HUMAN RIGHTS COMPLAINT

Against the Government of Canada:

Health Canada and the Public Health Agency of Canada

February 2009

COMPLAINT STATEMENT

We are gay, lesbian or bisexual (GLB) Canadians who believe that the GLB population does not receive equitable levels of programming supports based on needs when compared with programming supports for the general population and other minority populations, from Health Canada or the Public Health Agency of Canada. In particular, the GLB population is not included as a priority population and therefore receives no dedicated funding when addressing those health issues where GLB communities are disproportionately affected. Such inequities occur despite departmental and agency mandates, and precedents each have established in providing dedicated funding for other specific minority populations.

These government departments might suggest that GLB populations aren't specifically excluded from their programs and services. However, ignoring the unique health needs of our community is a form of discrimination against our communities.

Some comments and definitions to clarify the above complaint statement:

Numerous positions have been taken regarding what percentage of the general population GLB Canadians represent, because it is difficult to determine what percent of the general population is gay or bisexual due to two methodological hurdles. The first involves the definition of homosexuality. Since a firm demarcation between homosexual and heterosexual individuals does not exist, surveys differ in the characteristics of individuals considered to be homosexual. In short, there are variations in determining what is being studied: sexual *behavior,* i.e. the gender of the people one has committed sex acts with; sexual *orientation,* i.e. one's preference or inclination in terms of the gender of the people one has a spontaneous sexual attraction to; and sexual *identity* (a.k.a. self-identification), i.e. the demographic label one chooses to describe oneself to ourselves and to others.

The second and perhaps insurmountable obstacle to determining the representation of GLB Canadians within the general population is the reluctance of many individuals to disclose information about their sexual orientation because of the realistic fear that disclosure could be damaging to them.

Because sexual orientation operates along a continuum and is not static, it is a challenge to arrive at a percentage of the population that is gay, lesbian or bisexual. However, with the research we have studied as well as our experiences from working on issues related to sexual orientation, we consider it reasonable to state that 10% of the population is gay, lesbian or bisexual, taking into account behavior, orientation and identity.

Ultimately it should not matter what the numbers are. The Supreme Court of Canada has recognized GLB Canadians as a distinct population entitled to full equality in all areas of our lives including health and wellness. The provision of equitable health promotion information, services and programs should not be based on a population's size, but on the health status of that population.

Some studies that look at the prevalence of homosexuality and the issues involved are listed here. Unfortunately, none of these look at the prevalence of bisexuality.

www.rainbowhealth.ca/documents/english/homophobia_human.pdf

www.youth-suicide.com/gay-bisexual/notes.htm

www.emedicine.com/Med/topic3359.htm

We use two terms throughout this complaint and offer here our definition of those terms, in the interest of ensuring that our meaning is clearly understood:

Heterosexism: The belief that everyone is heterosexual and that heterosexuality is the only acceptable way of being. This belief, which relies on the idea that the majority rules and is therefore normal, is often the source of homophobia.

Homophobia: A negative attitude or feeling, an aversion towards gays and lesbians or towards homosexuality in general. It is also the rejection of people considered gay or lesbian and of all things associated with them, for example, gender non-conformity.

THE CONTEXT OF THIS COMPLAINT

HEALTH CANADA

Mission and Vision: Health Canada is the Federal department responsible for helping Canadians maintain and improve their health, while respecting individual choices and circumstances. Health Canada is committed to improving the lives of *all* of Canada's people and to making this country's population among the healthiest in the world as measured by longevity, lifestyle and effective use of the public health care system. *(emphasis added)*

Objectives: By working with others in a manner that fosters the trust of Canadians, Health Canada strives to:

1. Prevent and reduce risks to individual health and the overall environment
2. Promote healthier lifestyles;
3. Ensure high quality health services that are efficient and accessible;
4. Integrate renewal of the health care system with longer term plans in the areas of prevention, health promotion and protection;
5. Reduce *health inequalities* in Canadian society; and
6. Provide health information to help Canadians make informed decisions. *(emphasis added)*

PUBLIC HEALTH AGENCY OF CANADA

Mission: To promote and protect the health of Canadians through leadership, partnership, innovation and action in public health.

Vision: Healthy Canadians and communities in a healthier world.

