



Silent No More:

Research Report Summary
September 2003

Making Health and
Social Services Accessible to Lesbians

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The study was made possible through the financial support of the **Fondation Solstice** (project start-up grant awarded to the Groupe d'éducation-santé du Québec) and the **Ministère de la Santé et des Services sociaux du Québec (MSSS)**. Translation of the research report summary was funded by **Health Canada, Centres of Excellence for Women's Health**.

The report was published jointly by the Réseau québécois d'action pour la santé des femmes (RQASF) and the Groupe d'éducation-santé du Québec

Montréal

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ISBN: 2-9806433-6-X

Introduction

This study is a follow-up to a consultation with lesbians carried out in 1999 by the Réseau québécois d'action pour la santé des femmes (RQASF or the Réseau), when it was drafting its framework for women's health. Since then, the Réseau has been very concerned about lesbians' lack of access to services because of

the impact on the health of this segment of the population. It therefore invited women from different sec-

tors who are concerned about lesbian health to form a committee, the Comité Santé des lesbiennes. The committee decided to conduct research to examine both lesbians' access to health and social services and their experience of these services. The committee, which is coordinated by the Réseau, acted as an advisory group for the research project, discussed research findings and formulated recommendations.

The specific situation of lesbians

Because lesbians are not concentrated in urban areas, let alone in particular neighbourhoods of large cities, and because they are not considered at risk for HIV-AIDs, they have reaped fewer benefits from the efforts of public services to reach out to the gay, lesbian and bisexual (GLB) population. Yet, like gays,¹ lesbians are marginalized and suffer from heterosexism and homophobia, both in society and in the health and social serv-

ice system. The Ministère de la Santé et des Services sociaux' working group on mental health services for women published a report in 1997 entitled *Écoute-moi quand je parle* (Listen to me when I'm talking), which clearly identified sexual orientation as a health determinant.

Heterosexism : a type of power relationship that imposes heterosexuality as the only acceptable social norm, excluding homosexuality. According to the heterosexist norm, homosexuality is considered an illness, failing or perversion.

Most research makes no distinction between lesbians and gay men, as if their problems were identical. In recent years, reports on the difficulty of detecting psychological distress in men not only support the feminist demand for gender-based analysis but also confirm its relevance. Our position is that gender-based analysis must also be applied to gays and lesbians. This is why we have studied the specific needs of lesbians in the area of health services, in accordance with the government's status of women policy.

As women, lesbians are faced with specific social barriers, manifested principally by gender-determined participation in the labour market and a higher poverty rate. The Québec government's 1998 health and social survey, *Enquête sociale et de santé 1998*, showed that 21.2% of women are "poor" or "very poor" compared to 17.7% of men. In 2000, 9% or 618,896 Quebecers received social assistance, with a gender breakdown of 9.4% of women versus 8.8% of men.

¹ In this study, the term 'gay' denotes men only; however, several lesbians interviewed for the study use the word 'gay' instead of 'lesbian,' as can be observed in excerpts of interviews quoted in the full report.

The *Enquête sociale et de santé 1998* was the first probability study (conducted with a random sample) in Québec to include a question on sexual orientation. The findings confirmed the importance of paying particular attention to the gay and lesbian population, recognizing that gays and lesbians face specific problems arising from their sexual orientation: social isolation, suicidal thoughts, suicide attempts and general psychological distress. The survey also revealed that lesbians are proportionately twice as numerous in the “very poor” category: 15.5%, compared to 6.9% among heterosexual women. The same study showed that lesbians are less likely to use preventive services and are therefore more vulnerable to certain health problems.

Despite all these risk factors some authors² consider lesbians the least studied social group in Québec and Canada. Still less attention has been paid to older lesbians and racialized or ethnic minority lesbians. In

fact, to the best of our knowledge, this study is the first to give a voice to lesbians of diverse origins in Québec who face additional social barriers – due to their skin colour, family name, or language – and reveal the racism experienced by this group of women. We want to ensure that these women, like all lesbians in Québec, are finally accepted as full-fledged citizens.

Project goals

Besides giving a public voice to lesbians of different backgrounds (majority and minority), ages and regions, the study pursued two main goals. The first goal was to document from lesbians’ experiences the obstacles they face in obtaining health and social services in order to formulate specific recommendations to improve these services. The second goal was to record initiatives to increase service accessibility in order to identify the requisite conditions for the creation of such measures. If such projects already existed, we believed they should be publicized, adapted to different contexts and used to inspire the development of new intervention and awareness-raising tools.

Gender-based analysis : approach in which the situations of women and men are analyzed separately to highlight differences and inequality and enable the development of actions to reduce the gender gap.

