Nearly Queerly: The Life and Death of a Queer Health Advisory Committee

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Abstract. This paper examines how a group of grassroots activists successfully lobbied for the creation of a lesbian, gay, bisexual and transgender (LGBT) persons’ population health advisory committee in Vancouver-Richmond, British Columbia. It documents how committee members balanced the at times conflicting interests of an institutional structure (the public health system) with those communities historically marginal to such institutions. The specific achievements and challenges of the committee and its members during its four-year life span, 1997-2001, are discussed, including their ramifications in other contexts.

Résumé. Cet article examine comment un groupe d’activistes est parvenu, par ses pressions, à créer un comité aviseur sur la santé des personnes lesbiennes, gaiès, bisexuelles et transsexuelles à Vancouver-Richmond, Colombie Britannique. Il décrit comment les membres du comité étaient divisés entre les intérêts d’une structure institutionnelle (le système de santé publique) et ceux de leur communautés, historiquement marginalisées par les institutions. Les accomplissements spécifiques et les défis du comité et de ses membres durant une période de quatre ans, soit entre 1997 et 2001, sont discutés, incluant leurs ramifications dans d’autres contextes.

Since the early 1990s, health care in Canada has shifted from a geographically driven, services distribution towards a population health approach. Under population health, preventative and treatment strategies are tailored, based upon an understanding of the contexts in which persons become at-risk for disease. Instead of a system of services and care wholly structured around geographic catchment areas, indicators such as socio-economic status, gender, level of education, language and culture, and other social determinants are taken into account when design-
ing health promotion programs and setting health policy. According to Frank and Mustard, social determinants, including “people’s position in the hierarchy of a society, (and) the degree of control they enjoy…appear to be important factors in determining vulnerability to a wide range of diseases.” Thus under population health, health services are adapted based on the specifics of people’s real lives (with respect to socio-economic status, gender, culture, age, or any other social determinant), whereas a more traditional service model pursues broad services where users are expected to adapt to generalized systemic norms. In seeking to make services that are more fluid across and within contexts, population health represents a dramatic shift in health services delivery in Canada.

In 1994 British Columbia’s ruling left-oriented New Democratic Party moved the province to a population health approach. The Ministry of Health re-articulated the provincial health system in BC and created seven population health advisory committees (PHACs) to advise the Vancouver-Richmond Health Board (VRHB) on health services to particular constituent groups; additionally seven geographically determined Community Health Committees (CHCs) in Vancouver-Richmond were set up. By having an equal number of CHCs and PHACs, the needs of considering both socio-cultural and geographically determined “communities” were put on par with one another. Women, Aboriginal persons, the disabled, mental health consumers, children and youth, multicultural communities, and seniors were each afforded a unique PHAC. At that time lesbians, gay men, bisexuals and transgender (LGBT) persons were not perceived to have the sorts of unique health concerns which would necessitate a queer-specific PHAC. Shortly thereafter, members of the December 9th Coalition (a Vancouver-Richmond-area LGBT activist collective) formed an ad hoc committee and began lobbying VRHB officials to create a LGBT PHAC. In September 1997 this PHAC was formally constituted. In December 2001—a scant four years later—a change in provincial government led to the termination and dismantling of the entire population health structure in BC, including the PHACs.

From the Vancouver-Richmond LGBT PHAC experience, several important questions emerge:

- How did a group of grassroots activists successfully persuade the VRHB to create an LGBT PHAC?
- How did members of the LGBT PHAC negotiate the oftentimes competing interests of a highly institutionalized, bureaucratic health care system, with the health needs of their constituencies?
- What were the achievements of the LGBT PHAC, in material and symbolic terms?

Using documents from the December 9th Coalition and the Vancouver-Richmond Health Board, this research is unique in its examination of
the lifespan of the LGBT PHAC, from lobbying and creation through operation and cessation. While scholarly accounts of successful and unsuccessful grassroots activism in Canada have recently appeared, including Ayres, and Scott & Schmitt-Bosnick, none of these initiatives succeeded in changing the structures of government services to reflect their communities’ needs. In some instances, the LGBT (or queer, used here as an umbrella for LGBT) communities of Vancouver-Richmond did effect such change, advocating within and outside the system.

