

Improving the Access and Quality of Public Health Services for Bisexuals

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Executive Summary

This position paper arises as a result of the 2000 OPHA position paper “Improving the Access to and Quality of Public Health Services for Lesbians and Gay Men” submitted by the Public Health Alliance for LGBTIQ² Equity workgroup. In that paper, the authors note that they are unable to adequately represent the issues of bisexual people and in order to respect the differences between gay men, lesbians and bisexuals they include a resolution that the OPHA support the development of a community based research project and position paper specifically focussing on issues of accessibility and health services needs for bisexuals.

Existing research and literature on bisexuality and health has focussed primarily on two topics: HIV/AIDS and mental health, therapy or counselling. Those wishing to find information on other aspects of bisexual health and wellness must sort through the sea of research and writing on gay, lesbian and bisexual health to try to find any bits and pieces that specifically address bisexuals. Even in research where bisexuals are included they are usually not adequately represented and not looked at separately. Although sharing some common concerns with both gay/lesbian and heterosexual persons, bisexuals also have specific experiences and needs regarding health and wellness that need to be researched and addressed. This paper outlines a wide range of these specific experiences and needs based on the results of a community consultation that was undertaken with bisexual communities and individuals in Ontario, in conjunction with the relevant literature.

This is a community based participatory action research (PAR) project, which means it is designed for education and action, to work with and empower the people and communities involved in the project. The goal is to improve the access to and quality of public health services for bisexuals by gathering information from bisexuals themselves about their health and wellness needs and experiences, existing gaps in health care services, as well as the barriers they face with regard to meeting these needs and obtaining appropriate services and support. Between January - March 2003, 5 focus groups (4 in Toronto and 1 in Ottawa) and 43 individual semi-structured interviews were conducted for a total of 62 participants from across Ontario. People identifying as bisexual as well as those who have sex with both men and women but don=t necessarily identify as bisexual were invited to participate in this project.

The first section of the community consultation results addresses the social context of bisexual lives including unique issues facing bisexuals, relationships, social support, LGBT and bisexual community involvement, and specific issues for older bisexuals, youth, bisexuals of diverse cultures and trans people. The second section focuses on health and wellness issues such as disclosure to health care providers, experiences using services (including LBGT services), barriers to care and suggestions for change. The paper concludes with recommendations for action in the areas of additional research, service and program development designed to include bisexuals, public education, and education for providers on the the diversity, complexity and wholeness of bisexual people as well as resources and referrals pertaining to bisexuality.

² This refers to “Lesbian, Gay, Bisexual, Transsexual, Transgender, Two-Spirit, Intersexed, Queer and Questioning.” In this paper the shorter, more common acronym LGBT will be used.

Introduction

This position paper arises as a result of the 2000 OPHA position paper “Improving the Access to and Quality of Public Health Services for Lesbians and Gay Men” submitted by the Public Health Alliance for LGBTIQ Equity workgroup. In that paper, the authors note that they are unable to adequately represent the issues of bisexual people and in order to respect the differences between gay men, lesbians and bisexuals they included a resolution that the OPHA support the development of a community based research project and position paper specifically focussing on issues of accessibility and health services needs for bisexuals.

The need for such work is confirmed in recent literature as well. As Ryan, Brotman and Rowe (2000) observe, “[d]ocumenting the experiences of glbt-s [gay, lesbian, bisexual, two-spirit] people in accessing health care is essential to the project of adapting health services to meet the needs of these individuals, their families and communities.” (5) They point to the specific importance of doing research which addresses the experiences and needs of bisexuals. Davis and Wright (2001), in their study on health and wellness of gay, lesbian, bisexual and trans people in Ottawa, also conclude that bisexuals are a high need group and recommend that research be undertaken to investigate the needs of bisexuals.

Although sharing some common concerns with both gay/lesbian and heterosexual persons, bisexuals also have specific experiences and needs regarding health and wellness that need to be researched and addressed. This paper will outline a wide range of these specific experiences and needs based on the results of a community consultation that was undertaken with bisexual communities and individuals in Ontario, in conjunction with the relevant literature. The goal is to improve the access to and quality of public health services for bisexuals by gathering information from bisexuals themselves about their health and wellness needs and experiences, existing gaps in health care services, as well as the barriers they face with regard to meeting these needs and obtaining appropriate services and support. Specific recommendations, as well as OPHA resolutions towards this end, will be included.

Literature Review

A detailed literature review is beyond the scope of this paper due to space limitations. In the following section on the results of the community consultations, relevant literature will be mentioned where any exists, along with the specific findings of this research. There is a small body of literature and research on gay and lesbian health care, experiences, access and barriers, which will not be addressed here except to critique it from a bisexual perspective, as this paper's focus is specifically on bisexual health. For Canadian literature in this area the interested reader may refer to: Peterkin and Risdon (2003), Davis and Wright (2001), Hudspith (2001), Ryan, Brotman and Rowe (2000), Social Data Research Limited (2000), Luce, Neely, Lee and Pederson (2000), Taghavi (1999) and CLGRO (1997). Additional sources, with a primarily American focus, include: Jones and Hill (2002), Dean, Meyer, Robinson, Sell, Sember, Silenzio, Bowen, Bradford, Rothblum, White, Dunn, Lawrence, Wolfe and Xavier (2000), Gruskin (1999), Ponticelli (1998), Peterson (1996), and Eliason (1996). Recent years have also seen increased publication on LGBT health issues in the *American Journal of Public Health*, including the first ever special issue on LGBT health in June 2001 (vol 91, no6) and individual articles such as Boehmer (2002), Mays and Cochran (2001) and Russell and Joyner (2001).

Existing research and literature on bisexuality and health has focussed primarily on two topics: 1) HIV/AIDS and 2) mental health, therapy or counselling. Published research on bisexuality and HIV/AIDS includes (but is not limited to) two edited collections (Aggleton 1996 and Tielman, Carballo and Hendricks 1991) as well as a range of articles and chapters in books (Richters, Bergin, Lubowitz and Prestage 2002, Kennedy and Doll 2001, Myers 1998, Doll, Myers, Kennedy and Allman 1997, Stokes, Taywaditep, Vanable and McKirnan 1996, Rila 1996, Myers and Allman 1996, Einhorn and Polgar 1994, Ekstrand, Coates, Guydish, Hauck, Collette and Hulley 1994 and Wood, Krueger, Pearlman and Goldbaum 1993).

Most of the work on bisexuality and HIV/AIDS focuses on behaviourally bisexual men and is concerned with issues of bi men acting as a bridge for HIV/AIDS between homosexual and heterosexual communities. Kennedy and Doll (2001) observe that this bridge theory has been largely unfounded. This zealous focus on bisexual men and HIV/AIDS has taken precedence over any other types of research on bisexuality and health. It also served to further stereotypes about bisexuals, and bisexual men in particular, as disease carriers and as a danger to women.

Recent research on bisexuality and mental health by Jorm, Korten, Rodgers, Jacomb and Christensen (2002), reported that bisexuals have higher levels of anxiety and depression than both heterosexuals and homosexuals, along with "more current adverse life events, greater childhood adversity, less positive support from family, more negative support from friends and a higher frequency of financial problems" (423). Overall bisexuals had poorer mental health than either heterosexuals or homosexuals and are a "high- risk group for mental health problems and suicidal ideas and actions" (426). In Davis and Wright's (2001) study on health and wellness of gay, lesbian, bisexual and trans people in Ottawa, bisexuals also reported more depression and suicidal feelings than gays and lesbians.

There is also a small body of literature focussing on issues and guidelines for therapists dealing
Ontario Public Health Association position paper (2003)

with bisexual clients (Petford 2003a, Petford 2003b, Barnett 2002, Dworkin 2001, American Psychological Association 2000, Guidry 1999, Weasel 1996, Paul 1988, Gainesville Bisexual Alliance no date). In the area of bisexuality and mental health, therapy and counselling, there is an excellent book available edited by Beth Firestein (1996). *Bisexuality: The Psychology and Politics of an Invisible Minority* is a wonderful holistic resource that includes chapters on racial and cultural diversity among bisexuals, trans people and bisexuality, sex positivity, monogamy and polyamory, biphobia, and other counselling and therapy issues.

