexual orientation, and sexual abuse as a child. Two questions arise:

1. What service provider is best situated to respond to the needs of this client group?
2. Are the needed responses within the capacity of Public Health?



In answer to the first question, public health provides frontline access to services that include prenatal education, family and parenting education, as well as consultation and clinic services for sexual health. The public health mandate is to know of, and refer to resources in the community when appropriate (support groups, medical care). We therefore have two responsibilities. First, to advocate for the placement of community resources and community supports that are lesbian and gay positive and can respond to client needs. Since community organizations created by the gay and lesbian communities play an important role in the provision of service, collaborations with these agencies would serve to establish a political environment that will continue to support their work. This is important as public funding becomes tighter and financial survival becomes an issue for many lesbian and gay community organizations. Secondly; all public health services have a responsibility to provide an environment that is accessible through visible assurance that the public health environment is safe, approachable and gay and lesbian positive. Perceived safety is an essential component of facilitating access (Stevens, 1992; MacDonnell, 2000).

In response to the second question, whether the needed responses are within the capacity of Public Health, health unit capacity is limited by lack of training and by stigmatization; the ability to change ones reactions in order to counter heterosexist assumptions is met with suspicion. A step toward change would be to make the issue visible within our system and to the partners with whom we work. Learning about and then raising the issues that lesbians and gay men face is the responsibility of all public health professionals, in all divisions, in all parts of this province. Heterosexism within health care is unacceptable because it is a form of oppression and oppression does not benefit the public's health (Peel Health, 1997). Blumenfeld and Raymond (1988) quoted in Eliason et al. (1992), argue that:

“Mere tolerance actually promotes lesbian invisibility and allows for discriminatory practices to occur. [They suggested that] tolerance masks a basic underlying fear or hatred in individuals who cognitively support civil rights, but emotionally cannot accept lesbian sexuality. Tolerance is extended to children or immature individuals, thus often representing a condescending attitude.” (pp. 139-140).

It is not just the health care system that discriminates, heterosexism is pervasive within the educational system, the social services system and other government and non-governmental institutions. Health, because of the evidence of health impact, has a responsibility to collaborate with our partners to facilitate the development of non-discriminatory, welcoming and supportive services that are able to meet the needs of multiple client groups.

Health unit capacity is also limited by the paucity of literature and research that is available to drive and develop an evidence-based practice with regard to the provision of care to lesbians and gay men. The literature has been addressing lesbian and gay health concerns for many years. However, these publications are not necessarily indexed in ways that make the information accessible to professionals who require it (MacDonnell, 2000). One review of over 20 years of literature on lesbian health concerns found only four studies published in refereed journals (Stevens, 1992, cited in Trippet and Bain, 1993). Yet public health professionals base their practice on evidence from the research literature. Thus a recent article in the Journal of Public Health Medicine concluded that “if public health wishes to continue to claim that it is in the forefront of evidence-based decision-making, both the skills of the professionals and the resources available to them need to be improved” (Muir Gray, 1997). Getting off this cycle,

(no research on which to base practice, no funding to support research) will require health units to demand more information (MacDonnell, 2000). The Public Health Research, Education and Development Program should be approached to investigate the gaps in research. Health Canada has a role in the development of a national long-term research strategy.

Historically, health care training omits specific education surrounding the holistic needs of lesbian and gay clients, or focuses on specific issues such as HIV/AIDS or risk behaviours (Stevens, 1994; Townsend, 1997; Gibb, 1999). This places limits on the degree to which health care professionals are aware, informed, receptive and empathetic to needs. Dr. Allan Peterkin from the University of Toronto recently stated that in 1999 gays and lesbians are still uncomfortable disclosing their sexual orientation to medical doctors (Gibb, 1999). In the absence of disclosure, inappropriate testing, treatment, or referral is possible. Other health issues that are commonly avoided by health professionals include: preconception health, pregnancy and childbirth, partner inclusion, HPV screening, alternative insemination, domestic violence, and anti-gay violence. Ramsay (1994) cites specific incidents, such as a social worker who was unable to respond to a lesbian couple's request for a lesbian positive hospice and home care services in a situation of terminal illness (p. 24).

Medical residents in Peterkin's study perceive that their education with regard to lesbian and gay issues takes a pathological approach (Gibb, 1999). The Canadian Health Network on their website at <http://www.canadian-health-network.ca/customtools/homee.html>, is one of the most recent health resources available to the Canadian public. A description of a website link about homosexuality is written as follows, illustrating the pathological approach felt by medical students.