Methodology

We conducted a telephone survey of the 142 CLSCs (local community [health] service centres) in Québec to learn about initiatives carried out to date. We also went into the field to establish a picture of lesbians’ experience of health and social services. Some 53 lesbians, of different ages, ethnic origins and socio-economic backgrounds, participated in the study. Some took part in group interviews conducted in the Bas-Saint-Laurent, Centre-du-Québec and Montréal regions, and

² For references, see the complete report.

others were interviewed in depth (life histories), in Montréal. Observation in community organizations for young gays and lesbians (Project 10 and Jeunesse Lambda) gave us an insight into the situation of young lesbians.

This summary of the final report presents the main findings of Chapter II (telephone survey), Chapter III (qualitative research) and the recommendations issuing from meetings with the advisory committee. A more thorough discussion of the research topic; our selected approach and its theoretical basis; particular methodological issues connected with research on lesbians; and the employed methods is contained in the full version of the report. The complete report also quotes extensively from interviews with the lesbians who participated in the study.

Lesbians' access to health and social services in Québec

Are CLSCs familiar with Québec's ministerial guidelines, *Adapting Health and Social Services to Homosexuals*? How have they followed up on the guidelines? What measures have been initiated in Québec to improve these services' accessibility to lesbians? How were the two MSSS (department of health and social services) training sessions received in the CLSCs? Did they facilitate the emergence of other initiatives? Do regional disparities exist? From which institutions and job categories did MSSS training session participants come? These were the first questions in the telephone survey that was conducted with every CLSC in Québec.

The survey shows that up until now few measures have been initiated to improve lesbians' access to services in Québec. Most CLSC staff are unfamiliar with the government guidelines, *Adapting Health and Social Services to Homosexuals*. CLSC respondents share the view that you can prevent discrimination by treating all users in the same way. In fact, the opposite is true: offering the same treatment to people of differing or unequal social status is discriminatory. Some respondents affirmed there were few or no lesbians in their area. In some regions, lesbianism is taboo. Priority has been given to HIV-AIDS, completely overshadowing the issue of lesbians' health.

It appears that in the absence of a critical mass of gays and lesbians in a given territory or district, lesbians' access to services depends on individual initiative. A few concerned employees worked hard to ensure the government guidelines did not just remain on the shelves, and used them internally. Only four CLSCs initiated measures to improve their services' accessibility to lesbians (other than the MSSS training sessions). Three of

them were selected for more in-depth telephone interviews. Respondents from these CLSCs stressed the importance of awareness-raising to enable staff to offer services that respond to lesbians' needs.

The survey revealed regional disparities. According to our data, 80% of Québec CLSCs had not instituted measures to ensure that their services meet the needs of lesbians: rates vary regionally from 55% to 100%. The MSSS training sessions is virtually the sole measure being instituted on this matter throughout Québec.

CLSCs in the Côte-Nord, Laurentians, Laval and Nord-du-Québec regions had not evaluated the accessibility of their services to lesbians and had not participated in the MSSS training sessions. The Bas-Saint-Laurent, Estrie, Montérégie, Montréal and Outaouais regions also registered some of the lowest rates of the survey. The region with the most CLSCs that had worked on improving their response to lesbians' needs was Mauricie and Centre-du-Québec.

The most striking revelation of the survey concerns Montréal, a region where only two CLSCs out of 29, or 7%, expressed concern about their services' accessibility to lesbians. One of these CLSCs, located in the heart of the gay village in the south-west section of the city, has gay and lesbian staff members, and, according to the person interviewed, the CLSC is sensitive to the needs of lesbians. The other CLSC participated in the first of the two training sessions. It should be noted that not one CLSC in Montréal, nor any other institution in that city, offered the second training session, at least not before the end of 2000.

This data raises serious questions, because Montréal is the most populous region of Québec. Is one CLSC that has dealt with issues surrounding homosexuality sufficient to meet the needs of the whole island's clientele? Are lesbians really all concentrated in the territory of that one CLSC? Shouldn't it be a source of concern that so many CLSCs in Montréal are so indifferent when it comes to services for lesbians? People seem to think that the problem has been solved since the "gays" have "their own" CLSC—yet again, lesbians are subsumed by the terminology.

Since the MSSS training sessions appear to be the only measure that has been initiated up until now, we wanted to know who had expressed interest in registering and where they were from. The MSSS' statistics on participants in their training session show that the majority were "practitioners," most of them from community organizations and CLSCs. There were very few physical or mental health professionals. Compulsory training of all health and social service system staff would pave the way toward a system that takes the needs of lesbians into account.