THE CANADIAN CHARTER OF RIGHTS AND FREEDOMS:

15. *(1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, color, religion, sex, age or mental or physical disability.*

THE BASIS OF THIS COMPLAINT

We are filing this human rights complaint against Health Canada and the Public Health Agency of Canada because they actively and passively discriminate against gay, lesbian and bisexual (GLB) Canadians in their lack of dedicated research, information, programs and services, and most particularly funding. Both agencies provide programming to target specific health issues in a range of areas including working in partnership with specific minority populations to address those health and wellness issues unique to those populations. However, this approach is not applied equally to programming for GLB Canadians. Both the government department and the government agency claim responsibility for promoting and protecting the health of Canadians but we maintain that neither is actively or methodically working to address the unique health and wellness issues faced by lesbian, gay and bisexual Canadians. This despite repeated attempts over decades from representatives of GLB Canadians across the country to partner with them on such issues.

The health status of GLB Canadians is among the poorest of any population in Canada. These health and wellness issues have been linked through research to the experience of living in a homophobic and heterosexist culture that undermines the dignity of GLB people and impinges on their ability to strive for success and happiness. We assume that Health Canada and the Public Health Agency of Canada will tend to reflect the homophobic and heterosexist culture from which their personnel are drawn. On that basis, we insist that they have a responsibility to rise above that tendency in order to achieve their Mission and Vision as they apply to GLB Canadians.

Research into the causes and nature of health and wellness of GLB people is limited and needs to be supported at levels that will allow the appropriate catch-up relative to similar research aimed at the general population. What research exists to date clearly demonstrates that GLB people are significantly impacted by homophobia and heterosexism.

THE HEALTH ISSUES OF GLB CANADIANS

LIFE EXPECTANCY

While the number of studies on the life expectancy of GLB people is limited, what research exists consistently indicates that the life expectancy of GLB people is substantially lower than that of the general population.

It is difficult to research life expectancy issues for a population largely hidden due to GLB individuals' understandable reluctance to self-identify in surveys and other public data gathering tools. The HIV/AIDS epidemic has focused research on such issues as they relate to gay/bisexual men and this information provides some information as it relates to an important segment of the GLB population.

It has been estimated that gay/bisexual men have a life expectancy 20 years less than the average man in Canada. In their book *Caring For Lesbian and Gay People—A Clinical Guide,* [1] authors Dr. Allan Peterkin and Dr. Cathy Risdon suggest that the life expectancy of gay/bisexual men in Canada is 55 years. Less research has been conducted on the life expectancy for lesbians in Canada but health indicators suggest that while it is not as low as that for gay men, it is still lower than the life expectancy of the general population.

In 2001, a literature review sponsored by the Gay and Lesbian Health Services in Saskatoon estimated the economic cost of homophobia in Canada to be as high as $8 billion a year. A 2003 literature review estimated that as many 5,481 GLB Canadians die prematurely each year as a direct result of homophobia. [2, 3]

There are many factors causing a lower life expectancy for GLB Canadians, with the social isolation and marginalization caused by homophobia and heterosexism at the top of the list of major stressors in their lives. This is no surprise: We know that other populations such as Aboriginals, people of color, and the poor have poorer health status because of their marginalization.

SUICIDE

A significant number of studies focusing on the suicide rate of GLB people suggest that, when compared with the heterosexual population, GLB people commit suicide at rates that range from a low of twice as often, to a high of 13.9 times more often, than the general population. A more usually quoted number is that GLB people have a suicide rate 3 times greater than that of the general population and that GLB people comprise 30% of all suicides in Canada. Suicide is preventable and with appropriate programming the suicide rate in GLB people could be substantially reduced. [4]

SMOKING

Smoking is an unhealthy behavior that is typical in populations where individuals must deal with stressful life situations. Certainly, living in a homophobic culture is very stressful for those who are, and want to live happily as, GLB individuals.

Studies have found that GLB people have smoking rates ranging from a low of 1.3 times higher, to 3 times higher, than that of the general population. Studies of GLB youth have shown smoking rates even higher, with one study of young lesbians in the southern United States stating that 78% were smokers.