“... Defines homosexuality, outlines its **prevalence**, and summarizes social attitudes, including the possible reactions of family and friends to 'coming out'.” (emphasis added)

Using the word prevalence with regard to assumptions that are made about the number of gay, lesbian, bisexual, and transsexual/transgendered persons clearly indicates a lack of understanding regarding the complexities of generalization when it comes to sexual identity. In addition, prevalence is a common epidemiological term that reinforces a pathological approach, resulting in the medicalization of people. 'Prevalence' also reinforces that homophobia and heterosexism are efficient forms of social control. The site also uses the word homosexual, which is medical terminology. Most gay men and lesbians prefer not to use homosexual as a descriptive term.

Discrimination, prejudicial attitudes, lack of knowledge, myths and stereotypes are barriers to access. Equal access to health care is a basic human right in Ontario. It is within our capacity to advocate and develop criteria for the training of all health professionals in the post-secondary system in a manner that is inclusive of the needs of all client groups. Training for practicing health professionals is also necessary so that we can contribute to the deconstruction of heterosexism within our system.

## **Public Health Units as Workplaces**

Systems and institutions are also workplaces for many gays and lesbians. Workers who could be open about their sexual orientation in the workplace were more satisfied with their jobs (Centre for Research and Education in Sexuality, 1995, cited in McNaught, 1993).

“A mutually respectful work force that acknowledges and affirms its diversity is not only typically more productive, but also attracts and retains the “best and brightest” employees.” McNaught, 1993, p. xv)

McNaught goes on to state that “eliminating homophobia from the workplace profits everyone”.... (p. 1).

At a public forum held in the City of Toronto in 1993, health and social service agencies were identified as being among the worst employers in the province for employment equity for lesbians and gays. It was stated that in some environments there is fear that clients and service providers who are gay or lesbian will act inappropriately. No one would suggest that heterosexual interactions between clients and service providers might be inappropriate. Presently in public health, issues related to sexual orientation may be referred to people in the department that are seen as having a personal passion for the issue. It is not yet owned by all of us who provide service. Heterosexism is a power that controls and oppresses such that personal barriers and fears of being assumed to be “one of them” or “too gay positive” affect everyone. This is a public health reality.

Ramsay (1994) suggests that lesbian and gay staff provide a positive position that will benefit workplaces. They are able to affirm community reality as well as present their own requests for positive change. This is beneficial with regard to program development and placement, diversity in the workplace, and in the provision of leadership. But, she states that employees “will not do this unless they believe that their employer is making a serious and studied effort to create a homophobia-free and thus healthier work environment”.... (p. 25).

## **Part 2 - Health Impacts of Oppression**

### **Physical Health**

The difficulty in describing specific physical health issues pertinent to gay men and lesbians arises from the numerous problems with, and the inadequacies of the health care system, which ignores and maintains the invisibility (Buenting, 1993). Lesbians and gay men may be reluctant to give details to a health care provider, resulting in misdiagnosis and the possibility of inappropriate treatment (Lucas, 1992; Carroll, 1999). Another problem arises when the only information a health care provider may have regarding the health of lesbians and gay men is related to sexual health, which may or may not be related to the problem.

What is clear, however, is that many of the physical health/illnesses that lesbians and gay men present with to health care institutions may be visible symptoms of heterosexist and homophobic reactions. Conditions that inhibit disclosure of domestic and anti-gay violence may limit assessment of those who have been physically or sexually assaulted. Increased rates of depression, and alcohol and substance abuse are ostensibly related to the difficulties of living in a homophobic world.

O'Hanlan (1998) refers to what she terms "homophobic fallout". Homophobic fallout is the consequences of negative interactions with health providers who alienate lesbians and gays from the health care system, putting them at risk for higher morbidity and mortality from such things as cancer and heart attacks. These risk factors are applicable to all minority groups for whom discrimination is an issue.

### **Anti-Gay Violence**

Lesbians, gay men, bisexuals and transsexuals are the most frequent victims of hate crimes (Herek, 1989 as cited by The 519, 1998). The 519 Community Centre published a report on violence in 1998, which states that 78% of lesbians and gay men have experienced verbal assault because they were perceived as being gay or lesbian. Fifty percent of respondents had been threatened with physical violence. Most respondents (83%) knew of at least one person who had been gay-bashed. Statistics on the violence experienced by gays and lesbians tends to be under-reported and therefore do not represent the reality of experiences (The 519, 1998).

Gay men experience more verbal harassment by non-family members, threats, victimization in school and by police, physical violence, and intimidation than do lesbians (CLGRO, 1997). Lesbians face verbal harassment more often from family members, and have a greater fear of violence than gay men (Berril, 1990, cited in The 519, 1998). As well lesbians are at risk for misogynist, sexist and anti-feminist violence.