With no action plan or directives, the ministerial guidelines would have been forgotten if the MSSS had not offered the training sessions. These sessions represent the principal, if not the sole existing means for raising awareness in the health network about the situation of gays and lesbians. They are, however, isolated activities, and because they are not compulsory, the people who sign up for the sessions are mainly those who are already interested in the issue. At least, this is what the MSSS' data on participant profiles from 1997 to 2000 leads us to believe. The training sessions must be continued but they alone are insufficient

to ensure services that meet the needs of lesbians. Our survey testifies to this. It is time, then, that all health and social services practitioners received this training. The qualitative research, analyzing the experience of 53 lesbians, illustrates that the training sessions, although necessary, do not suffice to ensure lesbians' access to services in Québec.

Lesbians' experience of health and social services

“It shouldn't be an intervention as if the person were a sick patient or a client... I went there just because I wanted to meet other gay people and to see what the community was like. But then I was asked, 'what's your problem?' Like I'm supposed to have a problem? What's that equation all about?”

“Isolation fosters psychological problems: when you have no one to talk with, when you live in a society that doesn't reflect your situation, when you're ignored in your family (they think you're just crazy) ... At work, you laugh about the heterosexism, then you pretend the joke is funny. After a while, you realize you're a social outsider.”

Analysis of respondents' stories sheds light on the daily experiences of numerous lesbians. From this chapter emerges a portrait of the society in which lesbians live: one that differs from the one with which heterosexuals are familiar.

Profile of participants

The socio-demographic questionnaire that was handed out to lesbians who were interviewed in groups and individually provided us with a general profile of participants. The heterogeneous nature of the group in terms of age, socio-ethnic status, level of formal education, occupation, income, heterosexual experience or lack of, life situation and marital status, complicates the analysis but indicates that the situation of lesbians as a non-homogenous social group was explored.

Being a lesbian in Québec : relating to oneself and to others

Many lesbians participating in the research assess the current situation in Québec positively compared with that of earlier generations and in other countries. Some women consider themselves “privileged.” The majority of lesbians who were interviewed, aware of the climate in which preceding generations lived, are happy to *be able* to live their lesbianism. In the wake of the *Act instituting civil unions and establishing new rules of filiation* and the social changes these new rights should bring about, many women are optimistic

about the future despite the difficulties they sometimes face now.

This section underscores the existence of a broad range of experience. The comments were gathered mainly to shed light on lesbians' access to services and do not go into exhaustive detail about the different issues. Our aim was to highlight the *diversity of experience and the interaction of various factors*. Despite this limitation, we believe our data allows us to better grasp the overall picture, particularly the aspects of social invisibility, lesbophobia and lesbians' experience of the issues we raised.

Lesbophobia: Specific form of discrimination affecting lesbians.

The life histories method (in-depth interviews) turned out to be useful, not only for understanding the barriers faced by lesbians in obtaining health and social services, but also the hidden significance of these barriers. For example, this process was particularly important in enabling us to identify three factors affecting women's vulnerability to internalized lesbophobia and social isolation: a lesbophobic family; a weak social network (little or no support network); and negative experiences and discrimination (especially at work).

Our analysis revealed a generalized experience of discrimination and social isolation. At least six themes or stages in the life trajectory of lesbians became apparent; the way in which these stages unfold can have an impact on mental and physical health. We present them in the order they come up in the report, which does not necessarily correspond with their importance nor the order

“For sure, the question is always on your mind: ‘should I come out or not?’ If someone asks and I have a good feeling about them, I’ll come out to them. If they don’t ask, I won’t come out, even if I felt OK about the person.”

in which they occur in the lives of all lesbians. These moments, stages, or periods of life can exacerbate lesbians’ social isolation and jeopardize their health.

Coming out

Coming out to oneself is the *first* key moment in the life of a lesbian. We observed three principal forms of “coming out to oneself.” For some women it is simple –they believe they were “born” lesbian and entertain no doubt about the matter. Others, feeling attracted to both sexes, decided one day to live as lesbians. For women who discovered their lesbianism later in life, the process was more complicated and arduous, with a more or less painful detour through heterosexual marriage.

lems and job discrimination). These three factors of vulnerability to internalized lesbophobia render the coming out process more painful for some lesbians.

When they come out lesbians must struggle against the heterosexism and lesbophobia present in their relations with family, friends, educators, health and social service staff, etc.

Family

The family can be an important support network and play a crucial role in the development of strong self-esteem. Very few of the lesbians who participated in the research benefited from this advantage. Coming out to the family is thus a *second* critical moment in a lesbian’s life history.

While the experience of coming out to oneself varies substantially, in every case women must confront barriers imposed by their culture, religion, family or society in general—in other words, heterosexism and lesbophobia. In order to recognize and learn to value their preference for other women, lesbians must counter negative images and stereotypes they have been inculcated with since childhood by their family, school, and, for older women, the Church. This demands an impressive reservoir of inner strength. They must be able to resist the internalization of lesbophobic attitudes that may be exacerbated by certain factors such as relations with a lesbophobic family, the lack of a supportive network of friends, and the accumulation of negative experiences of all kinds (particularly family prob-

lem and job discrimination). These three factors of vulnerability to internalized lesbophobia render the coming out process more painful for some lesbians.