METHODS

To examine the history of the Vancouver-Richmond LGBT PHAC, I conducted a discursive analysis of materials related to the PHAC. Michel Foucault wrote at length about discourse, and the intersection of knowledge, power and sexuality; my analysis has been greatly informed by Foucault’s work in these areas—as both a scholar and activist. In embracing fluid and complex notions of knowledge, sexual identity and power/resistance, Foucault argued for a world where social justice work is determined/purposeful and often creative. In rejecting simplistic, linear notions of hierarchy-as-power, he articulates ways of resistance that are common knowledge to grassroots activists who, like me, have worked for change to the structures and systems of oppression, rather than merely responding to specific outcomes of hegemony. Intellectually and materially, Foucault’s work informs and inspires my own.

Materials used as data for this study related to PHAC were examined as “instances of discursive practice.” Not merely their content, but the ideas and values embedded in them are at the core of this analysis. In all, 65 documents were located and analyzed, including reports, newsletters, and meeting minutes from the December 9th Coalition, the LGBT PHAC and the Vancouver-Richmond Health Board (VRHB). Electronic, text-only versions of these documents were entered into an Atlas/ti qualitative data database, and coded thematically. Both the pragmatics of PHAC activity, and the issues faced by the PHAC members (and the December 9th Coalition members in pre-PHAC days), were coded. Coding was done relationally, with key words linked to common themes; for example, when coding for “aging” words such as aging, age, ageism, elder, elderly, retire, and older—were coded. A total of 27 codes were used, including terms related to communities represented (gay, bisexual, transgender, lesbian, youth, aging persons), issues faced by the communities (being out, access to services, addiction, closeted, depression, HIV reportability, mental health, stress, substance abuse, suicide), and health services administration (harm reduction, health reform, population health, reports, research, program funding, universal health care). These three themes—communities, issues and services—emerged as critical to the PHAC and its work.
This analysis is limited to materials produced by and about the LGBT PHAC. A perhaps more nuanced understanding of the history of this critical body would be found in the first-person accounts of PHAC, VRHB and December 9th Coalition members. Distance (I am currently based on Australia rather than Canada) precluded interviewing stakeholders for this project. Regardless, the discursive production with respect to the LGBT PHAC gives us a rich understanding of many critical issues related to its inception, operation and demise.

CHRONOLOGY

The experiences and issues are described in chronological order, although not intended to imply any linearity of causality between events. Instead, this chronology is offered to give a sense of how these issues unfolded. However, through the life course of the PHAC, a continuity of issues becomes readily apparent.


On 9 December 1967 Minister of Justice Pierre Trudeau tabled legislation which decriminalized homosexual activity between consenting adults. Taking their name from this momentous date in queer Canadian history, Vancouver’s December 9th Coalition “fights for equality for lesbian, gay, bisexual and transgender people under the law and in other areas” and “operates as a minimally-structured collective of persons dedicated to the full securing of human rights for LGBT persons.” It operated with only a postal address (actually a member’s place of business), and occupied no office space. Individuals in the Coalition could bring forward projects or issues to which they are individually committed, and used the Coalition as a venue through which to identify peers with whom to work, or to receive feedback regarding strategies by which to fulfill their objectives. In short, December 9th Coalition members acted as members of the Coalition, rather than on behalf the Coalition. This decentralized approach allowed for a plurality of projects to be pursued without consensus or majority support, maximizing use of the diverse skills present among the Collective’s members.

In October 1995, six months after the Vancouver-Richmond Health Board introduced PHACs, the Coalition submitted a written copy of A Community Report on the Health Concerns of the Lesbian, Gay, Bisexual, and Transgendered Communities to VRHB senior staff. This report was an absolutely critical document. It communicated problematic experiences of LGBT individuals seeking access to the health system. Data were collected via focus groups and individual interviews: over 100 consumers, service providers and non-governmental organization (NGO) workers
participated. The report explicated three reasons why queers constituted a community with unique interests which could not be adequately addressed via the other PHACS, based on “shared oppression and discrimination...a shared system of cultural values, beliefs practices and institutions...[and] share[d] courage, devotion, self-sacrifice and commitment in times of crisis.” The report integrated both peer-reviewed sources (24 citations from scholarly publications and government research monographs) and informant accounts. The report credibly and compellingly documented the specific health-related challenges faced by Vancouver-Richmond queers.