These hate crimes range from verbal assault and physical injuries, to death. The relationship of the violence to the reason for the violence makes it difficult for victims to seek medical attention. Often they feel the need to lie about the causes of injury in order to avoid disclosure of their sexual orientation. The psychological effects on victims include depression, anxiety, sleep problems, stress on personal relationships, self-doubt, and negative feelings about self. Lesbian and gay victims of violence often have nowhere to turn. Adapting services to respond to the lack of supportive places to access help should be considered a priority.

Current changes in legislation have resulted in changes in our social environment, including higher visibility of the lesbian and gay communities because the media reports on these changes. Accompanying such visibility is the explicit expression of anti-gay rights sentiment by politicians, and by religious, and community leaders. These statements are also represented in the media without an analysis of their discriminatory nature. Racist or sexist comments are named as such by the media and seldom tolerated, yet anti-gay comments are tolerated.

### **Domestic Violence**

Lesbians and gay men will often hesitate in reporting incidences of domestic violence because they fear the disclosure of their sexual orientation. Unknowns around confidentiality, court and legal issues can become an overwhelming experience. Often lesbians and gay men experience a lack of understanding of the seriousness of the abuse when reporting incidences of violence to a therapist, police officer or medical personnel.

Homophobia in society denies the reality of lesbians' and gay men's lives, including the existence of lesbian and gay male relationships, let alone abusive ones. When abuse exists, attitudes can range from "who cares", to "these relationships are generally unstable or unhealthy" (Finigan et al, 1997). Even in the lesbian and gay community, there is denial that domestic violence in same-sex relationships exists (Angeles, et al, 1999), and there is a sense of loyalty expressed as not wanting to give the community a bad name.

Some shelters for abused women are working to become more sensitive to same-sex abuse. The difficulties arise when service providers must identify the batterer and the victim within the couple. This is necessary because service needs for batterers and victims are different (Veinot, 1999). Abused gay men have even fewer agencies that offer a safe place to stay and few services that provide the support to regain control over their lives. Lehman (1999) cites a study of gay men where 92% of victims indicated they would seek support if it were available.

Lehman (1999) goes on to propose that programs for lesbians and gay men experiencing or perpetrating partner abuse can not be based on heterosexual domestic violence and abuse models. Services must adjust to the unique differences and difficulties associated with abuse in lesbian and gay domestic situations. Supportive funding for such resources has not been identified, leaving many shelters to add-on these programs to their regular workload. A Victim Assistance Program has been founded in Toronto, but services in rural areas are not available, nor do we have a complete picture of the need.

### **Family**

Coming out to one's family presents the highest degree of risk for lesbian and gay youth. One in four (25%) youth who disclose their sexual orientation to a parent is forced to leave the family home (Ramafedi, 1987). Negative reactions at home also account for a significant number of youth running away or being disowned by their families.

Families face the same myths, stereotypes and social stigma as their children, and may react with feelings of guilt, fear of blame, denial, hurt, or anger. They are poorly prepared to understand and respond to sexual orientation disclosures. Cultural considerations will complicate and heighten the intensity of the family disruption (Tremble et al, 1989, cited in Simpson, 1994). Families need support and information to deal with stereotypes and address their own fears. Families need a chance to mourn the life they took for granted for their children (Borhek, 1988).

When youth are accepted by their mothers, fathers, friends and academic advisors, they are able to experience higher levels of self-esteem and personal value (Sauvin-Williams 1989). Coming out in a warm, loving, supportive environment enhances one's ability to integrate self-identity in a positive manner. If rejected upon coming out, a person may experience increased levels of depression, and alcohol and illicit drug use, as well as confusion, isolation, loneliness and suicide ideation. Providing support for families to deconstruct the social myths and understand their child, is a public health role.

## **Parenting Challenges**

There are many gay and lesbian parents, but there is still an assumption that gay and lesbian people are necessarily childless. Many gay men and lesbians have become parents through heterosexual partnerships, and many thousands of lesbians for whom pregnancy has occurred via alternative insemination. There are also many adoptive, co-parent, step-parent and grandparent relationships in which gay men and lesbians participate. Many of these parents have remained selectively or fully invisible for fear of repercussions from friends, family members and institutional providers.

Receiving the primary parent role in custody settlements is less likely if the parent is in a same-sex relationship. The effects of separation and divorce become multi-layered for lesbians and gay men. Dealing with the trauma of losing the role of parent, in addition to the resolution of losing a relationship, compounded by having to newly face homophobic and heterosexist reactions can be overwhelming. Support groups for divorced or separated lesbians and gay men coming out of heterosexual relationships are virtually non-existent.

Myths and stereotypes that suggest same-sex families raise children with same-sex attractions continue to persist. Opposite-sex parents who raise children with same-sex attractions often feel they must have made a mistake in their parenting. The fact that these myths must be debunked brings another issue to the foreground: the need for dialogue regarding how one “becomes” a gay or lesbian person.