Coming out to one’s family, for many lesbians, means the beginning of a period of tension stemming from the anticipation of rejection or acceptance—a process that can be long, non-linear, frequently marked by denial and that does not necessarily end with acceptance. The interviews revealed that coming out to one’s mother had special overtones, perhaps because mother-daughter relationships are frequently more intense, and sometimes conflictual. Lesbianism may appear to a mother as a challenge to the proposed feminine model or spell the end of the dreams she may have had for her daughter.

“They assume that lesbians have no children. When he got to the section of my case history labelled ‘Do you have children?’ he answered for me, ‘no children.’ I said, ‘Hey, wait a minute, I have two children.’ That doctor, who didn’t recognize me as a mother... he’s the one that performed my surgery. He wouldn’t look me in the eye during the whole interview.”

Discrimination at school and at work

Discriminatory experiences at school and work constitute a *third* set of determining moments in lesbians’ life trajectory. Whether it consists of lesbophobic comments, behaviour or harassment at school or on the job, the aftermath of these experiences can sometimes affect every aspect of a women’s life over a long period. Because women are more likely to experience working conditions that undermine their mental health due mainly to poor work organization, psychologically demanding tasks and a higher rate of physical and psychological violence, the workplace is a high risk environment for lesbians. A large majority of lesbians refrain from coming out at work to avoid lesbophobia. Nevertheless, mere suspicion can generate increased harassment and lesbophobic stereotyping. As for “visible minority” lesbians, racist discrimination and harassment on the job top an imposing list of health risks.

Friendships

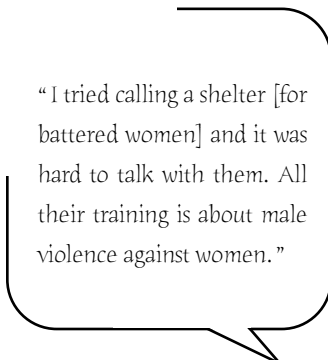
We have mentioned that having a lesbophobic “biological family” is a factor that increases vulnerability to internalized lesbophobia. The actions and words of actively lesbophobic families undermine lesbians’ health and push them into greater isolation. This is why lesbians construct a “chosen” family, by constituting a network of solid friendships with other women. The development of a network of strong friendships represents a *fourth* key element of lesbians’ health. Some women formed such a network of solid mutual aid and support with lesbian friends to make up for the shortcomings of their families. Other women,

especially young women and women from racialized minorities, created more diversified networks in terms of gender, sexual orientation and ethnical or national origin.

The same distinction, between the sub-groups of young women and women from “audible” and “visible” minorities, on the one hand, and the remaining respondents, on the other hand, was evident when it came to the relationship with the lesbian community. While for many women, the community played an essential role of social support, others said they didn’t identify with the lesbian community. Even though everyone agreed that the community is diverse and this is what constitutes its richness, some women felt isolated within the lesbian community. This was true of women who had been married, women who did not frequent places known for their lesbian clientele, women who had internalized a large dose of lesbophobia and others of different ages and origins. Women belonging to “visible minorities” stated they encountered neither more nor less racism in the lesbian community than in society as a whole. This indicates that they are confronted with more discrimination over the course of their lives, resulting in increased risk to their health.

The couple

If being in a couple is considered a health determinant, it is all the more so for a minority group like lesbians that suffers from social isolation. This is the *fifth* fundamental element in the life trajectory of lesbians. Several characteristics of the lesbian couple are particularly likely to affect the health of these women. Social invisibility and the small size of the lesbian community limit the



“I tried calling a shelter [for battered women] and it was hard to talk with them. All their training is about male violence against women.”

opportunity to meet one’s soul-mate. The internalized lesbophobia of either of the partners can cause problems. Growing dependency may develop, to the point of “fusion,” which may exacerbate the problem of the lack of social recognition of the couple. Last, lesbian couples differ from heterosexual couples in that spousal violence is denied, not recognized or considered taboo, although it is just as destructive.

Migration

The *sixth* and last major event in the life trajectory of lesbians concerns migration. This was raised in the section of the full report that addresses social isolation as a barrier to obtaining services. Migration can mark the beginning of increased social isolation, just as it can represent liberation, for women who have fled a lesbophobic environment.

To conclude this section about how lesbians relate to themselves and others, we observed that while lesbians feel comfortable in Montréal, they are not more likely to publicly express their lesbianism. Last, the respondents were very involved in community-based activities, which for many women is a strategy for reducing social isolation.