Health Canada and the Public Health Agency of Canada have funded extensive social marketing campaigns to reduce smoking rates, although few of those campaigns targeted GLB communities. As with suicide, smoking is preventable and with appropriate programming the smoking rate in GLB people could be substantially reduced. [2, 3]

ALCOHOL USE

As with smoking, the use of alcohol is a behavior typical of people trying to cope with stress in their lives and it frequently results in alcoholism within such populations. Studies into the rates of alcoholism in GLB people show a range from a low of 1.4 times higher, to a high of 7 times greater, than the general population. Some of the studies clearly linked the increased rate of alcoholism to homophobia.

Governments at all levels have funded programs to reduce the rates of problem drinking. More targeted programming for the GLB population is needed to address its particular needs in reducing rates of alcoholism. [2,3]

It is reported that GLB populations are less likely to seek support or treatment for alcohol addiction from mainstream services providers.

ILLICIT DRUG USE

People dealing with stressful environments in their lives may well turn to illicit drugs as a means of coping with that stress. Again, studies show that GLB people have higher rates of illicit drug use ranging from a low of 1.6 times higher, to a high of 19 times

higher, than the general population. Illicit drug use is another area that can be addressed through innovative programming. [2,3]

As with alcohol use, it is reported that GLB populations are less likely to seek support or treatment for drug addiction from mainstream services providers.

DEPRESSION

It is estimated that 5% of the general population experiences severe depression at some point in their lives. However, studies into depression within the GLB community show rates ranging from a low of 1.8 times higher, to a high of 3 times higher, than those within the general population. Once again, targeted programming is needed to address this health issue as it affects GLB Canadians. [2,3]

ACCESS TO CARE

A 2006 study by Statistics Canada indicated that GLB Canadians are twice as likely to have unmet health needs and to not have a family physician. Obviously, those GLB people responding to the national survey were "out" and willing to identify as gay, lesbian or bisexual. It can be reasonably assumed that many others were not comfortable disclosing their sexual orientation, and many believe that those hidden GLB populations have much poorer health and even less access to the health care system. This information indicates that more research as well as programming may be needed to address GLB issues in this area. [5]

HIV/AIDS

It is within the area of HIV/AIDS that the inequities in Health Canada and Public Health Agency of Canada policies and programs vis-à-vis GLB people are most clearly illustrated. Gay and bisexual men (referred to as men who have sex with men [MSM] by the epidemiologists) comprise 76.1% of the AIDS cases since statistics were first kept and 45% of the new HIV infections each year. The GLB community has borne the brunt of the HIV/AIDS epidemic, yet 25 years after the epidemic first appeared in Canada there has never been a dedicated program or strategy—and by extension, sufficient funding—to tackle this epidemic in the GLB community.

Health Canada and Public Health Agency of Canada have recognized the importance of developing strategies to address HIV/AIDS issues in the Aboriginal community. In the 1990s a specific strategy to address HIV/AIDS in the Aboriginal community was developed by Health Canada in partnership with Aboriginal communities. That strategy was provided with an initial funding of approximately $1.25 million to support initiatives nationally and in communities across the country. Many millions more in funding has since been provided by Health Canada through First Nations and Inuit Health specifically for addressing HIV/AIDS.

In the latest *HIV/AIDS Epidemiological Update* it is reported that while Aboriginals comprise 3.3% of the population they comprise 7.5% of HIV/AIDS cases in the country. The update also pointed out that the infection rate in the Aboriginal community was 2.8 times higher than the general population. [6]

We strongly support dedicated funding to address disproportionate representation of HIV/AIDS in specific populations such as the Aboriginal community. And we wonder why such a dedicated strategy and related funding are not also provided to the GLB community. Statistics on the percentage of GLB Canadians vary but it is clear that the HIV/AIDS infection rate in the GLB community is significantly higher than that of the general population.

If one uses the figure of 5% of the population being gay or bisexual men (roughly one half of the GLB population) then the HIV/AIDS infection rate in the GLB community is 9 times higher than that of the general population. If one uses Statistic Canada's figure of 1.7% for the percentage of the population that is GLB and becoming infected, then the infection rate is 26 times higher than the general population.