Research and writing on other areas focussing specifically on bisexuality and health is almost nonexistent. Two short reports have been published on health care needs and access issues for bisexual women (Ray and Landers 1999) and men (Fallas and Landers 1999) as part of the Voices focus groups series, and the few additional publications available include brief guidelines for public health outreach to bisexuals (Miller 2000) and for health care providers working with bisexual clients (Miller and Solot 2001).

For the most part, those wishing to find research on bisexual health and wellness must sort through the sea of research and writing on gay, lesbian and bisexual health and try to find any bits and pieces that specifically address bisexuals. This is particularly challenging as most research which includes the word “bisexual” in its title proceeds to lump bisexuals in with gay men and/or lesbians and thus “the needs and issues facing bisexual people often became subsumed under larger discussions of gay and lesbian health” (Ryan, Brotman and Rowe 2000, 16). Bisexuals also tend to be underrepresented in studies which claim to include them with gay men and/or lesbians, usually making up 10% or less of respondents (Ryan, Brotman and Rowe 2000). So even in research where bisexuals are included they are usually not adequately represented and not looked at separately. This is problematic for both bisexual and gay/lesbian research and knowledge. Fox 1996 notes that “[w]hen bisexual and homosexual respondents in sexuality research have been combined for the purposes of data analysis, information about both of these groups has been obscured” (20). Along these same lines, much work that says it is about lesbian and bi women or gay and bi men is only about the same-sex sexual experiences or relationships of the bisexuals. In public health research specifically, the focus is often on men who have sex with men (MSM) or women who have sex with women (WSW), but as Meyer (2001) points out “these terms should be used with caution; although they are respectful of the variety of sexualities, they erase important self-definitions and identities of gay men, lesbians and bisexuals” (856). This focus also misses the important piece of men who have sex with men and women, and women who have sex with women and men.

It is clear that there is a need for more research on bisexual health and wellness that expands on recent work on mental health, goes beyond an HIV/AIDS focus, and that addresses other areas of concern. In research on gay, lesbian and bisexual populations it is important that more bisexuals are included in future studies and that the results distinguish bisexuals from gays and lesbians.

A Note on Defining Bisexuality

Richters (1997a) outlines the three main ways of defining or conceptualizing bisexuality. The first is the experience of sex with both men and women (behavioural bisexuality), the second is sexual desire for both genders, and the third is self-identification as bisexual (19). She notes that much research uses the first, the broadest behavioural definition, and that this definition produces that largest numbers and by it, bisexuals outnumber exclusively homosexual men and women (1997a, 1997b). However, few people in this broad group self-identify as bisexual - it includes gays and lesbians who were heterosexual in the past or who occasionally have other-sex sex, as well as heterosexuals who have had some same-sex experience or heterosexual men who find other men are more available for sex, but for whom this has not been identity-forming. This behavioural definition also leaves out many in the latter two groups - people who have attractions to but not experience with both genders (ever or within a set period of time, as is often part of the criteria used by researchers using the behavioural definition) (Richters 1997b, 154) and people who self-identify as bisexual but who may not have had sexual experiences with both genders (or with anyone at all), ever or within a set period of time.

A general definition that encompasses all of the above - “bisexuality is the potential for being sexually and/or romantically involved with members of any gender” (McInnis and Kong 1998, 35) is used in this project. It is important to note that people who identify as gay, lesbian or heterosexual may have past or current sexual experiences with other- or same-sex partners respectively (Dottinga 2003, Bailey, Gurevich and Mathieson 2000, Miller 2000, Fox 1996). People identifying as bisexual as well as those who have sex with both men and women but don't necessarily identify as bisexual were invited to participate in this project.

Methods and Sampling

This is a community based participatory action research (PAR) project. This means it is designed for education and action, to work with and empower the people and communities involved in the project. Through the OPHA, it is intended to advocate for changes in health policy, services, and education for service providers based on the issues arising out of the research. It is also hoped that the OPHA will continue to promote ongoing relationships between bisexual communities and public health care institutions in Ontario.

PAR was implemented by means of the Public Health Alliance for LGBTIQ Equity workgroup seeking applications for the Principal Investigator position through bisexual communities and networks. Morris and Muzychka (2002) write that “PAR supposes researchers are from or are in touch with the community under study” (16). Thus the researcher hired for the position (Cheryl Dobinson) is a member of the community being engaged. They also note that “[i]f the researchers are a part of the community, the research might retain some momentum, as opposed to researchers coming in and leaving once the project is over” (20). The research process is understood to have an effect on the researcher’s life, and the skills learned and knowledge gathered become part of the communities the researcher is involved in and will help form the basis for future action and initiatives undertaken in a personal and/or professional context as part of a bisexual community. PAR projects influence everyone involved, including not only researcher and community participants, but in this case, the Public Health Alliance for LGBTIQ Equity workgroup as well.

A further advantage of this approach is that participants “may be more willing to talk with researchers from the community” (20). On the advertisements for the project it was clearly indicated that the Principal Investigator was a bisexual woman, and feedback during or after the interviews indicated that this was a key factor which allowed respondents to feel comfortable contacting the researcher, participating in the project and speaking freely about their experiences and needs.

Since the project was seeking to understand participants’ experiences, needs and lived realities regarding health and wellness, a qualitative approach was used. Both a convenience sample (via the strategic dissemination of project flyers) and a snowball sample (where community members invite others they know to participate) were used. Between January - March 2003, 5 focus groups (4 in Toronto and 1 in Ottawa) and 43 individual semi-structured interviews were conducted for a total of 62 participants from across Ontario. Additional information on recruitment strategies and demographic characteristics of the participants is available in Appendix B.

Community Consultation Results

Social Context

In all the interviews participants were asked to share the unique issues, experiences and challenges facing bisexual people (or people whose sexual experiences or attractions include both men and women if they didn't identify as bi). Interviews then addressed relationships, social support, and involvement with queer community and/or bi groups, before getting into more specifically health and wellness focussed questions. Why is this important? Because 1) these broader parts of life for bisexuals are important for overall health and relate to social, mental and emotional needs and well-being and 2) these are the kinds of things that health care providers should have an understanding of in order to provide effective bi-inclusive care.

Unique Issues for Bisexuals

When asked about the unique issues, experiences and challenges facing bisexual people one of the most common responses was to list the kinds of myths and stereotypes that exist around bisexuality, and which bisexuals must deal with. These include: that bisexuals must have a 50/50 attraction to men and women, that they are dishonest and cheat on their partners, that they can't be monogamous, that it's a phase or a transition, that bisexuals are wild and sexual, that they spread STDs/AIDS, that they are selfish, that they're playing the field, that they can't make up their minds, that bisexuality doesn't really exist and isn't a legitimate sexual identity, and that bisexuals stay in the closet and live a mainly straight life. The existence of such stereotypes and myths about bisexuals is outlined in current literature as well (Bisexual Resource Centre 2002, McLean 2001, McInnis and Kong 1998, Richters 1997a, CLGRO 1997)

Participants also talked about feelings of not belonging in either the straight or gay world, and about experiencing biphobia from gays and lesbians. They pointed out that bisexuals are largely invisible and that there is a lack of bisexual groups or a bisexual community to be part of. They mentioned isolation and loneliness, confusion, and mental health and self-esteem issues. Many felt that bisexuals experience pressure to choose to identify as gay or straight and also others being confused about what bisexuality means or why it is important. These feelings and experiences are also mentioned in the existing literature (Dennis 2003, Vargas 2002, Fallas and Landers 1999, Taghavi 1999, Vanasco 1999, McInnis and Kong 1998, Cornelson 1998, CLGRO 1997, Richters 1997a, Ochs 1996, Fox 1996, Alley 1996, Weinberg, Williams and Pryor 1994).

