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MEDICAL IMPLICATIONS OF LIBERALIZING CF HOMOSEXUAL POLICY

PART I - INTRODUCTION

BACKGROUND

1. Homosexuality, "a preference for sexual relations, either partially or exclusively, with members of one's own sex" (1) is not a medical issue. Medical sequelae of homosexuality can occur, however, as a result of the involved sexual practices, the psychic discomfort of some homosexuals regarding their sexual orientation and the prevailing negative societal attitude toward homosexuality.

2. Homosexuality is rather common in western society. Prevalence data were cited in Kinsey's reports of 1948 and 1953 (1,2,3) and subsequent studies indicate that homosexuality has likely not increased in prevalence since then, but has increased in visibility. It is estimated that 10 percent of the male population and five percent of females is more or less exclusively homosexual for at least three years between the ages of 16 and 55.

3. The prevalence of homosexuality in the CF is unknown and likely could never be accurately determined. The average of 18.6 males and 17.2 females released annually in the last five years under CFAO 19-20 surely underestimates the true extent of this sexual orientation in the CF. While the CF may not reflect the prevalence in the general Canadian population because of the overt antihomosexual stance of the CF, the number of homosexuals is likely "substantial".

4. Even if the administrative barriers against homosexual enrolment and retention are lifted, it is not likely that a "flood" of homosexual applicants or self-identification of serving homosexuals will occur. Negative attitudes toward homosexual orientation among CF members will likely be very slow to change.

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5. This report addresses the medical implications of liberalizing the CF policy concerning homosexuals.

.../2

RESTRICTED

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PART II - DISCUSSION

CAVEATS

6. No hard data is available regarding some key aspects such as: the current prevalence of homosexuality in the CF; the number of homosexuals that may be enrolled should an open policy be adopted; the risk factors for those homosexuals who would be recruited as to lifestyle factors (e.g., number of sexual contacts, sexual practices, stable relationships, recreational drug use); and the actual incidence of certain medical conditions among homosexuals (e.g. gonorrhoea, acute depression). It therefore is not possible to estimate the number of cases of a particular disease that could be expected if a specific number of homosexuals were enrolled and what the precise manpower, training or financial implications would be of such enrolment. Only general trends and issues are addressed here.

7. It is assumed that the same enrolment medical criteria (physical and psychological) would apply to homosexual as to heterosexual recruits. Further, it is assumed that the CF would not develop a recruiting policy to enrol homosexuals out of proportion to heterosexuals. Finally, there is no method of identifying a homosexual except by self proclamation.

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GENERAL CONSIDERATIONS

8. Education. An educational program may be required for homosexual members, especially homosexual males. The content should address the potential health problems associated with the homosexual lifestyle; the need for seeking medical care early for certain problems; the need for preventive medical encounters (see para 13b); and the need to practise "safe sex", especially in light of the AIDS threat (see para 14b below).

9. Confidentiality. Maintaining the required level of confidentiality of medical records is always vital. Despite an open policy, homophobic attitudes will be slow to change. Therefore the knowledge of homosexual behaviour may still be a tantalizing piece of the medical record. With increasing numbers of identified homosexuals, confidentiality may be more difficult to preserve.

.../3

RESTRICTED

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10. Psychiatry. Homosexuality per se is not considered to be a psychiatric illness. Further, therapeutic attempts to reorient the sexual orientation of homosexuals are not felt to be worthwhile. There is no compelling evidence that homosexuality is associated with an increased incidence of psychiatric illness. The major increase in CFMS psychiatric workload under an open policy would be in sorting out administrative problems resulting from the social stresses on unit personnel and dealing with the medical expressions of those stresses.

11. Alcohol Abuse. It is recognized that homosexuals in general, and females in particular, are at higher risk of alcoholism than heterosexuals (4). This elevated risk is related to the pressures of living in a homophobic society; the trend toward 'gay bars' as a place to socialize, and the disinhibiting and antianxiety effects of alcohol. The therapy of homosexual alcohol abuse may not be substantially different than for heterosexuals and is likely no more or less successful.