Given that the Aboriginal community merits a dedicated strategy and dedicated funding for an infection rate 2.8 times higher than the general population, does it not make sense that the GLB community should also have a dedicated strategy and dedicated funding to address an infection rate that is 9 to 26 times higher than the general population? Yet there is no such strategy for GLB Canadians. We interpret this as discrimination against GLB Canadians by Health Canada and the Public Health Agency of Canada.

Both Health Canada and the Public Health Agency of Canada claim that their decisions about programming and funding are based on the scientific evidence available to them. However, the science actually indicates that the GLB community, and all Canadians, would be best served by a dedicated HIV/AIDS strategy. Yet both agencies are apparently unwilling to put the resources into better addressing the many issues surrounding HIV/AIDS in the GLB community.

In 1999 the HIV/AIDS Policy, Coordination and Programs Division of Health Canada convened a group of gay men from across the country to develop a re-

port with recommendations on how the Division could better address HIV/AIDS in the GLB community. Health Canada provided approximately $250,000 for the National Reference Group (NRG) and recruited volunteers who were recognized for their expertise and experience in addressing HIV/AIDS in their GLB communities to sit on the NRG. The NRG's mandate was to develop a blueprint that would inform and guide the analysis and action of the HIV/AIDS Division in developing strategies to address HIV/AIDS in the GLB community.

In October 2000 the NRG presented their report to the HIV/AIDS Division of Health Canada. The report consisted of two documents, *Valuing Gay Men's Lives: Reinvigorating HIV prevention in the context of our health and wellness* and *Framing Gay Men's Health in a Population Health Discourse: A discussion paper.*

The reports looked at the science behind the HIV/AIDS epidemic in the GLB population and made 32 recommendations on how the HIV/AIDS Division could best address prevention within the GLB community. They also identified other countries that had reduced their HIV infection rates substantially by funding dedicated prevention strategies for gay and bisexual men. They further made a clear call for a dedicated strategy and funding to address HIV/AIDS in the GLB community. To date not one single recommendation of the NRG's reports has been acted on by Health Canada or the Public Health Agency of Canada. [7, 8]

CANCERS

Gay men, lesbians and bisexual men and women are at higher risk for some cancers as a result of their sexual orientation and because preventative messaging is not targeted at GLB communities. Because of higher rates of smoking and alcohol use, GLB populations are at a higher risk for lung and liver cancer. Sexually-active gay and bisexual men have a higher prevalence of anal cancer precursors due to frequent exposure to the human papillomavirus, a virus believed also to be a contributor to high rates of head, throat and neck cancers among this same population. Lesbians are reported to be at a higher risk for breast cancer based on particular risk factors more prevalent in this population. Lesbians are also at increased risk for cervical cancer due to practitioner ignorance about the need for lesbians to undergo regular pap testing.

VIOLENCE AND BULLYING

Members of the GLB minority population have a much greater risk of experiencing verbal and physical abuse, including murder, as a result of homophobia. Verbal abuse, and the threat of violence against one's person, can begin early on in the public school system and can continue throughout an individual's lifetime. Hate crimes perpetrated against GLB Canadians continue to occur at an unnecessarily high rate.

BLOOD DONATIONS

While we recognize that the Canadian Blood Services (CBS) is primarily responsible for the policies around the safety of blood transfusions, we believe that Health Canada, which funds the CBS, is ultimately responsible for the policy that prevents any gay or bisexual male from donating blood if they have had sexual intercourse with another man since 1977. Since this policy has no basis in science, is it possible that some Health Canada officials still fear a risk of being sued because of their role in the tainted blood scandal and are taking a course of action that protects them to the detriment of GLB Canadians?

Science clearly shows that those infected with HIV produce antibodies to the virus within three to six months of being infected, with the average being 22 days. Those antibodies can be detected by testing the blood. Anyone infected in 1977, or the 1980s or 1990s for that matter, is likely to be either dead, or diagnosed with HIV or AIDS by this point in time.

Other countries have examined their policies and made changes regarding blood donations from gay or bisexual men. France, Italy, Spain, South Africa, Sweden, Russia and Australia have lifted their bans, and none has seen a rise in contaminated blood. In fact, clinical evidence suggests lifting the ban has cut contamination. Italy screens donors on the basis of risk, rather than sexuality, and since introducing this policy in 2001 the number of HIV infections via blood transfusion has fallen by two thirds. Spain also screens according to risk. Its health ministry says HIV contaminations have plummeted 80 per cent.