One negative impact from social attitudes toward same-sex relationships and the myths and stereotypes, is challenging or doubting parenting competence. Internalized oppression related to compulsory heterosexuality describes a notion of what a “normal” family is; this may result in the internal invalidation of one’s perceived capacity to parent in the current social environment (Ariel & Stearns, 1992).

Children of lesbians felt that their schools did not acknowledge their families. In addition, children living in same-sex families felt isolated because they did not know many other children living in similar families (Pane, 1992). In addition, same-sex parents must “teach” their children how to interpret safety in their environments. They must be able to measure the risk of being honest about one’s family against the risk of maintaining the invisibility of their families (Epstein, 1996; Arnup, 1998).

For same-sex families, legal status defining the partners’ relationships to each other and to the children is absent. This can complicate experiences of medical emergencies, separation, or death. Challenges to current legislation are beginning to create a politically supportive environment, but work is still required in the social sphere to counter the social stigma experienced by same-sex families and children living in those families (Epstein, 1996; Arnup, 1998).

## **Youth**

Lesbian and gay adolescents could be considered a fairly recent phenomenon (Roesler & Deisher, 1972, cited in D'Augelli, 1996). Historically, homosexuality was described only within the adult reality (Ramafedi, 1987). This was done in the absence of accepting that the normal developmental tasks of adolescence include sexual identity formation, social and relationship skill acquisition, and building a sense of self-esteem (Simpson, 1994). Sexual identity formation is a process whereby one develops an identity through social interactions with others. The impact of factors such as sexism, homophobia and oppression contributes to the identity forming process (Rust, 1997, cited in Dimech, 2000). Dimech (2000) notes that most developmental literature recognizes the impact of social constructs such as gender conformity but excludes homophobic social attitudes and heterosexism as contributors. These heterosexist assumptions therefore impact at the individual level as well. Healthy child and adolescent development is a mandate of public health, yet the healthy development of lesbian and gay youth has not been considered outside of the sexual context.

“Sexual orientation is not just about sex and sexuality; it is about sexuality, emotionality and social functioning. The development of a sexual identity represents the integration of all these aspects of sexual orientation into a coherent whole, an authentic sense of self, with a self-label that is subjectively meaningful and manageable”.... (Appleby & Anasts, 1998. pp. 51).

Efforts need to be made to shift the perception that sexual behaviour is an absolute indicator that a person may be gay or lesbian; or that sexual behaviour is a significant part of forming or developing a gay or lesbian identity. We must always be cognizant that our work never reduces the lesbian and gay experience to sexual behaviour. Adolescent development of lesbian and gay identities must be included within a broader perspective that is supportive and affirming. It is a myth that adolescent homosexuality is a new phenomenon, the reality is that clinicians and researchers have only recently recognized adolescent sexual identity formation.

## **Homelessness**

It is believed that between 20 and 40% of street youth in cities are lesbian, gay or bisexual (Kruks, 1991, cited in CTYS, 1998). A report released by The Shout Clinic in Toronto show that, 14.1% of the homeless youth interviewed defined themselves as being bisexual, 4.6 % as gay, 2.3% as lesbian, and <1% as transgendered. Another 3.7% reported they were “not sure right now”. Seventy percent of respondents defined themselves as “straight”. This indicates that lesbian, gay, and bisexual youth are over-represented in the street population, a fact that may reflect the harassment and rejection experienced at school and/or at home by their peers and/or their caregivers (Gaetz, O’Grady, Vaillancourt 1999). Other risks associated with homelessness are poverty, lack of employment or education, poor nutrition, poor health status, prostitution, criminal involvement, anxiety and depression, pregnancy, sexually transmitted infections, substance abuse, violence, susceptibility to exploitations, HIV infection, and poor prospects for the future (CTYS, 1998).

## **School Environment**

Forty-five percent (45%) of gay males and 20% of lesbians are physically or verbally assaulted in high school. Twenty-eight percent (28%) of those experiencing violence will dropout (Besner & Spungin, 1995).

The school system serves to maintain the invisibility of lesbians and gays because it is heterosexist, homophobic and maintains strict rules of gender conformity (Elia, 1994 and O'Connor, 1994, cited in Jordon et al, 1997). Within the school environment there exists a significant lack of explicit support (signs of visible acceptance), no adult role models, and no inclusive curriculum or literature that reflects homosexuality as a valid social construction of self. Homophobia and sexphobia restrict discussion of the diversity of sexual expression as part of school education and sometimes public health education. This inhibits an appreciation of diversity, which is vital information, being kept from all students.