Specific coming out issues for bisexuals were also discussed by participants. Coming out as bisexual from a gay or lesbian identity was a concern for some, with specific issues including worries about coming out again to family and friends, fear of not belonging or of being rejected by gay and lesbian friends and community, the need to learn how to relate to the other sex in terms of relationships and sex and, for women, feelings of having betrayed lesbians and culture shock around dating men. Having to negotiate coming out to partners or potential partners was also cited as a unique challenge. Writing on bisexuality and coming out includes these (Barnett 2002, Matteson 1996, Fox 1996, Weinberg, Williams and Pryor 1994, Udis-Kessler 1990, Paul 1998) along with some additional issues such as difficulties because of the stigma and invisibility

surrounding bisexuality (Ryan, Brotman and Rowe 2000), how bisexuals' coming out is affected by both homophobia and biphobia (Bisexual Women of Toronto, no date, Weinberg, Williams and Pryor 1994), and the lack of a supportive community to come out to, so one may be developing and maintaining bi identity in isolation (Petford 2003a, Fox 1996, Ochs 1996). People may experience confusion over how to interpret sexual attraction to both men and women (Fox 1996) and it may be unsettling for those in opposite sex relationships (Ryan, Brotman and Rowe 2000). As Rust (2001) summarizes, "for individuals who do not fit neatly into culturally sanctioned monosexual categories, the task of developing a sexual identity is challenging" (62).

Participants expressed that women and men may experience some aspects of bisexuality differently. Bisexual women tend to be highly sexualized and eroticized by men, seen as 'easy' or doing it to please men. Bi women also have a particularly problematic relationship with lesbians (Bower, Gurevich and Mathieson, 2002, Bronn 2001, Rust 1995). Male bisexuality is less accepted and bi men are less visible than bi women (Dennis 2003, Steinman 2001). Other issues facing bisexuals that participants brought up include safer sex with both men and women, issues with identity labels, including the word "bisexual" (Bower, Gurevich and Mathieson, 2002), internalized biphobia (Barnett 2002, Ochs 1996, Paul 1988, Bisexual Resource Center 1990), and the fact that bisexuality upsets people because it is fluid and challenges categorization (Vanasco 1999).

Bisexuals in Relationships

Bisexuals in relationships may have unique issues and concerns as well, such as coming out to partners, difficulty finding supportive and understanding partners, and the importance and challenge of keeping a bi identity while in a relationship (see also: Barnett 2002, Queen 1996, Ochs 1996, Weinberg, Williams and Pryor 1994, Paul 1988).

In other-sex relationships, bi women with male partners talked about their specific concerns such as many men finding female bisexuality very sexy and expecting to be involved in threesomes with another women, other men finding it threatening and not wanting to talk about it, and male partners not being welcome in the queer or lesbian community. Bi men in relationships with women mentioned their partners not wanting to talk about it or wondering what it means for them, women finding it difficult in terms of their own identity and self-esteem, and partners trying to be supportive but finding it hard without support in place for themselves.

With regard to same-sex relationships, bi women talked extensively about their difficulties in establishing or maintaining relationships with lesbians. They spoke about lesbians not wanting to date bis, resentment from lesbians, and pressure to identify as lesbian while with a lesbian partner (see also: Weinberg, Williams and Pryor 1994, Rust 1995, Ochs 1996). Bi men didn't report the same level of difficulty with gay men, although some gay men were not accepting of bisexual men or interested in them as partners. This is consistent with current research which argues that although some gay men certainly do have negative views of bi men, that these have not been displayed as much or politicized in the same way as lesbians' unfavourable views of bi women (Steinman 2001).

Bisexuals who were in relationships with other bisexuals, or who preferred to date bisexuals felt

that this was easier than being with straight, gay or lesbian partners and that there was more understanding and connection. This is noted by Vargas (2002) and Queen (1996) as well. However, in many areas it can be difficult to connect with other bisexuals at all, so it isn't feasible for every bi person to seek a bi partner.

Polyamory was another theme in bisexual relationships³. For some people, bisexuality and polyamory were linked, and they found it hard to get understanding and acceptance for both. They also said there can be difficulties in maintaining relationships with men and women at the same time if that is what they want, also noted by Matteson (1996). Other participants found that the assumption they would want to be polyamorous was a problem in relationships, and that for bisexuals who wanted monogamy it could be difficult to get partners to believe them.

Children

Children are a part of the lives of almost half of the participants interviewed: 16 have children, 10 want to have children and 1 reported being a foster parent. 19 are undecided about whether they want to have children or not. A few bisexual parents have come out to their children, however many have not or are waiting until they are older. Some have concerns about being involved in the gay community because they don't want their children to find out, they don't feel they would be accepting.

Recent attempts to carry out focus groups for bisexual parents by the Family Service Association of Toronto as part of a series of groups for LGBT parents were unsuccessful (2003, Rachel Epstein, personal communication), which points to the difficulty of engaging bi parents in research and the possibility that bisexual parents may not participate in existing LGBT communities or disclose their status. Thus it seems significant that many bi parents participated in this community consultation process with its bisexual focus. There are implications for health care providers who work with families and prospective parents to understand the range of ways that bisexuals take on parenting roles as adoptive, biological, foster and co-parents, as well as the barriers to disclose.

Social Support

Lack of social support is harmful to health (Bailey, Gurevich and Mathieson 2000), so it was important to talk to participants about their social support systems. In terms of family, friends, work, religion and school, many felt that they did not receive support because of being queer, not specifically because of being bisexual. However, in some cases bisexuality was a specific factor affecting social support.

With regard to partners, some have very supportive partners, especially those who are bisexual as well. As far as straight, gay or lesbian partners, as was outlined above, not all were supportive of participants' bisexuality.

³ Rust (1996b) is a useful resource for those interested in research on monogamy and polyamory among bisexuals.

Family members were sometimes confused when participants came out as bisexual, or from gay or lesbian to bisexual. They were less supportive, wondered why the bi family member couldn't just be with the 'right' sex if they were attracted to the other-sex, and treated other-sex and same-sex partners differently. This is consistent with Jorm, Korten, Rodgers, Jacomb and Christensen's (2002) findings that bisexuals experienced less positive support from family than heterosexuals or homosexuals.

Jorm, Korten, Rodgers, Jacomb and Christensen's (2002) also report that bisexuals receive more negative support from friends. Participants in this research found that some friends were not supportive, rejected them, or tried to support them but didn't understand how to support a bisexual friend. Other friends were a great source of support, and bi friends especially were valuable.

At work it was common to experience problems and lack of support as a queer person, and many felt they couldn't come out at work. For those who were out, confusion was caused when colleagues assumed they were lesbian or gay, but then they found out about another sex partner. A small number of people worked in environments that were supportive of LGBT people, including bisexuals.

The one student currently in high school felt that being bi or trans was not as well understood as being gay or lesbian. He also reported having been accused of recruiting and making other students bisexual at a school previously attended.

With regard to religion and spirituality, negative experiences around being queer were reported, but nothing specifically related to bisexuality. On the positive side, a number of respondents were involved in wicca or pagan spirituality, which they found to be very open and supportive of bisexuality. Another supportive community mentioned was the BDSM⁴ community, which was described as open to all sexualities. In his research on bisexuals and BDSM, Lenius (2001) notes that the BDSM community is often an accepting place for bisexuals.

Some participants simply stated that they feel a general lack of social support in all areas of their lives or that their support is compartmentalized, meaning that in some places they had support for certain parts of their lives and identities but not others.

LGBT Communities

In their research on lesbian and bisexual women, health and community, community is defined as "[a] collective of people who experience their lives through a common social structure" (Bailey, Gurevich and Mathieson 2000, 2) and it is noted that emotional health is affected by sense of community. Some respondents feel they belong and are involved in a LGBT community, but many who are involved feel they don't fit in or belong as a bi person. They may have left certain organizations or groups because of biphobia, or have stayed but continue to struggle with it. Others are not very involved because they aren't sure if they would be welcome or accepted. A lack of support for other-sex partners is common, as noted by Bailey, Gurevich and Mathieson (2000) as well, as is not finding any other bisexuals in the organizations or activities they take part in. This

⁴For a detailed definition of this term, and other terms used in this paper, please see Appendix C.

could help explain why, according to Davis and Wright (2001), bis feel less of a bond to the LGBT community than gays and lesbians.

Only 3 of the people interviewed said they were not involved in the LGBT community at all, and 5 had minimal involvement. The rest were involved to varying degrees in a broad range of groups and activities. This is significant because it demonstrates that many bisexuals are actively involved in different facets of the queer community but often don't feel welcomed or accepted as bi.