This portrait of how lesbians relate to themselves and others counters many stereotypes, starting with the generalization that all lesbians fit into a fixed mould. Our findings challenge this simplistic vision, revealing lesbians and the lesbian community to be broadly diverse. We have seen that particular moments in the life trajectory of lesbians are determining factors with regard to their mental and physical health. Their health and degree of

social isolation and invisibility are directly affected by the nature of social relations constructed during these crucial periods.

Relationship with the health and social service system

Studies carried out in both the United States and Canada have shown that lesbians are very reluctant users of health services. Since medical practice has been built on the heterosexual model, the fact of being lesbian automatically marginalizes these women. Over a third of the women who were individually interviewed in Montréal said they consulted health and social services infrequently (10 women out of 26, or 38%). The majority of these women, of different ages, have no regular medical check-ups.

Despite the fact that they use the medical system less than the heterosexual population, numerous respondents are concerned about their health and actively seek out information on women’s health. They read books, talk with friends, develop “Self-Health” techniques, familiarize themselves with their bodies and learn how to prevent minor problems by taking care of themselves, for example, by watching their diet and taking walks or other exercise.

A number of respondents share the objections of feminists regarding the dominant bio-medical approach, centred on illness rather than individuals and prevention, and the resulting curative approach that is frequently dehumanizing, lacking in empathy and characterized by the consumption of toxic drugs having more or less harmful side effects. For this reason, many lesbians consult

“I wanted to say something that I think is an important factor among the lesbians I know. Some of them tell me they don’t see a doctor. So, yes, there is a serious problem of lack of trust of doctors.”

“It should be clearly stated as an option, because we are always in the situation where heterosexuality is the norm. I agree, it’s the majority, but it always places us in a very awkward position.”

“All I can say is that my doctor knows I am a lesbian, in fact he helped me deal with that. I was wondering about my sexual orientation and he gave me some suggestions. Today, when I see him, I thank him because he really helped me.”

alternative health practitioners. Alternative medicine is considered more humane and focussed on the person, rather than the illness.

Concerning lesbians’ physical and mental health, the collected data reveals the impact of barriers to the access to health and social services. Over one third of the respondents had never had a Pap test, mirroring a strong tendency reported in the *Enquête sociale et de santé 1998*. Nonetheless, all women who were eligible for a free screening mammogram had had one, revealing that our respondents are concerned about this area of their health. Nearly half the respondents had never seen a doctor about gynecological problems and the vast majority had never caught a sexually transmitted disease (STD). With regard to mental health, we examined phenomena linked to low self-esteem such as eating disorders, substance abuse, depression and attempted suicide. Lesbians are particularly vulnerable to each of these phenomena. The rate of depression and suicide attempts, among others, is cause for concern.

Lesbians’ needs in terms of access to services

What were the specific needs of the respondents with respect to health and social services? In general, their needs are the same as those of all women, but they also have several particular ones. The basic need to be respected and listened to was expressed again and again. They also desire a simple and frank relationship with health professionals. In addition to being respected, respondents want to be properly informed about their health. Faced with difficulty in obtaining satisfactory services, some women wanted specific

kinds of services. Others expressed the desire for “integrative health services,” featuring both conventional medical services and complementary medicine like acupuncture, homeopathy and osteopathy.

Barriers to obtaining health and social services

Five types of access barriers were considered in the analysis of lesbians’ experience of being made “invisible” and of lesbophobia in their relations with health and social services.

Heterosexist discrimination and lesbophobia

This is manifested primarily by an almost universal assumption of heterosexuality at the reception desk and on forms: the question of sexual orientation is never asked because “being a woman” means “being heterosexual.” The assumption of heterosexuality is discriminatory and affects lesbians’ relationship to health professionals. Lesbophobic discrimination and prejudice are also manifested by rejecting behaviour, denial and disrespect, offensive remarks and even, in some cases, the refusal to offer care. Heterosexism determines the definition of the family and perception of lesbians as mothers. It affects lesbians who seek pregnancy follow-up care, prenatal courses, pediatric care or psychosocial intervention with children of lesbian parents.

“A lot of people think we are not at risk for STDs, but that isn't true. I caught a sexually transmitted disease. I think ignorance is a big problem, and a lot of training is needed.”

“Older women like me, some of us don't even see their doctor for an annual check-up... There should always be someone in the health services, CLSCs or whatever, someone who is able to approach a woman who is too scared to talk about it... because there are women who have never talked about it. There are women who are still living with that secret. It's sad, but it's true all the same.”

Ignorance and incompetence of health professionals

This is partly due to the invisibility of lesbians and to lesbophobia. It means lesbians are prevented from obtaining important information on their sexuality (for example, protection from STDs) and appropriate mental health services.