In all likelihood the report’s contents were not revelatory for the activists who prepared it. As is often the case for grassroots activists, the report’s content most likely restated what was common knowledge for them and their constituents—what Foucault referred to as local, or subjugated knowledges, “a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity...local popular knowledges, these disqualified knowledges.” In preparing their report, Coalition members sought to assuage this gap by bringing their local, subjugated knowledge to the institution, in language that would withstand the institutional norms for credibility, namely scientific evidence. The report clearly and effectively refuted the rationale behind the VRHB’s refusal to constitute an LGBT PHAC. By adapting their argument to the explicit priorities of the Board’s policies (found in VRHB’s mission statement), the Coalition improved the likelihood of garnering support within the VRHB for their report’s findings. The VRHB’s initial stance—that there were adequate services for queers in the region, and that representation of queer-specific health needs could be adequately achieved through the VRHB Community Health Committees in areas with large, visible LGBT communities (presumably the West End and Commercial Drive)—was untenable, in light of the report’s findings.

In addition to integrating both quantitative and qualitative data from local, national and international sources, the report was structured to fit a population health model of health services delivery. Under population health, identified indicators (social determinants) of lower health status and barriers to accessing appropriate, effective information and services are the justification for context-specific endeavours. Perchal and Brooke’s report delineated eleven such social determinants: stress, higher incidences of specific diseases (lesbians’ 300% increased risk for breast cancer, shortened average life span for young gay men, and the higher prevalence of HIV among gay/bi men and transgender persons), substantial poverty, higher rates of substance abuse, same-sex domestic violence, abuse, hate crimes (a/k/a ‘gay bashing’), and epidemic depres-
sion and suicide rates. They documented five barriers to accessing adequate services: “prevailing negative attitudes and actions of health care providers,...insufficient education and training of health care providers,...prohibitve institutional structures, policies and procedures,...unique access issues (specific to disclosure of being queer),... (and) insufficient research.” Three appendices—“Examples of Heterosexism,” “Examples of Homophobia and Transphobia,” and “Barriers to Adequate Health Care”—further delineated the material implications of the current system’s inadequacies, with respect to the health of queers.

The report, which explicitly called for “the lesbian, gay, bisexual and transgendered community be designated a Population Health Advisory Committee as soon as possible,” was formally presented to the Population Health Coordinating Committee of the VRHB on 20 March 1996. Included in the submission were letters of support from the Minister of Health’s Advisory Council on Women’s Health; the LGBT caucus of Family Services of Greater Vancouver; the BC Coalition of People with Disabilities; UBC’s Department of Family Practice; AIDS Vancouver; Battered Women’s Support Services; YouthCo AIDS Society; the Centre for Lesbian, Gay, Bisexual & Transgendered Persons and Their Allies; St. Paul’s Hospital; and the Hospital Employees’ Union of BC. In gathering support from a cross-section of external stakeholder groups (including NGOs, health care providers, government entities, and the largest health workers’ trade union), the Coalition demonstrated that the political will existed in the region to support a new PHAC explicitly for queers.

On 7 June 1997—14 months after the December 9th Coalition presentation to the VRHB, and nearly two years after the Perchal and Brooke submitted their report to VRHB staff—the VRHB hosted a Gay, Lesbian, Bisexual and Transgender Health Conference at St. Paul’s Hospital in Vancouver. From those in attendance a working group formed to recommend selection procedures for LGBT PHAC membership, and applications for LGBT PHAC members became available. In September 1997, nearly two-and-a-half years after the other seven PHACs were formed, the newly constituted Lesbian, Gay, Bisexual & Transgendered Population Health Advisory Committee of the Vancouver-Richmond Health Board met for the first time.