SEXUALLY TRANSMITTED DISEASES (STDs)

12. General.

- a. Homosexual males are recognized as being at increased risk when compared to heterosexual males for certain infectious diseases transmitted by sexual means (Table 1). The risk for these diseases is not uniform among homosexuals but varies by sexual practices. There is increased risk associated with anal intercourse (with trauma to the anal lining allowing for readier passage of microbes), oral-genital intercourse (with the introduction of microbes into the oral cavity, including fecal organisms if anal intercourse precedes oral-genital intercourse) and oral-anal contact (providing direct transfer of fecal microbes into the mouth). Risk of infectious disease is also increased with increasing number of sexual partners, increasing number of anonymous partners, the exchange of body fluid and the failure to use a condom.
- b. The magnitude of any increase in these infectious diseases will depend on the nature (and number) of homosexual males recruited. Monogamous homosexuals will present little

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TABLE 1 - PROBLEMS MORE FREQUENT IN MALE HOMOSEXUALS*

<u>Viral Infections</u>	<u>Bacterial Infections</u>	<u>Parasitic Infections</u>	<u>Other Problems</u>
Hepatitis A,B, non-A-non-B	Salmonella	Entamoeba histolytica	Anorectal carcinoma
HTLV-III (including AIDS)	Shigella	Giardia lamblia	Sexual trauma and retained foreign bodies
Cytomegalovirus	Campylobacter	Strongyloides stercoralis	Psychosocial problems
Epstein - Barr Virus	E. Coli	Enterobius vermicularis	
Herpes simplex	Gonorrhoea	Dientamoeba fragilis	
Condylomata accuminata	Syphilis	Non-pathogenic:	
	Chancroid	E. nana	
	Granuloma inguinale	E. hartmani	
	Chlamydia	B. hominis	
	Non-gonococcal urethritis	Cryptosporidia	
	Urinary tract infection	Isospora	
		Scabies	
		Pediculosis	

RESTRICTED

-4-

RESTRICTED

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000414

RESTRICTED

-5-

problem, while highly promiscuous individuals may constitute a substantial problem. There is some preliminary evidence that sexual behaviour among homosexuals is moderating/changing in the wake of the AIDS epidemic. In New York City, homosexual-related gonorrhoea rates are decreasing (6) while self-reported safer sex practices (fewer sex partners, more condom usage, less oral sex) have been more prevalent among San Francisco homosexuals (7).

- c. Homosexual females are at less risk of sexually transmitted disease than either homosexual males or heterosexuals (3,8). This is due to the fact that their relationships are typically monogamous and to the absence of the heterosexual mechanisms of transmittal.
- d. Overall, under an open policy, the CF might suffer a noticeable increase in certain sexually transmitted diseases (STD).

13. General Preventive Considerations.

- a. STD Control. STD control in the homosexual male civilian community has proven difficult because of the multiplicity of sexual contact, the anonymity of such contact, the fear of revealing information by homosexuals to a homophobic bureaucracy, and the often asymptomatic infectious states. There is no reason to suspect that control in the CF will be any easier.
- b. Periodic Case-finding. It has been recommended that asymptomatic homosexual males undergo regular screening for STDs, in particular gonorrhoea and syphilis (9), but also intestinal parasites (5). Should the CF adopt these screening recommendations, extra expense would be incurred for:

- (1) professional time in obtaining the necessary health information and specimens and then debriefing the patient as to the test results. (cost estimated at \$12 total for two 15 minute encounters); and
- (2) direct lab costs for performing the tests (estimated at \$34 per screened individual).