Internalized lesbophobia and heterosexism

We use this term to describe lesbians who fear a negative reaction if they reveal their sexual orientation. This fear of being discriminated against develops both from personal experience and from identifying with a social minority that is a target of discrimination, in this case lesbians. Fear of being the object of discrimination can undermine the therapeutic relationship and lead lesbians to systematic avoidance of the health and social services system.

Poverty

Women are among the most disadvantaged population groups in Québec and this is even truer of lesbians. More than economic poverty, with its burden of daily discrimination and unequal treatment, they suffer a poverty of social networks. Lesbians often lack the financial means to choose their preferred therapeutic approach (for example, acupuncture and homeopathy). Some of them are even willing to go into debt in order to obtain alternative therapies. Others are forced to consult psychiatrists (covered by Québec health insurance) when they

would have preferred a psychologist.

Social isolation

Lesbians are more socially isolated than gay men. They benefit from fewer resources and services. This a factor that may lead lesbians to avoid consulting health and social service practitioners, giving rise to emotional problems.

To overcome these barriers, the respondents employ various strategies, such as protection (defensive), avoidance (of the obstacle) and “visibilization” (more offensive). When the source of social stigmatization is invisible, the main protection strategy against discrimination and rejection—whether the object is to keep one's job or ensure the respect of health professionals — is silence. Lesbians often look for indications of a person's open-mindedness, before revealing their sexual orientation. Denial is an adaptation strategy in a social context of lesbophobia and heterosexism. Silence and denial, however, are survival strategies against lesbophobic discrimination that can engender social invisibility and harmful consequences for lesbians' health.

“The doctor I mentioned earlier who wanted to send me to a psychiatrist to treat my lesbianism... when I left his office he phoned my mother to tell her that I was a homosexual.”

Specific barriers facing certain sub-groups

The five types of access barriers just mentioned concern all lesbians, but we also observed other barriers that are specific to certain sub-groups. Lesbians living in regions outside large urban centres undergo ongoing stress due to lack of anonymity in the services, scarce resources and heightened isolation. Young women made particular mention of the isolation and lesbophobia they experienced in high school. They described inappropriate interventions that were undermining to a smooth coming out process and to their psychological well-being. As for older lesbians, the majority of these women had lived their whole lives in silence on society's margins, the objects of various forms of discrimination. They were forced to tolerate the lesbophobia and heterosexism of the society around them in a time when homosexuality was considered a crime, a sin or a disease. These lesbians worry about how they will be treated in homes for the elderly and long-term care facilities, where lesbophobic discrimination has been documented. Lesbians belonging to “visible minorities” are even less likely to consult health and social services because of linguistic barriers and racism. They are also poorer.

Conclusion

The analysis of social relations revealed by the life trajectories of lesbians and the barriers confronting them in their access to health and social services demonstrates that lesbophobia has a major impact on the health of lesbians. Several myths and stereotypes have been put to rest. As our analysis shows, lesbians constitute an extremely heterogeneous social group. It is false to assume that because lesbians consult health services rarely or not at all, they are not concerned about their health. Lesbians avoid services that assume their heterosexuality; they avoid these encounters precisely because they are harmful to their health.

It is urgent that decision-makers at all institutional levels understand that lesbians constitute a minority group. Treating them “like everyone else,” as one CLSC respondent affirmed, gives rise to discriminatory practices that undermine their physical and mental health. The assumption of heterosexuality at the reception desk, in forms and in therapeutic relationships must be definitively eliminated from the practice of the health and social services system.

Last, this report demonstrates that even if the *Act instituting civil unions and establishing new rules of filiation* represents great progress, the law is not a panacea. It is imperative that Québec society adapt its services to this particularly progressive law. The law should be reinforced by concrete measures that put it into application and institute a gradual transformation of attitudes: for lesbians’ health, for an end to silence, and for lives lived to the fullest.

Recommendations of the Advisory Committee

Based on the barriers discussed in this report, the advisory committee drafted recommendations aimed at making health and social services accessible to all lesbians. They call on the involvement of decision-makers from all political and institutional levels: the federal and provincial governments, ministries, health and social service institutions, professional orders, community groups, and the gay and lesbian communities. We believe that all decision-making bodies, starting with the federal and provincial governments must be challenged to address the poverty of which lesbians are disproportionately the victims. Many studies have proved that health improves when poverty is reduced. Our first recommendation then, is that governments attack this social blight. The following recommendations refer to the barriers discussed in this report, beginning with lesbophobia, a form of discrimination that gives rise to all the other barriers.

1. To fight lesbophobic discrimination in society as a whole:

- The Ministère de la Santé et des Services sociaux (MSSS) should launch an awareness-raising campaign on homosexuality, including lesbianism, throughout Québec.
- The Ministère de l'Éducation (MEQ) should launch a campaign in the schools in support of young lesbians to enable them to be more visible, for example, distribute posters and pamphlets.