Still, school officials ignore school-based harassment of gay and lesbian students (Stover, 1992). The stigmatization and lack of action can result in ostracism, physical violence, and verbal harassment. Perpetrators include both peers and teachers. When a school is unsafe, students are impacted through the loss of academic performance, school failure, dropping out, and a decrease in school event participation. Rejection from friends can also be experienced by these youth. The impacts are documented in numerous works, including Durby, (1994); Eversole, (1993); Krivascka et al, (1992), cited in Jordan et al 1997; and Remafedi, (1987).

Alternative schools provide a solution, but the Ministry of Education in Ontario is closing them in response to education reform and financial restraint. The closing of alternative schools may increase student dropout rates if school environments maintain their current heterosexist standards.

### **Depression and Suicide**

Making choices about coping and understanding one's internal development related to sexual identity formation can be difficult and sometimes costly for gay and lesbian youth. Suicidality is associated with extreme psychological distress and a lack of social supports (Clermont et al, 1997). Most youth struggling with sexual identity issues experience mild to severe depression at some point in time (CTYS, 1998, Meth et al, 1998). It is estimated that 50% of lesbian and gay youth experience suicidal thoughts and that 20-35% actually make a suicide attempt. Up to 1/3 of adolescents who commit suicide are known to be lesbian or gay (Gibson, 1989). Very little has been done to expose the factors that lead young gays and lesbians to develop self-destructive thoughts or behaviours.

The fact that gays and lesbians as a group run a higher risk of committing suicide continues to be ignored by suicide specialists (Tremblay, P.J. 1995, cited in Clermont et al, 1997). There appears to be a wall of silence, especially with respect to the influence of "sexual orientation" as a high risk factor. This includes a recent publication by the Public Health Research, Education and Development Program (PHRED) entitled The Effectiveness of School-Based Curriculum Suicide Prevention Programs for Adolescents, (Ploeg et al, March 1999). The exclusion of sexual orientation as a primary risk factor in this document contributes to the ongoing spectrum of social silence. This is particularly remarkable when a Health Canada Report entitled Suicide in Canada Update of the Report of the Task Force on Suicide in Canada, from 1994, discusses gay men and lesbians as high-risk groups. Youth Net (CHEO, 1998) identifies sexual orientation as a risk factor, however, their primary audience appears to be mainstream youth.



One must question the perceived safety of the focus group environment, which is needed to draw out the feelings and experiences of lesbian and gay youth.

### **Isolation**

One of the highest risks for youth and adults who self-identify as gay or lesbian is invisibility or isolation (Simpson, 1994). Lesbian and gay youth suffer from and internalize the negative beliefs of society, as do other minorities. They lack the benefit of sharing their minority status with their families and friends, as would be common for visible minority groups. Role models and mentors are absent and support services are few.

Issues of isolation are compounded by whether the individual is in an urban or rural environment. The isolation of gays and lesbians living in rural communities is complicated not only by geographic distance from services (often located in urban centres) and the lack of role models, but also a fear of loss of confidentiality that results from being “outed” within their community. Young people in rural communities may feel compelled to leave for the urban environment because they perceive it as safer for them.

Again, these facts direct us to build the supports where lacking, or to facilitate access to services that are already available. A priority need is to inform the lesbian and gay community, and young people, of support systems that can help them cope with their situations before a crisis occurs.

## **Part 3 - What next? Considering Sexual Identity as a Determinant of Health**

As Love et al (1999) argue, we repeat the same error as we have historically when we do not consider gender, sexual identity, race, ethnicity, culture, ability, as determinants requiring equal consideration regarding their impact on health, well-being and health care services. Love cites Vertinsky (1992) who asked if sex is a “difference that makes no difference” or the “difference that makes all the difference”. When such contributing factors are excluded from the analysis of each determinant we lose the ability to incorporate the impacts of social constructs on well-being.

All people construct their identities within the social environment that includes homophobia and heterosexism. It therefore has an impact on our health and well-being. Hancock & Perkins (1985), cited in Rootman and Raeburn (1994), present a Mandala of Public Health that portrays the individual at the centre of a set of environments that include family, community, the human-made environment, the culture and the biosphere. They discuss how individual development is constrained by a lifelong socialization process and by the psycho-social environment, including cultural and community values and standards. Public health services need to pay attention to the social and political influences and inequities and the complexity of interactions that exist in order to develop initiatives that will have a positive impact on the health outcomes of lesbians and gay men.

## **Education**

The dropout rates of youth who are non-gender conforming are higher than the population average. Decrease drop out rates and health status improves. This demands that work be done to create the social support and social cohesion needed to create a healthy social environment for lesbian and gay youth. This requires the elimination of the oppression that stems from homophobic and heterosexist assumptions. Public health collaborations with education and other community agencies can help to ensure ongoing support for lesbian and gay students and their families and teachers.

## **Employment and Job Security Issues**

The Human Rights Code has made it illegal to discriminate or harass a person based on their sexual orientation. However, it still happens; the military is a primary example. Currently, legislative policies are in place that help society make progress on basic human rights, but policies alone are insufficient to bring progress on changing human attitudes or the myths and stereotypes held by people.