.../6

RESTRICTED

000415

RESTRICTED

-6-

- c. Surveillance. It would be medically useful to institute a surveillance system to monitor the incidence of STDs among the homosexual male CF population. This system would identify the magnitude of disease entities; the location, population and risk factors to which the CFMS should pay particular attention for disease prevention; and the success of any instituted prevention strategies. Such a system would require knowing the number of CF members who are homosexuals, preferably by locale and having a reporting system for the STDs that includes the sexual orientation of the patient. Identification, early in a member's career (e.g., on recruitment) of sexual orientation, would also assist in the application of any preventive strategies (e.g. Hepatitis B (HB) vaccine). It is unlikely, however, that the CF could identify sexual orientation, even for valid medical reasons, without a serious civil rights challenge.
- d. Blood Supply. In wartime, a walking donor pool may need to be used to meet transfusion requirements. Testing of these donations for syphilis, HB and HTLV-III infection, as is standard peacetime practice, may not be operationally practical. In an 'all' heterosexual CF, it might have been acceptable not to test since the expected prevalence of these diseases would be low. Under an open policy, even with self-deferral of homosexual males from donating blood, testing may become obligatory.

14. Disease-specific Considerations

- a. Hepatitis B (HB). This viral infection of the liver is easily transmitted by sexual intercourse. Homosexual males are at very high risk of acquiring HB with 35-80% of homosexual males having evidence of previous infection and 6% being chronically infectious to others (vs. 3-5% and 0.3% respectively in healthy adults) (10). Infectious persons pose a significant risk to health care providers exposed to their blood. An

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RESTRICTED

-7-

effective vaccine to prevent HB has been available since 1982 and homosexual males are among the high priority groups for receipt of this vaccine. One can anticipate, under an open policy, that an aggressive (although likely not compulsory) HB vaccination program directed at homosexual male members will be proposed. This program would entail identification of homosexual males, screening for susceptibility to HB (\$11 per test) and vaccination of susceptibles (\$130 per vaccination). Further, a firmer HB vaccination program for appropriate CFMS personnel would be necessary, since these personnel would be at increased risk of HB from health care contact with the increased reservoir of HB virus among homosexual males enrolled under an open policy.

b. Acquired Immune Deficiency Syndrome (AIDS).

- (1) This infection has received much media (and scientific) attention. The causative viral agent is the Human T-cell Lymphotropic Virus Type III (HTLV-III). Infection with HTLV-III has a wide clinical spectrum from healthy (the bulk of infections) to the fatal AIDS. There is no effective treatment or preventive vaccine for this infection. HMs are the largest numerical and one of the highest risk groups for AIDS. Prevention relies solely on avoiding high risk behaviour. In the case of homosexual males, this consists of limiting the number of sex partners, using a condom and avoiding the exchange of body fluids (especially semen).
- (2) A blood test is available to detect antibodies produced by the body in response to HTLV-III infection. A positive test in an asymptomatic person means previous infection has occurred but does not discern if the patient is infectious to others, whether a clinical illness will develop and how (or when) the infection was acquired. An open policy could force the CF into a recruit and serving member screening program (\$3-4 per test) for HTLV-III infections, since the

.../8

RESTRICTED

000417

RESTRICTED

-8-

prevalence of infection in the CF is bound to increase. Identifying HTLV-III infected persons (most of them homosexual males) would allow counselling to prevent further transmission and the prohibition of CF exposures that may be harmful to infected persons (theoretical risks associated with the receipt of live virus vaccines and exposure to tropical diseases). An HTLV-III screening program at the recruit level would cost an estimated \$50-60K to establish and \$35,000 per year for lab costs alone and untold administrative problems.

- (3) The medical care cost associated with a single case of AIDS is about \$40,000. The CFMS can expect some increase in AIDS cases under an open policy (although a recruit level screening program would mitigate this increase) and thus increased expense. Further, asymptomatic but infected persons will need periodic medical follow-up to assess their immune system status.
- (4) Should a vaccine protective for AIDS be developed, a program for the identification of susceptibles (especially HMs) and administration of vaccine to susceptibles will be necessary.

PART III - CONCLUSIONS

15. An open recruitment policy regarding homosexuals, because of the expected increase in STDs among homosexual males, may generate additional medical costs for screening programs, HB vaccine and patient treatment.

16. There is no medical reason why an open policy toward homosexual recruitment could not be effected, although some increase in resources may be necessary to adequately serve this population.

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000418

RESTRICTED

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