LGBT PHAC (1997-2001)

From the very beginning, the workload—and concomitant expectations—for the LGBT PHAC, the first of its kind in North America, was daunting. Meeting minutes summarize its baptism by fire:

In our first month of operation, the LGBT PHAC began assuming responsibilities assigned by the Board. We were faced with the review of (project grants applications), review of acute and rehab services, orienting ourselves with the
Nearly Queerly

various systems of the Board and working to establish the operational principles of our committee. Within our first year we were asked to complete a Health Plan in which our issues would be inserted in the Regional Health Plan.\(^\text{16}\)

Almost immediately, the administrative and bureaucratic workload of working inside the VRHB’s institutional structures was felt. On average, committee members, who were unpaid volunteers, were expected to read 2-4 detailed reports each month (on subjects including health services, research monographs and policy guidelines). In addition to the committee’s monthly three-hour meeting, representation on various other VRHB committees was needed; about half of the PHAC members attended one or two additional VRHB meetings each month, as well as consultations with community groups and members on an ad hoc basis. And many PHAC members had pre-existing commitments to other community-based organizations; many PHAC members found those sorts of time demands difficult to maintain in the longer-term. Although members of the PHAC ostensibly served a two-year term, only two of the original nine members completed their full terms, a pattern throughout the PHAC’s history. This pattern of turnaround, as well as a 10-12 week processing period for all new VRHB volunteers, made keeping a full slate of 15 PHAC members very difficult.

The high degree of turnover exacerbated another problem faced by the PHAC: member recruitment. Given the range of stakeholder communities they served, the initial PHAC members were committed to parity or near parity between the different constituencies served by the Committee (gay men, bisexual men, bisexual women, gay or lesbian women, trans men and trans women). With the exception of gay and bisexual men, maintaining and recruiting members was an ongoing challenge, particularly from women and transgender persons. These constituencies often had reduced or no representation on the PHAC, despite ongoing and rigorous recruitment efforts by PHAC members and VRHB staff.

During its first two years, PHAC members strove to represent their communities’ interests within the VRHB. PHAC members sought input from their constituents through meetings, community forums, and by liaising with individual community members. Through such consultations, four issues quickly gained prominence: lack of accessible health care services, lack of appropriate research on LGBT communities, substance abuse; and program funding.\(^\text{17}\) During this same time period PHAC members had to manage program funding. Each of these areas generated its own set of documents.

ACCESS

Access was the first issue addressed; PHAC action regarding the issue was initiated almost immediately in 1997 and continued until the
PHAC’s demise. Members attended committees and met with key VRHB staff persons to bring the issue of access to the forefront, with respect to VRHB processes and procedures, and with respect to worker training. Subsequently, VRHB staff became frequent guests at LGBT PHAC meetings, and the VRHB Board of Directors became better educated on LGBT issues. In 2000, at the request of the LGBT PHAC, the Board voted to add gender identity as a protected group to VRHB employment equity policy—the first government body in Canada to do so:

Vancouver-Richmond Health Board (VRHB) has acknowledged that lesbian, gay, bisexual and transgender (LGBT) people also experience systemic barriers in employment. Systemic barriers exist due to systemic discrimination, including accessing training and education, applying for and retaining positions, seeking promotions, and in deciding whether to list relevant experience or training in resumés which might disclose sexual orientation or gender identity. In April 2000, the Board of Directors at VRHB decided to immediately integrate sexual orientation and gender identity with the same force as applied to gender, visible minorities, people with disabilities and Aboriginal people in a full-scale Employment Equity plan.18

During its tenure, the LGBT PHAC also became involved in a community-based controversy regarding access: that of male-to-female transgender women seeking access to woman-only services. After a controversial human rights case involving a women’s anti-violence services and a trans woman seeking to volunteer, the PHAC help initiate a dialogue in the women’s community regarding transgender issues and Transphobia. The Queer Women’s and TransHealth Series, with support from the PHAC, was launched because transgender women “are invisible in the healthcare system or have to deal with misinformed or prejudiced service providers. Many stop accessing healthcare altogether and suffer a lower health status as a result.”19

RESEARCH

The lack of empirical data on the communities served by the PHAC, and efforts to locate or instigate such research, proved to be more challenging than the access issue. Efforts to encourage VRHB-sponsored research on the experiences of lesbian, gay, bisexual and transgender persons in the region—specifically, or as part of a region-wide health services needs assessment—were unsuccessful. Much of the rationale in the Perchal and Brooks report came from US-based research—somewhat relevant to Canada—but a strong consensus existed among PHAC members that research on Canada (particularly Vancouver-Richmond) was needed. With no action forthcoming on the part of VRHB staff, LGBT PHAC members took it upon themselves to facilitate queer health research in Vancouver-Richmond. PHAC members, VRHB staff, university- and community-based researchers and interested community mem-
bers met to discuss research issues in March 2000. From this meeting a Vancouver-Richmond LGBT health research listserv was started.