2. To fight lesbophobic discrimination and the "invisibilization" of lesbians in the health and social services network :

- The Ministère de la Santé et des Services sociaux (MSSS) should design specific programs addressed to lesbians, who, because of lesbophobia, poverty and social isolation, are at increased risk of developing mental health problems (substance abuse, depression, etc.).
- The Ministère de la Santé et des Services sociaux (MSSS) should design posters and pamphlets that will be visible and available in all health clinics, hospitals and CLSCs.

3. To fight lesbophobic discrimination and prevent the separation of immigrant lesbian couples :

- The Ministère des Relations avec les citoyens et de l'Immigration (MRCI) should encourage lesbian couples to submit their immigration application as a common-law couple rather than separately ("independent immigrant" category), by publishing the information and making it clearly visible and easily understandable on the department's Web site and in other information documents.
- The MRCI should train its staff so that heterosexuality is not assumed, thereby facilitating independent immigration applications for common-law couples.

4. To educate and inform professional staff in the health and social services network and facilitate lesbians' coming out process in safe surroundings :

- The Ministère de la Santé et des Services sociaux (MSSS) should ensure that the following actions are carried out, or fund organizations to do this in conjunction with service providers (CLSCs, clinics, hospitals, etc.) :

- modify forms so they take sexual orientation into account;
- continue the training sessions, now provided only on request, throughout Québec, and make them compulsory;
- set up a centre that will collect all available information about lesbian health and provide support services to lesbians to reduce their social isolation;
- design a Web site and support tools for physicians and therapists.

- Professional orders (psychologists, physicians, nurses, etc.) should adopt directives on interventions with lesbians.

5. To educate and inform future health practitioners, the Ministère de l'Éducation should review, in association with the MSSS and other departments, technical, professional and university training programs :

- Include lesbian health in technical and professional programs in the field of health and social services.

6. To educate and inform community organization staff :

- The government should provide adequate funding to community organizations (women's groups, battered women's shelters, etc.) to ensure provision of staff training on lesbianism.

Without question, the Government of Québec should :

Ensure the funding of front-line organizations that are already working with and for lesbians;

Promote existing initiatives;

Implement the ministerial guidelines;

Adapt services to the Act instituting civil unions and establishing new rules of filiation;

Fund research on health (particularly mental health), lesbians' needs and experience, and interventions with this group.

RQASF Recommendations

Adopted in November 2003

Presentation

The Réseau québécois d'action pour la santé des femmes (RQASF), in collaboration with the Comité Santé des lesbiennes¹ (advisory committee), conducted field research about lesbians' access to health and social services in Québec. Based on the research findings, the committee drew up recommendations aimed at making health and social services accessible to all lesbians. Following the launch of the research report, *Silent No More: Making Health and Social Services Accessible to Lesbians*,² the Collective (board of directors) of the Réseau québécois d'action pour la santé des femmes (RQASF) met on October 16, 2003, to discuss the committee's recommendations. Members of the Comité Santé des lesbiennes and RQASF staff were also invited to the study session.

The goals of this meeting were the following: inform all participants of the research findings and create an opportunity for free discussion; discuss the recommendations and eventually amend them; adopt the recommendations; prioritize the recommendations and identify those that the RQASF should implement; and last, refer recommendations that, while adopted in principle by the RQASF, are considered to be more appropriately the responsibility of other bodies.

The goals for the session were met. The time allocated for the presentation of the research report enabled participants to gain a thorough understanding of the research topic, and the opportuni-

ty for free discussion was much appreciated by participants.

RECOMMENDATIONS OF THE RQASF

The RQASF and the Comité Santé des lesbiennes believe that decision-makers, beginning with the federal and provincial governments, must address the poverty that lesbians experience to a degree that is disproportionate to their numbers. Many studies have shown that health improves when poverty is reduced. The RQASF therefore supports all initiatives and policies that attack this social blight.

The recommendations of the research advisory committee were adopted overall by the RQASF's Collective. Following the discussion, several corrections and clarifications were made in their formulation, and recommendations to be implemented by RQASF were identified. They are, by order of priority: recommendations 4, 3, 6 and 5. Recommendation 1 was adopted, meaning that all policies, actions or projects of organizations or bodies working for its implementation would receive the support of the RQASF. While Collective members support Recommendation 2, it was decided it would be more appropriate for other organizations to take the lead in pressing for its implementation. Short explanatory paragraphs were added to some recommendations.

¹ This committee is composed of Diane Heffernan (Réseau des lesbiennes du Québec), Karol O'Brien (Groupe d'intervention en violence conjugale chez les lesbiennes), Carole Tatlock (RQASF member), Shari Brotman (McGill School of Social Work) and Marlo Ritchie (Projet 10).