Other countries are examining changes to their bans including the United States, where in 2006 the American Association of Blood Banks, the American Red Cross and America's Blood Centres all supported a change from a lifetime ban to one year since most recent contact. One study suggested that such a change would result in one case of HIV transmission by transfusion every 32.8 years. A spokesperson from the American Red Cross said, "It does not appear rational to treat gay sex differently from straight sex."

There is no real scientific justification for maintaining the discriminatory lifetime ban on blood donations by men who have sex with another man. However, such a policy sends a powerful message that

gay and bisexual men are a threat to public health. Thus, it contributes to the maintenance of homophobia within Canadian culture as well as within Health Canada and the Public Health Agency of Canada. Is it not likely that such a homophobic message causes bureaucrats within both agencies to tread softly when it comes to GLB Canadians? Certainly, the anecdotal information we have from GLB individuals in those bureaucracies indicates this is the case.

ORGAN DONATIONS

Last year Health Canada publicly announced that gay men are not allowed to be organ donors if they have had sex with another man in the past five years. An immediate question arises: Why is there a lifetime ban on donating blood by men who have had sex with other men since 1977 but merely a five year ban on donating organs? This discrepancy does not seem to be based on science. Could it be another indicator of homophobic bias?

People working within the organ transplant field have also questioned why, when there are 4,000 people at any given time waiting for an organ transplant, that potential donors would be excluded simply for being gay or bisexual men.

Other countries are relying on behavioural risk factors, instead of identity, to screen organ donors. This also serves the purpose of screening out heterosexuals who engage in high-risk sexual activity instead of a blanket ban on gay men which only serves to stigmatize that population.

We recognize the importance of protecting the blood supply as well as organ donations. However, we do not believe the current policies regarding donating blood and/or organs have any basis in science. Rather, it appears to us that they derive from the institutional homophobia that is part of both organizations. They help perpetuate homophobia which contributes to increased health risks to GLB Canadians by describing gay and bisexual men as threats to public health.

SENIOR'S HEALTH

A four year McGill study of gay and lesbian seniors concluded that the life-long effects of homophobia often prevent these seniors from identifying their orientation to others and therefore often fail to receive the health and social services they require. As seniors would have experienced a time in their lives when homosexuality could result in imprisonment, hospitalization, loss of home or employment, many are now unable to comfortably identify their sexuality to health care practitioners such as physicians, home care workers, or staff at senior's residences.

RESEARCH BUT NO ACTION

The National Reference Group (see page 5) is not the only instance where Health Canada funded a study looking at health and wellness issues in the GLB community. In 2000 Health Canada provided funding for a group of researchers at the McGill School of Social Work to examine the research and provide Health Canada with a report on access to care issues experienced by GLB Canadians.

In May of 2000 the McGill researchers presented Health Canada with their report: *Access to Care: Exploring the Health and Well-Being of Gay, Lesbian, Bisexual and Two-Spirit People in Canada.*[9] (Two-Spirit refers to Aboriginal GLB people). The researchers undertook a literature review of previous research on GLB health and wellness issues, combined with conducting a number of focus groups across the country. As a result of these activities, the researchers made a number of recommendations including "That the federal government play a key leadership role in the articulation of best-practice with regards to the health and well-being of glbt-s people." To date not one of the recommendations in this report have been acted on by Health Canada or the Public Health Agency of Canada.

In 2001 Health Canada also provided funding for researchers to look at populations in Canada that are underserved in their health and wellness needs. In their report *"Certain Circumstances" Issues in Equity and Responsiveness in Access to Health Care in Canada,*[10] presented to Health Canada, the researchers examined access to care issues for Aboriginals, immigrants and refugees, persons with disabilities, the homeless, visible minorities and GLB people. Again they called for federal government action to address the health and wellness issues of GLB people by developing strategies and funding GLB community health and wellness groups. They also made similar recommendations in regards to the other underserved populations they examined. Once more, none of the recommendations regarding GLB people have been acted upon by Health Canada or the Public Health Agency of Canada.