At the same time, the PHAC broadened the initial community consultation initiated by December 9th (which culminated in the Perchal and Brooke report). Additional focus groups were conducted, and a self-administered questionnaire on persons’ experiences in seeking health services was distributed widely. A preliminary, descriptive analysis was conducted and published as a research monograph, and a broader recruitment for study participants undertaken. Unfortunately, neither the PHAC nor members of the LGBT Health Association had the means to analyze the data; to date, no reports of the findings have appeared in the popular press, VRHB publications, or academic circles.

SUBSTANCE ABUSE

Of the three critical areas initially identified by the PHAC, the issue of substance abuse in the LGBT communities was the most thoroughly addressed. From its inception, the PHAC sought involvement in VRHB committees and events regarding substance abuse in the region; key community-based stakeholders from substance abuse programs like Watari and the Broadway Youth Resource Centre were invited to attend PHAC meetings. Still, the members of the PHAC saw a need to gather more precise information regarding substance abuse issues in the LGBT communities. In 2000, a community consultation was initiated by the PHAC; over 18 months a community forum, focus groups, and individual interviews with community members were held.

Findings from this consultation were published as a research monograph in February 2003. Their report made 18 recommendations regarding substance abuse services for queers, including “develop social marketing and education programs targeting” LGBT persons, “dedicate funding for expansion of existing services, develop additional activity-based programs for…queer youth,” “develop a range of social supports related to drug use,” “agencies (should) take responsibility for ensuring equitable access to appropriate service for LGBT persons” and “(should) ensure their staff have taken part in comprehensive education to develop competency in serving LGBT populations,” “expand existing treatment programs…ensure they have the capacity to appropriately serve LGBT people,” and “develop a range of addictions services specifically for the LGBT population.” It remains to be seen what impact this report will have on substance abuse services for queers in Vancouver-Richmond.

PROGRAM FUNDING

PHAC activities were not the only ones supported during the committee’s history. As part of its commitment to bringing a population health
lens to health care delivery in Vancouver-Richmond, the VRHB sponsored annual program grants under the Sharon Martin Community Health Fund (SMart Fund). Funding for both large ($100,000 or more per annum) and small (less than $100,000) projects was made available. The SMart Fund “invests resources in communities that develop innovative health promotion projects to respond to health needs that they themselves have identified. All supported projects must be community-based initiatives in conception, ongoing operation, and evaluation.”

To equitably distribute these grants among various populations in the region, three PHACs were allocated one large and one-to-two small grants once every three years (on a rotating basis), through an open competition. This meant that a major LGBT health initiative could be funded every third year—unprecedented levels of funding for LGBT-targeting health initiatives in Vancouver-Richmond. Between 1997 and 2001, a community health education program and an LGBT seniors program both received large grants. PHAC members were an integral part of adjudicating the proposals received, necessitating the straddling between the competing norms of the institutional setting (VRHB) and their grassroots constituencies. From the date each annual SMart Fund competition was announced, PHAC members set up information meetings between SMart Fund staff and LGBT community members preparing submissions, spent approximately 30 minutes of each committee meeting discussing adjudication processes, referred LGBT community members to SMart Fund staff as possible peer reviewers, and held one extraordinary committee meeting to adjudicate and rank completed proposals with LGBT content. With the SMart Fund’s triennial opportunity to support LGBT-specific, community-based health initiatives came an increased work load to already overtaxed committee members.

Even as LGBT PHAC members were spearheading such activities, vigilance was still required, in terms of keeping queer health issues on the larger agenda of the VRHB. For example, in 2000 the VRHB Directional Plan For 2000-2003 explicitly mentioned at least one specific health concern for each PHAC—except the LGBT PHAC!23 By 2001, as the Region was drafting its Drug and Alcohol Framework,24 PHAC members were “glad that LGBT populations were explicitly mentioned.”