Income security is an issue that is related to HIV infection, however the impacts of long-term stress and illness are also relevant. Income security is at risk when individuals need time off for illness. People who are ill tend to have higher unemployment rates. There have been some changes for HIV infected people, particularly with disability support and life insurance assistance. Societies that allow all citizens to participate and play a full and useful role in the social, economic, and cultural life of the society will be healthier.

## **Stress**

Stress has been documented in numerous studies as a major cause of health problems. Stress is particularly related to inequities and lack of perceived ability to have some control in one's environment (Brunner & Marmot, 1999). These social and psychological stresses can accumulate during life and culminate in long-term stress and illness. Lesbian and gay people must deal with their experiences of difference from early adolescence, or even earlier for some (children of same-sex parents). Dealing with the stress arising from the oppression of the social environment, without support or positive affirmation, can lead to long term stress and/or illness. Public health services can be equipped to prevent such stresses by responding to individual and family needs with regard to sexual identity formation.

## **Social Exclusion**

Social exclusion usually refers to the barriers that prevent a person's participation in the socio-economic system in such a manner as to influence their well-being (World Health Organization, 1998). This would include such determinants as exposure to poverty, unemployment, and homelessness. Missing from this analysis is social exclusion that results from the experience of invisibility, the exclusion of lesbians and gay men. Programs responding to poverty and homelessness must consider the needs of lesbian and gay people. Public health partnerships and the provision of information to prevent crisis, provide visible mentors and positive attitudes will help to bring down barriers.

## Part 4 - A Call to Action

### What is Public Health's role?

Public health is obligated to understand the diversity of the population to whom service is provided. Our role then is to ensure inclusion, to eliminate oppression at all levels (individual, community, organizational and societal), to identify potential risks, to educate with a goal to change attitudes, and to provide insight with sensitivity to the issues. There are some key interventions suggested by Clermont et al (1997) for the province of Quebec that are necessary to create affirming social attitudes, accessible health services and healthy individuals and families. These include, building relationships and networks, completing an inventory of existing needs and services, knowledge development, advocacy for research, policy review and the creation of a committee to take action on recommendations.

D'Augelli (1996) suggests a comprehensive education plan that operationalizes the strategies and considers the impacts upon the client, the family, parents, siblings, peers, teachers and health care providers. Suggesting that the most effective strategy for preventing the problems that affect lesbians and gay men is changing the attitudes and reactions of others. Approaches must deconstruct heterosexism, homophobia and harassment in the social and political environment. A comprehensive approach must operate at several levels:

Tertiary prevention	Addressing the current problems that face lesbians and gay men.
Secondary prevention	The explicit inclusion of sexual orientation as a risk when precipitated under particular circumstances.
Primary prevention	The creation of the circumstances that prevent the development of heterosexism.

Primary prevention of heterosexism should be the ultimate goal. The discussion in the previous section, considering sexual identity as a determinant of health, begins the process of deconstructing heterosexist attitudes.

### Social Support

Social support can be described as friendship, positive social relations, and networks providing connections. Social support provides emotional and practical resources that serve to develop feelings of being cared for, loved, esteemed and valued. All these elements provide a protective effect on health. Social support operates at the individual, family, organizational and societal levels and works to decrease the isolation of lesbians and gay men (World Health Organization, 1998).

For public health units to be accountable for creating supportive environments, lesbian and gay health issues must be part of the programming for all public health services, including Healthy Children, Parenting, Reproductive Health, Family Health, Cancer Detection and Chronic Disease Prevention. This can be accomplished through our relationship with the Ministry of Health in Ontario and making the appropriate changes to the Mandatory Core

Guidelines. These changes would then be monitored by the yearly survey of health units. Accessibility and inclusion must be considered key outcomes for this work.

Services need to be adapted so that there is province wide acceptance of gay and lesbian experiences at public health units. Services need to be provided that are perceived as safe, welcoming, affirming and non-judgmental. Public health services must impact the social and political realms at the regional or municipal level, as well as the provincial and federal levels. This necessarily means policy review and advocacy, as well as mass media campaigns that uphold the values of diversity, respect, appreciation and celebration.

### **Social Cohesion**

Social cohesion is the existence of mutual trust and respect in the community and wider society. Public health, in order to impact the roots of oppression, can work at improving social environments in schools, workplaces and the community in general. The outcome of this work would be people feeling valued and supported in more areas of their lives, and therefore experiencing greater well-being and emotional health (World Health Organization, 1998).