GOVERNMENT RESPONSES TO GLB CONCERNS

The following events are a description of experiences individuals have had in recent years when dealing with Health Canada and the Public Health Agency of Canada. It is important to note that they are merely representative anecdotes, a microcosm of what the GLB community, through its various organizations, has experienced over the years and across the country. We offer them here as indicators that the political and administrative leaders of Health Canada and the Public Health Agency of Canada have no real interest in addressing the many health and wellness issues faced by GLB Canadians.

The Canadian Rainbow Health Coalition (CRHC) is a national organization focused on GLBT health issues. Since its inception in 2002 it has attempted to meet with federal health ministers and senior bureaucrats with mixed results.

In 2002 the CRHC wrote the Hon. Anne McLellan, Minister of Health, to inform her of the formation of our national coalition and to request a meeting with her to discuss the issues outlined in our letter. The Coalition also asked for the opportunity to work in partnership with her department to address the health and wellness issues that faced GLB Canadians.

Three months later the Coalition wrote again as it had received no response to its initial letter. After a number of letters the Minister arranged for Coalition leaders to meet with officials from four departments under her jurisdiction: the Assistant Deputy Minister, Population and Public Health Branch; the Executive Director, Women's Health Bureau; a representative of the Director, HIV/AIDS Division; and a Senior Policy Advisor of the Mental Health Promotion Unit. These representatives assured the Coalition leaders that they would investigate how they could better address the issues that were highlighted. Unfortunately, no change occurred as a result of that meeting nor were there any attempts from these individuals to follow up with the Coalition directly or indirectly.

After the meeting the CRHC wrote Ms. McLellan once again thanking her for the meeting and asking her to: (1) identify an area in her department that would take the lead on GLB health issues in order to provide an identifiable entry point for GLB community organizations; (2) identify sources of funding to enable the CRHC to host national conferences to bring together professionals working on GLB health and wellness issues; (3) recognize GLB populations as target populations within Healthy Living programs; (4) ensure that the profile of GLB populations and their health issues was raised in research funding priorities; and (5) assist the CRHC in contacting regional director generals in her department to enable GLB groups to access local funding sources. Once again the CRHC received no answer from Ms. McLellan or her department about these issues.

When Ms. McLellan was replaced as health minister by the Hon. Ujjal Dosanjh the CRHC again wrote requesting a meeting and pointing out the issues raised with his predecessor. Though the Coalition was unable to secure a meeting with Mr Dosanjh, he did arrange for a meeting with two representatives from his office. In that meeting the representatives said they would arrange for the then Director General for Healthy Human Development with the Public Health Agency of Canada to be a contact with the Coalition to develop a partnership to address GLB health and wellness issues. A month later the Coalition wrote the Director to ask for a meeting but never received a reply. It was later learned that the Director was never informed about the meeting with Mr. Dosanjh's staff and their subsequent commitment.

In the same meeting the two representatives also promised that they would work with the Coalition to help open doors in other departments within the federal government that should have an interest in the health of GLB Canadians. In a follow-up letter to that meeting the Coalition asked for any progress in this area but received no response.

In August of 2005 the CRHC wrote the Hon. Carolyn Bennett, Minister of State (Public Health) asking for a meeting with her. Coalition leaders were able to meet with her and discuss GLB health and other issues, but unfortunately Parliament fell the following week and nothing resulted from that meeting.

In February of 2005 the Coalition requested a meeting with Dr. David Butler-Jones, Chief Public Health Officer, and was able to meet with him in August of that year. Dr. Butler-Jones was very aware of the many health issues endemic to the GLB community but expressed no willingness to do anything to address those issues. A staff member with him in the meeting offered the suggestion that the Coalition approach the First Nations and Inuit Health Branch for funding consideration, even though they were well aware that the Coalition's focus was not on the basis

of race or culture. As usual, no changes have resulted from that meeting.

In May of 2006 the CRHC once again wrote to the health minister, this time the Hon. Tony Clement, informing him of the many health and wellness issues endemic to the GLB community and asking for a meeting. To date there has been no response to that letter.

What these "leaders" demonstrate through their inaction is a disregard for the lives and well-being of a sizeable proportion of the population. Such a lack of leadership ensures the perpetuation of systemic homophobia, the common cause of premature death and poorer health status among of GLB Canadians.