PHAC NO MORE (2001-02)

In May 2001, the ruling New Democratic Party lost power in a landslide victory for Gordon Campbell’s Liberal Party, which swept 77 of 79 seats. Sworn in as Premier in early June, Campbell had campaigned as a fiscal and social conservative on a number of issues, including health care reform. In their election platform, the Liberals promised to “focus funding on patient care, by reducing waste in the system and eliminating
administrative duplication and costs from provincial government mismanagement." As a part of this commitment, the Ministry of Health announced in December 2001 that health care in British Columbia was to be restructured. Instead of 52 regional health authorities, five mega-authorities now serve the entire province. The Vancouver Coastal Health Authority includes the Vancouver-Richmond region, as well as Howe Sound, the Sunshine Coast, and North and West Vancouver—25% of the province’s entire population. With this restructuring the population health approach to health services was rejected outright. All PHACs were dismantled as of April 2002. British Columbia thus became the only province in Canada to reject a population health-based approach in favour of a wholly geographically based system.

IMPLICATIONS

From lobbying to creation and through operation and cessation, the Lesbian, Gay, Bisexual and Transgender Population Health Advisory Committee of the Vancouver-Richmond Health Board found success in several areas. At its inception it became the first regional health entity dedicated to the health care interests of lesbians, gays, bisexuals and transgender persons in North America. PHAC members successfully lobbied for more accessible services for their constituents, and educated many VRHB staff on issues germane to the LGBT communities. The PHAC helped build relationships between NGOs and public health entities, fostering new collaborations. Transgender persons were integrated into VRHB human rights policy, a first for Canada. And an in-depth community consultation on substance abuse was conducted, generating much needed data on an issue long believed to be a problem for a disproportionate number of queers. All in all, an impressive list of accomplishments.

It cannot be argued that the Vancouver-Richmond Health Board failed to constitute a queer PHAC in order to jeopardize the health of queers in the Region. Rather, the VRHB’s limited notion of community, delineated in a population health-driven health care system, delayed this committee’s establishment. Of the original seven PHACs, five (women, Aboriginal, youth, multicultural and seniors) were for communities whose marginalization is based on outward appearances; the remaining two (mental health consumers and disabled persons) are constituency constructs based on broad groupings of chronic health care issues. These myopic criteria precluded the creation of committees based on other constituencies, including queers. But the effective advocacy work of the December 9th Coalition persuaded the VRHB to significantly amend its structures to accommodate queers.

The initial objective of the December 9th Coalition activists was the creation of an LGBT PHAC. But this is actually a component of a broader
interest in seeing gay men, lesbians, bisexual and transgender persons receive relevant, sensitive and timely health care services—uncommon experiences for too many queer persons in the Region. This is the core tension: the VRHB was amenable to adapting the health care system to mitigate inequities, but it was only able to see how queer persons in the Region were marginalized in the system after a group of community members adapted their knowledge to the Board’s norms. It might also be argued that the LGBT PHAC’s efforts to garner research data on their communities’ health needs reflect some degree of co-optation or compromise: does the LGBT PHAC’s emphasis on research represent a victory for the knowledge regime over local, subjugated knowledge? No. In its efforts to encourage research on their communities’ issues regarding health, the PHAC endeavoured to place the questions of the communities at the fore of the process—evidence of a sustained commitment to local knowledge. Still, in convening an LGBT PHAC, VRHB officials empowered members of the community to provide logistical, instrumental and financial support to local queer NGOs. An ongoing challenge to the PHAC’s members became negotiating the dual roles of government representative and grassroots activist. The question remains unanswered: what else could the Vancouver-Richmond LGBT PHAC have achieved, had it not been dismantled by the newly elected provincial Liberal government? We very nearly, queerly, knew.

NOTES
7 Foucault, History of Sexuality, p. 12.
10 Perchal and Brooke, “Community Report.”
12 Foucault, “Body/Power,” p. 82.
16 Vancouver-Richmond Health Board, Lesbian, Gay, Bisexual and Transgender Population Health Advisory Committee, Minutes, September 1999.
17 Vancouver-Richmond Health Board, Vancouver Richmond Health Board Lesbian, Gay, Bisexual & Transgender Population Health Advisory Committee Fact Sheet (Vancouver: Vancouver-Richmond Health Board, 1998).
21 Devon Macfarlane, LGBT Communities And Substance Use—What Health Has to Do with It! (Vancouver: LGBT Health Association of BC, 2003).
22 Vancouver Coastal Health Authority, Sharon Martin Community Health Fund. 2003.
23 Vancouver-Richmond Health Board, Directional Plan.
25 LGBT PHAC Meeting minutes, October 2001.