Bisexual Communities

34 of the participants are or have been involved in some form of bisexual community, mostly in Toronto and Ottawa. In other areas, they may be involved in a virtual community through the internet. Petford (2003a) notes that bisexual community may exist more on the internet than in person and Peterson (2001) looks at online community as well as significant for bi men.

Most participants gave glowing praise to their bisexual community. They found it meant less worry about fitting in with gay and lesbian communities and was validating, empowering and affirming to them as bisexual people. On the negative side, one man expressed that it wasn't as helpful for those coming out from gay to bi. Feelings or fears of not belonging or being welcome as a trans person were also mentioned.

Issues for Older Bisexuals

Only 3 of the project participants were over age 50. With regard to aging and being older, the need for coming out or support groups for older bisexuals coming out was mentioned, as older people may have some different issues than younger people coming out. The difficulty connecting with other older bis was discussed, as was the uncomfortable feeling that they should have sorted this out already, be established and not have any questions about their sexuality or about sex.

A community sounding with 2 older bisexual women at the 519 Church Street Community Centre in Toronto (Older GLBT Programme 2002) reported some similar results, such as difficulty meeting other older bisexual women, feeling that existing bisexual groups attracts a younger crowd, lack of community programming, not being welcome in gay or lesbian groups of older folks, and wanting a discussion group or social event for older bi women. Keppel (2002) argues that an additional problem for many older people who experience attraction to both men and women is that they may identify as heterosexual or homosexual, have done so for a long time, and suffer from those choices as they can't fully be themselves.

Youth Issues

One person under the age of 20 was interviewed, plus 14 who were age 26 or under. Participants commented that youth services are often not inclusive of bisexuals and that in LGBT youth groups and services it usually isn't accepted to mention an other-sex partner. It was felt that there are not a lot of places bi youth can fully fit in. Particular programs to help meet the needs of bisexual youth, such as mentoring, a helpline, education and support services were proposed. The literature on bisexuality and youth reflects both these concerns and also the issues and experiences of bisexual adults which affect youth in distinct ways. McLean's (2001) research on bisexual youth describes

issues for young bisexuals including the double closet⁵, pressure to choose a heterosexual or homosexual identity, fear of discrimination in the gay and lesbian community, and a lack of resources, role models or peers. Dennis (2003) suggests that young bisexuals are more prone to mental health problems because of feelings of not belonging and pressures to be either gay or straight. Travers and O'Brien (1997) report that bisexual youth experience more isolation and confusion than their gay and lesbian peers, feel that their needs are not understood and find that gay and lesbian groups which include youth are not inclusive of bisexuals, while most bisexual resources are adult-oriented. They argue that bisexual youth need resources, support groups exclusively for bi youth, and supportive, understanding providers.

In terms of health risks, behaviourally bisexual high school students are more likely to report suicide attempts, drug use, unhealthy weight control practices, and experiences of being harassed, threatened or injured by others (Robin, Brener, Donahue, Hack, Hale and Goodenow 2002), and young men specifically report high levels of AIDS risk behaviours (multiple partners, unprotected intercourse, STDs and injection drug use), (Goodenow, Netherland and Szalacha 2002) compared to youth with only same-sex or only other-sex sexual activity. Young lesbians, bisexual women and those unsure about their sexual identity experience increased risks of unplanned pregnancy (off our backs, 1999). Blake, Ledsky, Lehman, Goodenow, Sawyer and Hack (2001) offer preliminary evidence of the benefits of using gay-sensitive HIV instruction in high schools to reduce sexual risk behaviours among gay, lesbian and bisexual youth, and the need for school-based AIDS prevention education specifically targeting bisexual youth is emphasized by Goodenow, Netherland and Szalacha (2002).

Youth is a period “characterized by fluidity with regard to sexuality” (Russell and Seif 2002, 81) thus issues around bisexuality are of particular interest when considering young people regardless of their sexual identity or behaviour. Russell and Sief also note that in their research more youth report attraction to both sexes than to exclusively the same sex. This is important because many studies of youth and sexuality only look at identity or sexual behaviour, and don't include a consideration of sexual attraction. More research needs to be done on bisexuality and youth which takes into consideration broad definitions of bisexuality and factors other than expressed identity and sexual behaviour. Bisexual youth are a particularly vulnerable population and it is important to understand their experiences and provide education and services that include and support them.

Cultural Diversity

Ten of the participants identified as people of colour. There are many different cultural ideas,

⁵ This refers to bisexual people maintaining their bisexuality by not coming out of the closet, but rather by staying in it twice, hiding their heterosexual activities from their homosexual friends while simultaneously keeping their homosexual activities from heterosexual friends.

references and experiences around homosexuality and bisexuality. Participants of colour felt that these differences were not often acknowledged in the LGBT community, bi communities or services directed at these communities. They also explained that it can be hard to find a place of belonging for all parts of oneself - as a person of colour, queer and bi. Bailey, Gurevich and Mathieson (2000) argue that it is a problem affecting health and wellness to not be able to find a community where all parts of one's identity are validated. Confidentiality in small ethnic communities was also mentioned as a concern. One respondent spoke of a possible resonance between being mixed race and being comfortable with a 'fuzzy' sexuality, which is also mentioned by Rust (1996a).

Rust (1996a) examines issues for bisexuals from culturally diverse backgrounds. She discusses how sexuality is not necessarily considered a basis for identity in some cultures, and there may be different organizing concepts around sexuality with the Western model not relevant for all. For example, a Latin American model of male sexuality is organized around the receptive/insertive role (pasivo/activo) rather than the sex or gender of one's partner. Different family issues may be present as well, such as family being more important and more a source of support. This can mean there may be more to lose in being rejected by one's family and ethnocultural group and less to gain, especially for bi people who may not be welcomed by gay and lesbian communities and have no bi group or community to go to.

Trans Issues

Five participants identified as transgendered or transsexual. Trans participants talked about people not understanding that gender identity and sexual identity are different, and some felt they were not included in their local bi community. One trans woman felt that her bisexuality was emerging with hormone therapy, as she had previously been only interested in women. Denny and Green (1996) note that research shows there is a high degree of bisexuality among trans people, however they strongly critique Weinberg, Williams and Pryor's (1994) assertion that trans people adopt a bisexual identity because they have a problem attracting partners. Denny and Green (1996) also point out that bisexuality as a term may not be useful when gender is deconstructed and we consider that there are more than two genders.

Health And Wellness Issues

Disclosure

46 of the participants said that they come out to some health care providers and 15 said they do not disclose. Some disclose only when asked and others when it seems relevant and/or safe. Reasons for not disclosing included feeling that it isn't relevant in some situations, fears around confidentiality/privacy and fear of negative reactions such as judgement, awkwardness, discomfort, lack of understanding, humiliation, or poor treatment. Ray and Landers (1999), Fallas and Landers (1999), and CLGRO (1997) mention similar issues. When asked if they wish they could come out, some said they wished they could have disclosed comfortably every time, and others mentioned that they would like to be asked, so they can disclose but don't have to bring it up themselves.

The reasons for wanting to come out, or why disclosure is important, included the desire to be seen

as a whole person, with bisexuality being part of who they are, to increase comfort levels and understanding, so proper diagnoses can be made and relevant information given, so providers can be sensitive and understanding to the issues being faced, for appropriate resource referrals, and generally because it is important for mental health and emotional wellness. This is consistent with the reasons reported by Fallas and Landers (1999) and Ray and Landers (1999). A small number of participants felt that it was not important or relevant to disclose their sexuality.

When asked about the actual or possible effects of disclosure on their treatment participants suggested that the effects could be either positive (being treated more holistically, getting proper safer sex information) or negative (provider becoming distant, being confused or uncomfortable, fear of being judged, faced with stereotypes and assumptions, being treated differently, discriminated against) depending on the provider. In order to deal with these issues, in addition to not disclosing when it doesn't seem safe, some participants research providers to make sure they are bi positive.