FUNDING BY ACCIDENT, NOT BY DESIGN

Over the years Health Canada and the Public Health Agency of Canada have made funding available to address some of the health and wellness issues faced by GLB Canadians. However, these have been exceptions rather than the rule, discretionary funds distributed to "one off" initiatives rather than the strategic funding levels required to address the issues methodically and systemically.

One example is the CRHC, which received a one-time contribution of $2.3million from the Primary Health Care Transition Fund, *Rainbow Health—Improving Access To Care,* to address access to care issues for GLB Canadians. That contribution enabled the organization to begin the process of educating the health care community about the unique health and wellness issues faced by GLB Canadians. However, that funding ended after 2.5 years and no further funding has been made available to continue the work that was begun. Is it not puzzling that this national organization and its programs enjoyed such a level of funding for a period—a clear indication they were valued and supported—only to be refused any funds since then?

In those instances where GLB organizations do receive funding from Health Canada or the Public Health Agency of Canada, it is too often the case that they do so by accident rather than by design. That is because funding structures and policies do not explicitly target GLB issues or concerns and therefore tend to be accessed through the good graces of individual project officers who provide information and support to overcome these barriers. We maintain that programs and related funding not only need to be targeted to GLB Canadians, but must also be readily accessible and transparent as tools for addressing their specific health needs.

THE INTERNATIONAL RESPONSE

According to the World Health Organization, "Vulnerable and marginalized groups in society bear an undue proportion of health problems. Many health disparities are rooted in fundamental social structural inequalities, which are inextricably related to racism and other forms of discrimination in society." The International Covenant on Economic,

Social and Cultural Rights enumerates the grounds for non-discrimination in health by proscribing "any discrimination in access to health care and the underlying determinants

of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin,

property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health."

Many countries have developed targeted responses to the unique and specific needs of their GLB populations. Through its Centers for Disease Control and Prevention, its Department of Health and Human Services, and its National Institutes of Health, the government of the United States provides specific GLB health information. Seven member countries of the Pan-American Health Organization have launched an anti-homophobia campaign to improve

the health status of its GLB populations. The National Health Services of the United Kingdom provides GLB-specific resources for smoking cessation, mental health promotion, decreasing alcohol and drug use, and how to work collaboratively with health care practitioners, an approach mirrored by the Government of Australia. This compares with a search of the Public Health Agency of Canada website which returned just over 20 hits to a search of "gay men's health" (almost all related to sexually transmitted infections), while a search of "lesbian health" returned fewer than five results. In health promotion specific sections of the PHAC website there were no targeted resources for GLB communities in the areas of mental health, smoking cessation, cancer, alcohol use, or drug use. Health Canada's national guidelines, "Screening for Cancer of the Cervix in Canada," makes no mention of lesbians

CONCLUSION

Health-related federal activities and funding for GLB Canadians provided either directly by government or supported through non-governmental GLB organizations is sporadic and un-sustained, providing only intermittent and non-integrated services to the GLB population across Canada. This population is identifiable and represents a sizeable percentage of the overall population, and its health issues are sufficiently specific to warrant a focused and strategic approach to addressing them. Certainly, the health needs of GLB Canadians are comparable to other populations which enjoy such a strategic approach.
What do we seek? Simply put:

Equitable and dedicated Health Canada and Public Health Agency of Canada programming and funding on the basis of demonstrated health needs. This includes being acknowledged as priority populations for health issues where we are disproportionately represented relative to the general population, and having Health Canada and the Public Health Agency of Canada follow through on such prioritization with effective programming and sufficient levels of funding.

Clearly defined and accountable programs within Health Canada and the Public Health Agency of Canada through which GLB Canadians can have an influential voice about policy on, and access to funds related to, their health and wellness needs including funds for educational initiatives.

Culturally appropriate/sensitive responses to our communities and their health needs. This includes having Health Canada and the Public Health Agency of Canada apply a "sexual orientation lens" to policy and program development, and ensuring broad and meaningful consultation with the GLB population and its representatives as integral to that development process.

More and relevant research focused on GLB Canadians' health and wellness needs as well as follow through on resulting recommendations. Such research initiatives would need to include GLB-articulated queries and concerns.

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