CANADIAN FORCES POLICY ON HOMOSEXUALITY
QUESTIONS AND ANSWERS FOR COMMANDERS

Q.1 What changes have been made to the CF policy on sexual orientation?

A.1 On 27 October 1992, the CDS announced that the CF policy on homosexual conduct was cancelled. The policy contained in CFAO 19-20 was revoked effective that date.

Q.2 What was the CF policy on the enrolment and retention of homosexuals?

A.2 Since February 1986, the policy was that the CF neither recruited nor retained practising homosexuals. Effective January 1988, an interim policy permitted the retention of practising homosexuals but under career restrictions.

Q.3 Why has the policy been revoked? Is it because the policy was challenged in the courts?

A.3 The policy has been under almost continuous review since 1984. In April 1985, Section 15 of the Canadian Charter of Rights and Freedoms came into effect. That section provides all Canadians with "--- the right to the equal protection and equal benefit of the law without discrimination ---". Although Section 15 does not specifically include sexual orientation as a prohibited ground of discrimination, it provided the basis for court challenges to the CF policy. On 27 October 1992 the Federal Court of Canada Trial Division issued a declaration that CF policies restricting the service of homosexuals are contrary to the Charter.

Q.4 Why did the CF bar homosexuals from military service in the first place?

A.4 Over the years there have been a number of reasons given for the maintenance of an exclusionary policy. Included in these reasons have been concerns about discipline, security, health, privacy, cohesion and morale, and recruiting. More recently the policy was largely based on the privacy, cohesion and morale, and recruiting concerns.

Q.5 Will not the presence of known homosexuals lead to more disciplinary problems?

A.5 The discipline issue has been studied carefully. The 1986 report of the Charter Task Force quoted a number of statistics about the relative incidence of sexual assault by homosexuals and heterosexuals. The source data have been reviewed and it has been determined that the study giving rise to the statistics was unreliable. The fact is we do not know and the data are not available to determine whether or not homosexuals are more likely than heterosexuals to be involved in cases of sexual assault. However, we do know that the CF has its share of both heterosexual and homosexual sexual misconduct and it seems appropriate that the focus be on misconduct rather than on the sexual orientation of the perpetrators. A second dimension of the discipline concern is the possibility of heterosexual members engaging in physical violence against known homosexuals. That kind of behaviour is indicative of a problem with individual heterosexuals rather than homosexuals and is not acceptable and will not be tolerated.

Q.6 Is it not true that homosexuals are more vulnerable to blackmail and consequently are more a security threat than heterosexuals?

A.6 Security experts do not consider homosexuals as a group to be any more of a security risk than heterosexuals as a group. Security risks are assessed on an individual basis. As a matter of policy, specific references to homosexuality were removed from the mandate of the SIU on 21 November 1990 by ADM(Per) message 081/90 issued as CANFORGEN 049/90 and CANRESGEN 031/90.

Q.7 Do homosexuals present a risk of transmitting certain infectious diseases (eg; HIV, hepatitis B) to heterosexual members of the CF?

A.7 In the main, the answer is no. Obviously, homosexuals who are not infected pose no risk of disease transmission in any circumstance; such uninfected persons would comprise the large majority of homosexual members. The diseases "associated" with male homosexuality are usually transmitted by sexual intercourse

and not by casual non-sexual contact in the workplace or living spaces. By and large, female homosexuals are at even lower risk of sexually transmitted disease than are heterosexuals.

Q.8 What about the risk of disease transmission from male homosexuals in the peacetime health care setting?

A.8 Certain diseases, while usually acquired through other methods (eg; sexually), can be transmitted through exposure to blood: these diseases include HIV and hepatitis B. Hence, persons with these diseases present some risk of transmission to their health care providers (eg; through needlestick injuries). However, the risk is lowered by the use of appropriate barrier protection when exposure to applicable body fluids (principally blood) is likely and by hepatitis B vaccination. The risk to CF health care personnel is no greater than that found in the usual civilian health care setting in Canada.

Q.9 What about the risk of disease transmission from wounded male homosexuals on the battlefield?