Richters (1997a) notes that disclosing bisexuality can be more complicated than for other sexual identities "because many providers, even gay- or lesbian-friendly ones, will read the clues of, say, contraceptive use as indicating exclusive heterosexuality, or the presence of a same-gendered partner as meaning childlessness" (19). Recent research also indicates that bisexuals are less likely to come out to health care providers than gay men or lesbians (Dottinga 2002, Davis and Wright 2001, Taghavi 1999, CLGRO 1997). Schilder, Kennedy, Strathdee, Goldstone, Hogg and O'Shaughnessy (1999) write that "[l]ack of safety to disclose within health care contributes to health care avoidance and poor care-seeking behaviours... The bisexual community has great difficulty divulging its legitimate health needs because of pervasive biased assumptions on the part of health care professionals" (120).

Experiences Using Services

Participants described using a full range of health and wellness services, both mainstream and alternative. They reported both positive and negative types of experiences related to their sexuality. In terms of negative or problematic experiences, many had experienced homophobia and/or heterosexism because of their same-sex partners or sexual experiences. However, they also had problems specifically around bisexuality, such as providers equating bisexuality with having multiple partners, not receiving appropriate information about safer sex with male and female partners, voyeurism, inappropriate jokes or comments, bisexuality being seen as the problem, and being told that you're either gay or straight.

"The most awkward times have been with regular doctors at hospitals or walk in clinics, with feelings of judgement, or real awkwardness or voyeurism from male doctors... stupid jokes like 'the more the merrier.'"

"I've given up therapy basically. It's tough to find somebody who gets the bi thing. I've had to deal repeatedly with biphobic remarks"

Positive experiences with services included the provision of inclusive forms and use of inclusive language (such as the intake form at the Sherbourne Health Centre and being asked about sex with men and women), bi positive counsellors or therapists, and providers who don't make assumptions

and who are supportive of bisexuality. 11 respondents said they have had a bi positive provider and 6 have had an out bisexual provider (in most cases a therapist). Having a bisexual provider was described as being validating, comfortable, and helpful in terms of her/his understanding of the issues of bisexuals. Other participants expressed that they would like to have a bisexual provider if possible, to legitimize their experiences and provide a role model, which is also mentioned by Fallas and Landers (1999). Even a bi positive provider who could discuss bi issues effectively, support a bi person's identity, and help them access a range of appropriate services and resources would be appreciated.

LGBT Services

Participants were asked whether services developed for the lesbian, gay, bisexual and trans communities are adequate to meet the need of bisexuals or if some separate services for bisexuals are needed. A few said that they were or that some specific service had been inclusive, but overall the feeling was that bisexuals are currently not well served by LGBT health and wellness services. This is backed up by the literature, where it is noted that gay or gay-positive providers are not always understanding about bisexuality and bisexuals may feel alienated in gay-oriented groups, programs and services. (Fallas and Landers 1999). McInnis and Kong (1998) observe that queer spaces are not necessarily safe for bisexuals and there is a need for bi-friendly clinics in gay communities. In short, “[s]ervices designed for gay and lesbian people frequently leave bisexual people feeling as though no one quite knows what to do with them.” (CLGRO 1997, 31)

Two ways of dealing with this problem were discussed: the first being the development of separate services for bisexuals and the second being better training and inclusivity around bisexuality in LGBT programs and services. Most commonly people felt that a combination of both approaches would be ideal so that bisexuals could have some bi-specific services and supports, but they could also utilize broader LGBT services for other health and wellness needs. Ideally the broader LGBT services should have bisexual specific education, include out bi providers and staff members, and make more of an effort to deal effectively with the unique issues of bisexual people. Some of the separate services that people felt would be helpful for bi people were counselling/mental health services, coming out groups, support/discussion groups and telephone support or information lines. Those in smaller areas realized that separate services for bisexuals were not realistic and felt that working for full inclusion in existing or developing LGBT services would be a more effective strategy.

“GLB groups need specific training about bi awareness. You can't just add it on and expect things to be different. Improvements need to be made to existing organizations to be more truly inclusive.”

“You always need both - a combination of separate and shared space, partly because notions of shared space often assume equal power and privilege. Issues of marginalized groups may be lost, therefore the need for some separate spaces to deal primarily with bi issues. This can be especially important when coming out.”

Barriers to Care

When asked if services have been inclusive of bisexuality and bisexuals, 36 said no or mostly not,

7 said some were, 12 said yes and 2 were not sure. When asked if providers were knowledgeable about bisexuality and bisexual issues, 38 said no, 7 said some were, 5 said yes and 5 said they don't know. A similar lack of inclusivity and knowledge was reported by the focus group participants in Ray and Landers (1999) and Fallas and Landers (1999). It is important to note that even when providers don't demonstrate negative attitudes, they may still be lacking the education needed to work well with bisexuals. This demonstrates how individual biphobia can be negligible in some instances, but monosexism, or institutionalized biphobia, remains an issue and a barrier to proper care and service for bisexuals.

When asked about barriers to health and wellness, including accessing services, many participants reiterated their points about barriers to disclosure, negative experiences using services, and the inadequacy of most LGBT services for bisexuals. Biphobia⁶ was also mentioned - including environments that felt unsafe, fear of judgements and negativity, not being welcome, along with assumptions that everyone is either straight or gay⁷ or that sexual behaviour equals sexual identity. Not being asked about bisexuality or sex with men and women was also seen as a barrier. As is implied above in the low number of people reporting knowledgeable providers, the lack of understanding, knowledge and education around bisexuality was another problem. This is consistent with the experiences of the focus group participants in Ray and Landers (1999) and Fallas and Landers (1999). Accompanying these barriers is the issue of having to educate providers, which is also discussed by Ray and Landers (1999), Fallas and Landers (1999), and Bisexual Women of Toronto (no date).

A particular barrier mentioned by bisexual women is in the area of safer sex and birth control for those who have been out as lesbians or have been perceived as such by their providers. They describe feeling awkward, afraid or uncomfortable about asking for birth control or safer sex information for sex with men, as well as fears that providers won't understand their issues and concerns about sex with men as women who have mainly been with women. It is important for providers to be aware that lesbian and bisexual women may still want or need information about fertility, pregnancy, infertility, abortion etc. (Luce 2002, Ryan, Brotman and Rowe 2000, off our backs 1999) and that to assume they don't creates problems for these women.

“I'm afraid to go see my doctor and ask to go on the pill. I had been planning to have children with my last partner through donor insemination. He'll raise his eyebrows too - going from fertility drugs to birth control. It's kinda strange”

“At that point in my life I got a new family doctor and said I'm primarily dating women. A few months later I came in and said I needed the morning after pill. She put her pen down and said “I thought you told me you were a lesbian”.... That's not a guarantee or a contract that I would only every date women or that I would get my doctor's approval about future liasons with men. That didn't mean I was locked in for life for heaven's sake.”

⁶ Ochs (1996) emphasizes that “[b]iphobia cannot be understood in isolation. It shares many characteristics with other forms of oppression, especially with homophobia, and persons who are bisexual generally experiences their share of both” (221).

⁷ Alley (1996) reports that almost 40% of social work students he surveyed felt that bis are confused and are really either straight or gay.

Other barriers named include the lack of research on bisexual health issues, lack of appropriate information on STDs/safer sex that targets bisexuals (also mentioned in Ray and Landers 1999, Fallas and Landers 1999), and reluctance to seek care, especially from traditional medical professionals. This last point was mentioned more often by women, in conjunction with a preference to seek alternative treatments and therapies when possible.

The literature also outlines a few additional barriers to health and wellness or accessing services which did not come up as strongly in this research, although they were mentioned by a few participants. These include: providers focussing more on either other-sex relationships or same-sex ones (Mathieson 1998, Bisexual Women of Toronto, no date), providers questioning same-sex feelings/experiences in ways that other-sex feelings and experiences are not questioned (Matteson 1996), fewer service providers specializing in bisexual issues compared to gay and lesbian issues (Davis and Wright 2001), and the additional work needed to find suitable providers for bisexuals (Fallas and Landers 1999).