² Isabelle Mimeault, in collaboration with the Comité santé des lesbiennes, *Silent No More: Making Health and Social Services Accessible to Lesbians*, Research Report (Montréal: RQASF, May 2003).

1. To fight lesbophobic ³ discrimination in society as a whole :

-The Ministère des Relations avec les citoyens et de l'Immigration (MRCI) should launch an awareness-raising campaign on homosexuality, including a specific component on lesbianism, throughout Québec. The campaign should illustrate the diversity of the lesbian community and aim to increase lesbians' visibility.

The study showed that the social presumption of heterosexuality affects all lesbians. Lesbians live everywhere—in every neighbourhood; they are present in all occupations and use the full range of services.

-The Ministère de l'Éducation (MEQ) should launch a campaign in the schools in support of young lesbians to enable them to be more visible, for example, distribute posters and pamphlets.

The RQASF refers the following recommendation to the Fédération des femmes du Québec (FFQ) and the Réseau des lesbiennes du Québec (RLQ) :

2.To fight lesbophobic discrimination and prevent the separation of immigrant lesbian couples :

-The Ministère des Relations avec les citoyens et de l'Immigration (MRCI) should encourage lesbian couples to submit their immigration application as a common-law couple rather than

separately ("independent immigrant" category), by publishing the information and making it clearly visible and easily understandable on the department's Web site and in other information documents.

-The MRCI should train its staff so that heterosexuality is not assumed, thereby facilitating independent immigration applications for common-law couples.

The heterosexist⁴ definition of the couple and the family in every society of the world, and lesbophobic discrimination and invisibility endanger the health, safety and lives of numerous lesbians in different countries. This is why many decide to emigrate. Since this recommendation concerns immigration policy and not health services, the RQASF recommends that it be referred to other organizations.

3.To fight lesbophobic discrimination and the "invisibilization" of lesbians in the health and social services network :

-The Ministère de la Santé et des Services sociaux (MSSS) should design awareness-raising program for all its professional and administrative staff in order to ensure a minimum level of knowledge and openness to the situation of lesbians in this sector.

-Second, the MSSS should design posters and pamphlets that will be visible and available in all

³ Both homophobia and lesbophobia are products of sexism. Because sexism affects women and men in fundamentally different ways, homophobia refers to a form of domination experienced by men, while lesbophobia refers to a form of domination specific to lesbians.

⁴ Heterosexism is a type of power relationship (often not perceived as such by heterosexuals) that imposes heterosexuality as the only acceptable social norm, excluding homosexuality (and bisexuality).

health clinics, hospitals and CLSCs in which employees have been educated concerning the situation of lesbians, in order to reach out to lesbian clientele and encourage them to use these services.

The responsibility for increasing lesbians' visibility should not rest solely on the shoulders of lesbians: it is up to services whose employees have participated in awareness-raising sessions to demonstrate their openness to lesbians.

4.To educate and inform professional staff in the health system so that services are offered in an environment where lesbians can feel safe :

-The Ministère de la Santé et des Services sociaux (MSSS) should ensure that the following actions are carried out and fund organizations to do this in conjunction with service providers (CLSCs, clinics, hospitals, etc.):

- modify forms in order to avoid heterosexist bias;
- continue the training sessions on homosexuality now offered to practitioners in different sectors throughout Québec, and 1) update them to ensure that the specific situation of lesbians is presented; 2) focus on interventions with lesbians rather than theoretical content; and 3) promote these training sessions with front-line professional health and social service staff (especially in CLSCs);
- gather all available information about lesbian health in a service to be offered by an organization that would receive adequate funding for

this task; this information service should be publicized and recognized within the health and social services network;

If such information were collected and made available, physicians and therapists could have rapid and efficient access to the lesbian health information they require in the practice of their profession. It is essential that the existence of such a resource be made known throughout the health and social services system.

- design a Web site and support tools for physicians and therapists.

This site could be set up by the service referred to above.

-Urge professional orders (psychologists, physicians, nurses, etc.) to adopt directives concerning interventions with lesbians; this implies modifying the core training received by health professionals.

5.To educate and inform future health practitioners, the Ministère de l'Éducation should, in association with the MSSS and other departments :

-Revise technical, professional and university training programs in the field of health and social services to include lesbian health in the core program.

6.To educate and inform community organization staff so they may offer services to lesbians :

-The government should provide adequate funding to community organizations (women's groups, battered women's shelters, etc.) so they have a budget for the provision of staff training on lesbianism and the delivery of support services designed for lesbians.

In sum, the Government of Québec should :

Ensure the funding of front-line organizations that are already working with and for lesbians;

Promote existing initiatives;

Implement the ministerial guidelines;

Adapt services to the *Act instituting civil unions and establishing new rules of filiation*;

Fund research on health (particularly mental health), lesbians' needs and experience, and interventions with this group.

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