A.9 It is acknowledged that a potential exists for transmission of a bloodborne infection when providing first aid to infected wounded persons (regardless of sexual orientation) on the battlefield. Overall, the risk appears small, especially when compared to other battlefield risks. Most reported cases of HIV transmission in a health care setting have been the result of deep needlesticks or exposure to concentrated virus, not the situation expected on the battlefield.

Q.10 What about the risk of disease transmission from male homosexuals through blood transfusion obtained on the battlefield?

A.10 Blood transfusion from a person, regardless of sexual orientation, infected with a bloodborne agent presents a substantial risk of transmitting such agent to the blood recipient. Red Cross blood donation screening procedures minimize this risk. It is CF doctrine to use blood supplied by the Red Cross for battlefield

transfusion. Should it be necessary to obtain blood "on the battlefield" (eg; from other members) the risk of transmission would be reduced by using the same donor exclusion criteria as the Red Cross.

Q.11 Will the admission of homosexuals to the CF alter the current approach to HIV testing in the CF?

A.11 At present, HIV testing in the CF is only performed after obtaining written informed consent; this is consistent with civilian policy. While the policy may be reviewed, it will not necessarily be changed. If a testing program were instituted, it probably would not be based on the sexual orientation of those being tested.

Q.12 What useful information do we have about homosexuals and homosexuality?

A.12 Factual information is limited. What is frequently presented as fact is often simply theory or speculation or is based on questionable data. Some points:

* We know there are a number of homosexuals in the CF. We do not know exactly how many.

* We know that homosexuals feel a sexual attraction for members of their own sex. We do not know why some individuals are homosexual and why others are heterosexual.

* We know that some heterosexuals have a strong aversion to homosexuality and are uncomfortable with the idea of working with homosexuals and sharing personal space with them.

* We know that some CF members, despite a strong personal aversion to homosexuality, have no difficulty working with homosexuals provided they are professionally competent. We do not know how these personal feelings are set aside: we believe that for many CF members a sense of duty and a sense of fairness are stronger than feelings of personal discomfort.

* We know that some homosexuals are outstanding service members while others are average or below average. We do not know if their

performance as a group is better, worse or the same as the performance of heterosexuals: we believe the pattern is likely the same.

Q.13 How will the CF deal with those who refuse to accept and work with homosexuals?

A.13 It is a fact of life that members of the CF have to work together for the CF to be effective. Moreover, it is also a fact of life that members normally do not get to choose their working companions. Members who are unable to adapt to the policy change will be treated in the same way as members who are unable to adapt to the military for other reasons. It is anticipated that the number, if any, of such cases will be small.

Q.14 Will serving members who do not wish to share sleeping quarters with declared homosexuals be permitted to refuse to share such sleeping accommodation?

A.14 Operational and organizational requirements take precedence. Consequently, there will be no entitlement to refuse to share sleeping accommodation.

Q.15 Will two homosexuals who form a relationship be entitled to spousal benefits such as married quarters, service pensions, travel and removal benefits, etc?

A.15 All spousal benefits are determined by government policy. Any expanded entitlement to benefits would only be provided by the CF in step with government policy.

Q.16 Is it intended to establish some form of formal monitoring to assess the impact of the presence of known homosexuals on operational effectiveness?

A.16 No special monitoring agency or procedures are now being considered. No general decrement in operational effectiveness is expected. Present reporting procedures are considered adequate.

Q.17 Will such activities as dancing, hand holding, and embracing between same-sex members be accepted at mess social functions?

A.17 Standards of conduct for homosexual members will be the same as those for heterosexual members. Common sense and good judgement will be expected and required of all members.

Q.18 What should a service member do who feels that some other member is "hitting" on him or her?

A.18 CFAO 19-39, Personal Harassment, provides guidance on how to deal with cases of personal harassment including sexual harassment. The guidance applies equally to both heterosexual and homosexual sexual harassment.

Q.19 Can a commander ask a subordinate if he or she is a homosexual?

A.19 The circumstances that would justify such a question would be very rare. This information cannot be collected for the purpose of determining suitability for promotion, posting or other career action. However, the question might be asked if the answer is essential to counsel a member who is experiencing some personal or medical difficulty. In those rare cases, the information must only be used for the purpose for which it was obtained. Moreover, if individual counselling related to sexual behaviour is required, it should normally be done by a health care professional.