A final important point is that providers often don't realize that bisexuals experience biphobia from gays and lesbians as well. "This oppression of bisexuals by gay and lesbian people is largely unrecognized and/or not understood by professionals working within queer populations... When professionals don't understand that bisexual clients may be oppressed by or isolated from both gay and straight communities, they aren't able to assess stress, anxiety, relationships or risk appropriately." (Keppel 2002)

Action Plan for Public Health: Recommendations, Solutions

Suggested Changes

New or Expanded Services

Participants described a broad range of new or expanded programs and services as well as changes to existing services which would improve access to and quality of health services for bisexuals. They would like to see better sex education at all levels which is inclusive of bisexuality and information and resources around sexual health developed specifically for bi people. Establishing coming out and support groups for bisexuals was another recommendation, including a group specifically for bi seniors. The need for these kinds of supports is acknowledged in the literature as well (Matteson 1996, Ochs 1996, Paul 1988). Support, programs and resources for nonbi partners of bisexuals and their families were also considered important, as mentioned by Ray and Landers (1999) and Paul (1988). Participants would like to have bi positive and bi focussed counsellors and mental health services, and an anonymous phonenumber or website for bi health questions. A directory of bi and bi positive services would be helpful, along with any other methods for increasing the awareness of services that include or are for bi people such as advertising as willing to serve bisexual community. Similar ideas are raised by Fallas and Landers (1999), Bisexual Women of Toronto (no date) and Sheehey (1999). It was also suggested that services and programs specifically for bi youth should be developed, including mentoring, a helpline, education and support groups or services, and something specific in health units. They would also like to see bi staff and service providers, increased funding for these various services and increased education for providers about bisexuality and sexual diversity. This need for provider education also emerged in Ray and Landers (1999) focus group with bisexual women.

“A lot of the help I’ve had has come through [bisexual] grassroots organizations. So where are the health services funded by the Ontario government for that type of adjustment? It’s a mental health issue. So much good is done by people with no funding and no resources except their own time. Why is this necessary? Why isn’t it treated as a bonafide health issue? There are lots of issue-specific health groups, so where are the adjustment or support groups that have official funding or status?”

It was also recommended that education and outreach for bi people around bisexual health issues was important. This could include consciousness-raising around how being bi could have an impact on health and the benefits of disclosing and strategies for locating a bi positive provider or determining if a provider is bi positive.

Participants also offered suggestions for broader changes to improve life for bisexuals. These included a large-scale media and public information campaign for bi awareness, increased bi visibility, increased public awareness and education, education targeting the gay and lesbian community, information on coming out as bisexual, and the development of bi social spaces, groups and communities.

“Bisexuals need a sense of community... We need to be able to talk to people about what affects us... With the help of community I accept who I am. The most important thing a

community can give an individuals is comfort in themselves, a sense of self-knowledge they wouldn't achieve on their own. I love my bisexual community.”

Inclusive, Safe and Accessible Services

As noted by CLGRO (1997), health care and social service agencies must provide adequate services for bisexuals, recognizing that “there are important differences between bisexuality, heterosexuality and homosexuality”(131) and that biphobia is distinct from homophobia. In order to create inclusive, safe and accessible spaces participants feel it is important for providers to be non-judgemental and easy to come out to, use inclusive language⁸, ask open ended questions, ask again later as things may change over time, be the ones to initiate discussion around bisexuality, and demonstrate visibly that they are inclusive and supportive of various sexual identities and behaviours, including bisexual, and of those who do not identify with any sexual identity. They also suggested the explicit inclusion of the word “bisexual” in posters, pamphlets, advertising, forms and other print materials. Similar approaches to creating inclusive services are mentioned by Miller and Solot (2001), Miller (2000), Ray and Landers (1999), Sheehey (1999) and The Centre (no date). Participants also felt that providers should ask about bisexuality, be comfortable saying the word and validate that being bisexual is okay.

“I don't want to have to guess if I'm included. I don't want to have to stress about it. Stress is bad for your health. Talk about things in different ways. Be inclusive.”

Participants emphasized repeatedly that it is of utmost importance that providers not make assumptions and specifically, that they not label people or assume that sexual behaviour equals sexual identity. Providers need to recognize that these are two separate things and they may not match up in the ways one might expect, so they should ask about behaviour if they want to know about sexual behaviour, and about identity if they want to know about sexual identity. This emphasis is reflected in the literature as well (Gay and Lesbian Medical Association 2003, Miller and Solot 2001, Gruskin 1999, Sheehey 1999, Ray and Landers 1999, Stokes, Miller and Mundhenk 1998).

Miller (2000), the coordinator of the BiHealth Program at the Fenway Community Health Center in Boston, offers steps to successful public health outreach to bisexuals which reflect many of the above points and offer some additional suggestions: 1. Educate yourself about bisexuality through reading, the Internet and/or having a bi community member come in to speak; 2. Understand the difference between behaviour and identity; 3. Advertise beyond the LGBT community; 4. Use the word bisexual - in your office, brochures, advertising. Don't always have it linked with gay and lesbian, sometimes have it stand alone; 5. Remember that lesbians and gay men may also have sex

⁸ For examples of inclusive forms and interview questions see Gruskin (1999), Sheehey (1999) and Sherbourne Health Centre's intake form.

with other-sex partners or be questioning whether they might be bisexual; 6. Reach out to other sexual minority communities such as polyamorous, swingers, BDSM; and 7. Connect people with bisexual resources.

Education for Providers

When asked what information or education providers should have about bisexuality and bisexuals, time and time again participants said the most important thing was for them to know “that we exist” and that being bisexual it is real and legitimate sexual identity and not a just a transitional phase. They also suggested that providers be educated about the diversity, complexity and wholeness of bisexuals - that bisexuality isn’t just about sex, that identity is important even when you’re not in a relationship, that bisexuals have separate issues from gay and lesbian people and there are many different ways of being bisexual. Providers should learn about bisexual issues through competency or sensitivity training, as suggested by Ray and Landers (1999) and Miller (2000), and be aware of resources in order to make appropriate referrals to books, websites, support groups and other resources focussed on bisexuality, as recommended by Miller (2000), Gainesville Bisexual Alliance (no date), Sheehy (1999) and Paul (1988). Education about polyamory was also mentioned, with the caveat that providers should be aware that not all bisexuals are polyamorous and that polyamory could be relevant for people of any sexuality.

Participants felt that providers should be aware that being educated about gay and lesbian issues is not enough, that they should specifically be trained to not make assumptions regarding people’s sexuality, sexual identity or sexual behaviour. The importance of listening and understanding the specific reality of different people’s lives was also emphasized.

“All health care providers should be taught to shut their mouths and open their minds.”

Recommendations

Based on all the evidence collected and presented in this paper on the social context of bisexual lives, their specific health and wellness needs and experiences, the barriers they face with regard to meeting these needs and obtaining appropriate services and support, as well as the suggestions for change proposed by participants themselves, the following recommendations are advised:

1. Research:

More research needs to be conducted that specifically looks at bisexuals and health, and that differentiates between gay men, lesbians, bisexual men and bisexual women. Where possible this research should take a community based participatory action research approach in order to best serve the communities and individuals being studied. Particular subgroups where more research is required include men, trans people, people of colour, people with disabilities, homeless/underhoused, youth (under 20), seniors, and those from northern or rural communities

2. Service and Program Development:

Visible inclusion in all public health services is recommended along with programs, services and providers which make conscious efforts to be safe, inclusive, and accessible for various sexual identities and behaviours, including bisexuality, and of those who do not identify with any sexual

identity. This recommendation further includes having bi staff and service providers, using inclusive language in forms and interviews, and explicit inclusion of the word “bisexual” in posters, pamphlets, advertising, forms and other print materials. Providers should ask about bisexuality, be comfortable saying the word and validate that being bisexual is okay. It is of utmost importance that providers not make assumptions and specifically, that they not label people or assume that sexual behaviour equals sexual identity. Providers need to recognize that these are two separate things so they should ask about behaviour if they want to know about sexual behaviour, and about identity if they want to know about sexual identity.

With regard to LGBT services, bisexual specific education should be incorporated, out bi providers and staff members should be included, and efforts should be made to deal effectively with the unique issues of bisexual people following the guidelines outlined above for all health services and programs.

It is also recommended that a range of bi specific programs and services be developed including information and resources around sexual health developed specifically for bi people, better sex education at all levels which is inclusive of bisexuality, coming out and support groups for bisexuals, support, programs and resources for nonbi partners of bisexuals and their families, bi positive and bi focussed counsellors and mental health services, an anonymous phoneline or website for bi health questions and a directory of bi and bi positive services. The creation of specific services and programs for bi youth, such as support groups, mentoring, a helpline, and targeted HIV/AIDS prevention education, is also recommended. Community partnerships in the area of creating support systems for bisexuals and building bi community is advised, along with education and outreach to bisexuals around bisexual health issues.