Strengthening local health unit relationships and networks with community groups and services for lesbians and gay men will begin the process of change. Public health is mandated to work with the education sector, the tertiary health care sector, the workforce (workplaces), and the community at large. It is our responsibility to do anti-homophobia work with all our partners in order to support the development of respect, appreciation, and celebration of the diversity of the human condition.

The provision of documentary support for funding requests of community groups, and then committed partnerships, are necessary activities for all Public Health Units. Geographic barriers are only restrictive because little action has been taken. A strategy for working within rural environments is important. Assistance for such work can be obtained through partnership between health units that are well connected with the lesbian and gay community and a Provincial Advisory Panel. Once it is safe to be open about sexual identity, there will be a response from local community members.

### **Education, Research and Programming**

There is a significant advocacy role for the Ontario Public Health Association with regard to health professional education and a long-term national health research strategy. Additional contributions must be made with respect to public education, other sector education, and evaluation. The components of a comprehensive curriculum must include deconstructing oppression, appreciating diversity, understanding the impact of myths and stereotypes, enhancing coping skills, sexual identity development, discrimination, conflict resolution, and the health impacts that are concomitant with the social determinants of health. Education, research and programming are not limited to schools and therefore must be extend to all levels of influence including the community, family, religious groups, organizations, workplaces, politicians and society.

## **Eliminating Discrimination**

Action is needed on the social factors at the root of discrimination. Social attitudes can be changed over time by making explicit the oppression of lesbians and gay men. This works to relieve the isolation, increase dialogue and improve collaboration across sectors. A Population Health Provincial Advisory Committee has been established in British Columbia; Quebec facilitates a similar Regional Committee meeting on issues of accessibility to health services (Clermont et al, 1997). Both committees work in an advisory capacity for health planning, identification of issues, development of measures for the evaluation of health status, the development of responsive policies, and advocacy. Quebec emphasizes the importance of collaborating with community and provincial organizations that work in the gay and lesbian community. Both ensure appropriate representation of the lesbian and gay community.

The Ontario Public Health Association, in partnership with the Ministry of Health, should facilitate the creation of a Provincial Advisory Panel. The panel should recruit participation from the lesbian and gay community, organizational decision-makers, ministry officials, health/medical associations and community organizations. The committee would act to plan, recommend, and consult with a mandate to ensure the provision of accessible services. Roles of the committee could include outreach to other sectors (such as education), to ensure public health units have access to anti-discrimination training, and to develop tools with which to measure the needs of health units.

## **Summary**

Labonte (1993) states that initiatives must consider both the individual and the structural influences that impact each of us.

Unless we practice thinking simultaneously in both personal and structural ways, we risk losing sight of the simultaneous reality of both. If we focus only on the individual, and only on crisis management or service delivery, we risk privatizing-rendering personal-the social and economic underpinnings to poverty and powerlessness, [oppression]. We may offer personally empowering service but *de facto* reinforce a structural powerlessness. But if we only focus on the structural issues, we risk ignoring the immediate pains and personal wounding of the powerless and people in crisis (p. 57)

The approach for change suggested throughout this paper requires that there be participation from all public health professionals, all public health units, the provincial bodies, and the professional associations. It requires that we see what is needed personally, professionally and organizationally in both the immediate and the long-term, in order to create and maintain services that will improve the quality of interactions of gay men and lesbians with the health sector. In the end, our ultimate goal must be the prevention of homophobia and heterosexism as forms of social control that affect all of us.

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## **Resolutions            Improving the Access to and Quality of Public Health Services for Lesbians and Gay Men**

**WHEREAS** the individual and systemic oppression of gay men and lesbians has a significant impact on their health;

**WHEREAS** public health services have not consistently provided accessible and appropriate service to lesbians and gay men;

**WHEREAS** public health services and professionals may be inexperienced, uninformed and uncomfortable with the experiences and situations of gay men and lesbians;

**WHEREAS** public health services are legally, professionally and ethically obligated and mandated to understand the diversity of gay and lesbian clients, including their experience, situation, ethnicity, religion, ability and age;

**WHEREAS** the experiences and situations of bisexual and transsexual/transgendered persons are different from the experiences and situations of lesbians and gay men:

**THEREFORE BE IT RESOLVED THAT** the Ontario Public Health Association adopt the Access to Services for Lesbians and Gay Men position paper.