3. Public Education:

Recommendations for public education include a large-scale media and public information campaign for bi awareness, increased bi visibility in media and public life, and education targeting gay and lesbian communities.

4. Education for Providers:

Providers and students training to be providers need to be educated during their professional programs and as part of ongoing professional development on issues specific to bisexuals (recognizing that education on gay and lesbian issues is not enough), the diversity, complexity and wholeness of bisexual people, resources and referrals pertaining to bisexuality, polyamory, and the importance of listening and understanding the specific reality of different people’s lives. As well, education for providers should emphasize the necessity of not making assumptions regarding people’s sexuality, sexual identity or sexual behaviour.

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APPENDIX B: Recruitment Strategies and Demographics of Participants

Recruitment Strategies

Potential participants were reached through multiple points of entry including: bisexual, queer and feminist email lists, the OPHA newsletter, personal contacts, Toronto and Ottawa bisexual groups, flyers sent to queer and feminist groups in Ontario (targeting northern Ontario as well as groups for people of colour, aboriginal people, youth, street-involved and deaf people in Toronto), a classified ad in Share, (a Greater Toronto Area Black and Caribbean community newspaper), an ad in the Thunder Bay Chronicle Journal (a daily newspaper serving Northern Ontario), word of mouth and the email being passed on to people’s friends, lists and contacts.

Demographic Profile of Participants

Gender	Participants included 22 men, 39 women and one gender fluid person. Of this total, 5 were trans people: 2 female-to-male and 3 male-to-female.
Age	Ages ranged from 16 to 67, with an average age of 33. 15 youths (aged 26 and under) and 3 seniors (aged 50 and over) were interviewed
Place of Residence	Almost half were from Toronto (27), 9 were from Ottawa, and 5 or less were from the following locations: Aurora, Barrie, Belleville, Elora, Guelph, Kingston, Kitchener/Waterloo, London, near Mitchell, North Bay, Oakville, rural Stratford, Sudbury, Thunder Bay, and Walter’s Falls.
Birthplace	Most were born in Canada, with only 13 reporting a birthplace outside Canada.
Race/Ethnicity	The majority were white, only 10 identified as people of colour (including Afro-Caribbean, Anglo-Indian, Asian/Ismaili, Black/West Indian/African, Chinese, mixed race, mixed race - Jamaican Black and Canadian white, and mother Philipino, father Swiss).
Education	The participants were a highly educated group with 38 having completed a bachelor’s degree or higher. Only 3 had high school or less.
Housing	All reported that they currently have housing.
Employment	In terms of employment, 24 reported being employed full-time, 14 reported being full-time students, and the remaining were either unemployed, employed or attending school part-time, on social assistance or ODSP (Ontario Disability Support Program), retired or stay home parents
Income	An income under \$15,000/year was reported by 23 participants, \$15,000-40,000/year by 22 participants and over \$40,000/year by 17 participants.

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Health	Most reported that they did not have a disability or long-term physical or mental health condition (40). Conditions reported include depression (7), asthma (2), chronic back pain (2), Attention Deficit Disorder (1), post traumatic stress disorder (1), borderline personality disorder, severe chronic unipolar affective disorder, acute anxiety disorder (1), chronic fatigue immunodeficiency syndrome and fibromyalgia (1), classic migraine (1), Multiple Sclerosis (1), mild environmental allergies (1), physical disability due to fibromyalgia, degenerative disc disease (1), thyroid disease (1), post surgical thyroid cancer (1) and transsexuality (1).
Sexual Identity	In terms of sexual identity, most identified as bi, bisexual, or bisexual in combination with another identity, such as bi-dyke, bi-fem or queer bisexual (46), with others identifying as lesbian, queer, straight with a 'bend', two-spirited, just plain sexual, transensual, polyamorous, stone femme, phreak, changing, pansexual, Kinsey 2 ⁹ , or saying that it depends or that they don't identify. All reported that they have had sexual experiences with more than one gender
Relationships	Participants reported a variety of relationship situations with both other-sex and same-sex partners. These include: common-law with an other-sex partner (7), common-law or union with a same-sex partner (5), dating (sex of partner not specified) (8), long-distance relationship (1), single (24), married to an other-sex partner (11), long term committed monogamous partner (3), divorced (2), and polyamorous (4).
Children	16 participants have children, 10 want to have children and 1 reported being a foster parent. 19 are undecided and 16 do not want to have children.
Openness about their Bisexuality	Participants reporting varying degree of outness, with 24 saying they were very open or totally open, 1 not open to anyone at all, and the rest falling somewhere in between, being out in some areas of their lives and not others.
LGBT Community Involvement	Only 3 were not involved in the LGBT community at all, and 5 had minimal involvement. The rest were involved to varying degrees in a broad range of groups and activities.
Bisexual Community Involvement	34 are or have been involved in some form of bisexual community, mostly in Toronto and Ottawa.

⁹ This is based on the Kinsey Scale, which is a continuum model of sexuality, placing exclusively heterosexual on one end (a Kinsey 0) and exclusively homosexual on the other end (a Kinsey 6), with all points in the middle being some combination of homosexual and heterosexual (Klein 1993). A Kinsey 2 would be predominantly heterosexual but with some degree of homosexuality.

Limitations

Many more women than men contacted me about participating in the project, and in the end men made up only 1/3 of the respondents. Such a gender difference is not unusual in research on bisexuals (Taghavi 1999). Although the sample did include a wide diversity of people, there are certain groups which were underrepresented: people of colour, people with disabilities, homeless/ underhoused individuals, youth (under 20), seniors, and those from northern or rural communities.

APPENDIX C: Definitions

- BDSM:** “A four letter acronym that stands for six words. BD stands for “bondage and discipline”; DS stands for “dominance and submission”; and SM stands for “sadism and masochism” (Lenius 2001, 71-72)
- Biphobia:** Prejudice, discrimination and oppression against bisexuality and bisexuals
- Bisexual:** Richters (1997a) outlines the three main ways of defining or conceptualizing bisexuality. The first is the experience of sex with both men and women (behavioural bisexuality), the second is sexual desire for both genders, and the third is self-identification as bisexual. A general definition that encompasses all of the above is that a bisexual is someone with “the potential for being sexually and/or romantically involved with members of any gender” (McInnis and Kong 1998, 35).
- Health:** “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. It is the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs and, on the other hand, to change or cope with the environment” (World Health Organization). “Wellness includes your mental, spiritual, sexual, intellectual, social and emotional well-being. Being healthy is about having the skills and resources to meet your needs and goals, and to change or cope with what life brings. It is about you as an individual and the broader environment in which you live” (Lockwood and Bursery 2001, 2).
- Monosexism:** The effects of the pervasiveness of the heterosexual/homosexual dichotomy and the assumption that everyone fits into one of these two groups. It is "the belief that people can or should be attracted to only one sex/gender and that there is something wrong with those who cannot or will not choose" (Highleyman 1995, 87).
- Pagan:** Earth centred polytheism, see also **Wicca**
- Polyamory:** Responsible nonmonogamy, which may include all forms of having more than one sexual or romantic partner where these relationships are conducted in an open and honest way with all the parties involved
- Two-spirited:** “The term Two-spirited, though relatively new, was derived from interpretations of Native languages used to describe people who displayed both characteristics of male and female. Traditionally, the Two-spirited person was one who had received a gift from the Creator, that gift being the privilege to house both male and female spirits in their bodies.” www.mcgill.ca/interaction/mission/twospirit/
- Wicca:** A specific type of pagan spirituality, based on ancient nature religion, which celebrates the earth and the cycles of life and death. Modern wicca, or witchcraft, is a “rich kaleidoscope of traditions and orientations” (Starhawk 1999, 35) with common elements including love for all life, the sacredness of all forms of loving sexuality, the interdependence of all things, and the belief that the Goddess or the divine is present in all forms of life, including human beings.

APPENDIX D: Bisexual Resources

BISEXUAL GROUPS IN ONTARIO

Toronto

Toronto Bisexual Network - www.torontobinet.org (416) 925-9872 x2810

Bisexual Women of Toronto - www.biwot.org (416) 925-9872 x2810

Bisexual Men of Toronto - (416) 925-9872 x2810

Ottawa

Ottawa Bi/Poly Group - www.polyamory.org/SF/Groups/obpd.html

Bi women's discussion group - www.pinktriangle.org/pts_site/Eng/obwdg.html (613) 237-9872 x2117

Additional groups, events and resources in Ontario for gay, lesbian, bisexual and trans people can be found at: www.binetcanada.org/en/on/

INTERNET RESOURCES

General bisexual sites

Bisexual Resource Center - www.biresource.org

Bisexual.org, bringing bisexuals together - www.bisexual.org

BiNetCanada - www.binetcanada.org

All Things Bisexual, the bisexual directory - www.allthingsbi.com

Bi The Way - <http://bitheway.org/Bi>

bi.org, serving the world's bisexual community - <http://bi.org>

Bi All Means...the bisexual person's guide to the internet! - www.biallmeans.org

Bisexual health related sites

Bisexual Health Links - www.biresource.org/health

Bisexuality and HIV Prevention - www.biresource.org/bothteams

Gay, Lesbian & Bisexual Health Links - www-hsl.mcmaster.ca/tomflem/gay.html

COMMUNITY RESOURCES

The Canadian Gay, Lesbian & Bisexual Resource Directory

This directory provides information on gay, lesbian and bisexual resources throughout Canada.

You can look up resources in your area on their website: www.gaycanada.com/index.php or by calling 1-800-245-2734.

Sherbourne Health Centre

This Toronto health centre provides counselling and primary health care services for gay, lesbian, bisexual, transgender and transsexual people. It is located at 333 Sherbourne Street and you can get more information from their website: www.sherbourne.on.ca or by calling (416) 324-4180.

EMAIL GROUPS

There are a number of bisexual email groups available through yahoo groups. To sign up for a group, go to the yahoo groups website at: <http://groups.yahoo.com/> and it will guide you through the steps to join a new group by group name. Here are a few local and Canadian bi groups:

- binetcanada - a discussion group for bisexual people in Canada
- Bisexual_OntarioCanada - a group for bisexual and bi-curious people in Ontario
- BISEXUAL_IN_ONTARIO - a group for bisexuals in Ontario seeking friendship and/or sexual encounters
- Bi-Polyamory-Ottawa - a group for bisexual and/or polyamorous people in Ottawa
- bito - a discussion group for members of Toronto's bisexual community.
- biwot - the bisexual women of Toronto discussion group
- bimot - the bisexual men of Toronto discussion group

There are lots of other bisexual email lists and newsgroups available, many of which are listed at www.biallmeans.org and www.biresource.org/maillinglists.html

BOOKS

The Bisexual Resource Guide 2001. Robyn Ochs

The Bisexual Option. Fritz Klein

Bi Any Other Name: Bisexual People Speak Out. Loraine Hutchins and Lani Ka'ahumanu

Bisexual Horizons: Politics, Histories, Lives. Sharon Rose and Cris Stevens et al

Bisexual Politics: Theories, Queries, and Visions. Naomi Tucker

Bisexualities: The Ideology and Practice of Sexual Contact with Both Men and Women. Erwin J. Haeberle and Rolf Gindorf

Bisexuality: The Psychology and Politics of an Invisible Minority. Beth Firestein

Bisexuality in the Ancient World. Eva Cantarella

Blessed Bi Spirit: Bisexual People of Faith. Debra Ruth Kolodny

Dual Attraction: Understanding Bisexuality. M. Weinberg, C. J. Williams, D.W. Pryor

Vice Versa: Bisexuality and the Eroticism of Everyday Life. Marjorie Garber

Bisexual Women

Plural Desires: Writing Bisexual Women's Realities. The Bisexual Anthology Collective

Women and Bisexuality. Sue George

Closer to Home: Bisexuality and Feminism. Elizabeth Reba Weise

Bi Lives: Bisexual Women Tell Their Stories. Kata Orndorff

Bisexual Men

Bisexual Men in Culture and Society. Brett Beemyn and Erich W. Steinman

Bi Men's Lives: Bisexual Men Tell Their Stories. Mark Zepezauer

Bisexuality in the Lives of Men: Facts and Fictions. Brett Beemyn and Erich W. Steinman

Bisexual and Gay Husbands. Fritz Klein and Thomas Schwartz

Resolution

WHEREAS the individual and systemic oppression of bisexuals, which overlaps with the oppression of gay men and lesbians, but also takes forms specific to bisexuals (biphobia and monosexism), has a significant impact on their health and well-being;

WHEREAS there is a gap in culturally competent education addressing bisexual health for health care providers, policy makers and researchers across communities resulting in limited institutional capacity to support the health and well-being of bisexuals in a public health context;

WHEREAS health professionals, LGBT communities and the general public often have limited understanding of bisexuality and the holistic needs of diversely situated bisexuals;

WHEREAS public health services are mandated to support the needs of vulnerable populations;

WHEREAS public health services have not consistently provided safe, inclusive and accessible programs and services for bisexuals;

WHEREAS there is a lack of comprehensive and accessible research evidence that addresses bisexuality and the holistic needs of bisexuals in a public health context, specifically that which addresses bisexuality, separately from that of lesbians and gays;

WHEREAS there is a gap in funding to support the development of research capacity to address the health and well-being of diversely situated bisexuals in a way that facilitates ethical research and development of community capacity

THEREFORE LET IT BE RESOLVED THAT the Ontario Public Health Association adopts the “Improving the Access to and Quality of Public Health Services for Bisexuals” position paper;

BE IT FURTHER RESOLVED THAT the Ontario Public Health Association advocate for the inclusion of bisexual health issues within the program standards of the Ontario Mandatory Health Programs and Services Guidelines, across all public health programs, especially for groups such as youth who may be at risk; and

BE IT FURTHER RESOLVED THAT the Ontario Public Health Association advocate for the inclusion of bisexuality and the needs of diversely situated bisexuals into standards of practice and cultural competency education for health professionals, service providers and LGBT communities; and

BE IT FURTHER RESOLVED THAT the Ontario Public Health Association petition the Canadian Public Health Association and Health Canada to increase research capacity for bisexual health by supporting the development of national research strategies to address bisexual health issues and by advocating for research funding and community based participatory action research

processes which enhance the possibility that diversely located bisexuals can define their health issues and participate in the development of inviting public health and community partner support.

Suggested Implementation Strategies

1. This paper will be presented to the general membership of the OPHA at the Annual General Meeting, November, 2003 (PHA).
2. Collaborate with partners to build on existing services to increase access to and provision of bi-positive community health services (OPHA/PHA)
3. Advocate for accessible and relevant programs and services for bisexuals which include those targeted specifically to bisexuals and those which are integrated across programs (OPHA)
4. Advocate for large scale public awareness across communities, including LGBT communities, and education for bisexual individuals and communities on bisexual health issues for inclusion in mandatory program and service guidelines (OPHA)
5. Distribute this position paper to bisexual individuals and organizations (OPHA)
6. Support broad public health education strategies to increase knowledge and understanding, e.g., media campaigns (OPHA/PHA/community partners, e.g., Rainbow Health Network)
7. Advocate to Ministry of Education and Training for inclusion of bisexual health issues in school curriculum (OPHA President)
8. Support educational initiatives for practitioners, researchers, and policy-makers across both LGBT and mainstream communities that emerge from collaboration with the bisexual communities (OPHA/PHA)
9. Distribute this position paper to key health professional, policy-making and research stakeholders (public health units, community health centers, professional programs) and the LGBT communities, e.g., Rainbow Health Network (PHA/OPHA)
10. Disseminate the research findings through conference presentations and publication of articles in scientific and scholarly journals (Principal Investigator/PHA)
11. Advocate at the Board of the CPHA for a national research strategy on bisexual health (OPHA President)
12. Advocate to funding bodies (e.g., Health Canada, CIHR) for research on bisexual health, especially projects using a community based participatory action research model (OPHA)
13. Support the development of resources (ethical research guidelines, body of literature and network of researchers) in collaboration with LGBT communities (PHA/Rainbow Health Network, National LGBT Health Researchers) and academic research communities (OPHA/PHA)