**BE IT FURTHER RESOLVED THAT** the Ontario Public Health Association advocate for the inclusion of lesbian and gay health issues within the program standards of the Ontario Mandatory Health Programs and Services Guidelines, in all public health program areas; and

**BE IT FURTHER RESOLVED THAT** the Ontario Public Health Association work with the Ministry of Health to convene and fund a Provincial Advisory Panel on Gay and Lesbian Health Issues and to put into effect the recommendations of the position paper; and

**BE IT FURTHER RESOLVED THAT** The Ontario Public Health Association petition the Canadian Public Health Association and Health Canada to develop a national research strategy that will contribute to a body of literature that will inform public health practice; and

**BE IT FURTHER RESOLVED THAT** the Ontario Public Health Association support the development of position papers on the issues of accessibility and health service needs for bisexual and transsexual people; and

**BE IT FURTHER RESOLVED THAT** the Ontario Public Health Association advocate to include lesbian and gay issues in the standards of practice for all health professions, and support health unit education; and

**BE IT FURTHER RESOLVED THAT** the Ontario Public Health Association distribute the *Improving the Access to and Quality of Public Health Services for Lesbians and Gay Men* position paper to key provincial stakeholders; and

**BE IT FURTHER RESOLVED THAT** the Ontario Public Health Association examine the level of support from health units for the incorporation of anti-homophobic and anti-heterosexist provision of care and workplace support and develop a plan of action.

## Implementation Strategy

**THEREFORE BE IT RESOLVED THAT** the Ontario Public Health Association adopt the Access to Services for Lesbians and Gay Men position paper.

Implementation Activities	Role
The paper will be presented to the general membership of the OPHA, at the Annual General Meeting, October 2000.	PHA

**BE IT FURTHER RESOLVED THAT** the Ontario Public Health Association advocate for the inclusion of lesbian and gay health issues within the program standards of the Ontario Mandatory Health Programs and Services Guidelines, in all public health program areas

Implementation Activities	Role
1. Ensure that program public health professionals who are experienced, informed and comfortable with gay and lesbian issues review requirements and standards to ensure the inclusion of lesbian and gay issues.	OPHA Mandatory Core Guideline Review Committee/ PHA
2. Distribution of position paper to committee (via website?)	OPHA Office

**BE IT FURTHER RESOLVED THAT** the Ontario Public Health Association work with the Ministry of Health to convene and fund a Provincial Advisory Panel on Gay and Lesbian Health Issues and to put into effect the recommendations of the position paper; and

Implementation Activities	Role
1. Collect additional information on the Lesbian and Gay Advisory groups in BC and Quebec.	Equity Committee / PHA
2. Write a letter to the Ministry of Health proposing the establishment of the Provincial Advisory Panel	OPHA Board of Directors
3. Convene such a group and develop terms of reference etcetera.	To be determined

**BE IT FURTHER RESOLVED THAT** The Ontario Public Health Association petition the Canadian Public Health Association and Health Canada to develop a national research strategy that will contribute to a body of literature that will inform public health practice; and

Implementation Activities	Role
1. The OPHA advocate at the Board of the CPHA the need for a national research strategy.	OPHA President

**BE IT FURTHER RESOLVED THAT** the Ontario Public Health Association support the development of position papers on the issues of accessibility and health service needs for bisexual and transsexual people; and

Implementation Activities	Role
1. Review literature and research and develop papers	PHA / Equity Committee

**BE IT FURTHER RESOLVED THAT** the Ontario Public Health Association advocate to include lesbian and gay issues in the standards of practice for all health professions, and support health unit education; and

Implementation Activities	Role
1. Develop or research as to the existence of such standards of practise.	PHA/ Equity Committee
2. Letters to the colleges of health professions, and the colleges and universities.	OPHA Board

**BE IT FURTHER RESOLVED THAT** the Ontario Public Health Association distribute the Improving the Access to and Quality of Public Health Services for Lesbians and Gay Men position paper to key provincial stakeholders; and

Implementation Activities	Role
1. Develop a letter of support to accompany document.	OPHA Board
2. Key Provincial Stakeholders such as: Medical Officer’s of Health, Minister of Health, Professional Education Institutions, Health Profession Governing or Regulating Bodies Provincial Lesbian and Gay Organizations	OPHA
3. Obtain feedback and follow up.	PHA/OPHA

**BE IT FURTHER RESOLVED THAT** the Ontario Public Health Association examine the level of support from health units for the incorporation of anti-homophobic and anti-heterosexist provision of care and workplace support and develop a plan of action.

Implementation Activities	Role
1. Complete an exploration strategy and gap analysis.	PHA / Equity Committee
2. Analyze and report results.	

**Regarding resolutions, position papers and motions:**

**Status:** Policy statements (resolutions, position papers and motions) are categorized as:

**Active, if:**

1. The activities outlined in the policy statement's implementation plan have not yet been completed; or
2. The policy statement addresses an issue that is currently relevant to public health in Ontario.

**Archived, if:**

1. The activities outlined in the policy statement's implementation plan have been completed; or
2. The policy statement addresses an issue that is not currently relevant to public health in Ontario or is not based upon the most current evidence. The statement remains the position of the OPHA until a new statement is adopted that effectively reverses or essentially negates all or major elements of an earlier statement. In this instance, the former supersedes the latter

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