A LEGAL REMEDY FOR HOMOPHOBIA: FINDING A CURE IN THE INTERNATIONAL RIGHT TO HEALTH

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INTRODUCTION

In what Michel Foucault famously likened to the discovery of a new species, the homosexual as a discrete category of person emerged on the scientific scene in the second half of the nineteenth century.1 The American Psychiatric

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1. “The nineteenth-century homosexual became a personage, a past, a case history, and a childhood, in addition to being a type of life, a life form, and a morphology. . . . Homosexuality appeared as one of the forms of sexuality when it was transposed from the practice of sodomy onto a kind of interior androgyny, a hermaphrodism of the soul. The sodomite had been a temporary aberration; the homosexual was now a species.” MICHEL FOUCAULT, THE HISTORY OF SEXUALITY 43 (Robert Hurley trans., Vintage Books 1978) (1976). The word “homosexual” made its first recorded appearance in an 1868 letter from Károly M. Kertbeny, an early advocate of sexual privacy rights, to Karl Heinrich Ulrichs, one of the first advocates for homosexual rights. Jean-Claude Feray & Manfred Herzer, Homosexual Studies and Politics in the 19th Century: Karl Maria Kertbeny (Glen W. Pepple trans.), 19 J. HOMOSEXUALITY 23, 29 (1990).
Association (APA) officially announced the inherent pathology of this newly identified human type midway through the next century, when homosexuality entered the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952. The classification remained in the DSM in that form until 1973, when it was replaced with "sexual orientation disturbance," a condition marked by "distress" over one's own sexual orientation. The APA took pains to distinguish this condition from homosexuality itself, whose removal from the DSM marked a major and early breakthrough in contemporary gay and lesbian history. In 1978, sexual orientation disturbance was renamed ego-dystonic homosexuality. Finally, no longer able to maintain that distress over homosexuality was medically different from distress over anything else, the APA decided in 1986 to strike the diagnosis altogether. Since then, the DSM has not included any gay-specific disorders.

Foucault describes how the invention of "the homosexual" partook of the late nineteenth and early twentieth centuries' "multiple implantation of perversions," whereby a positivist project in human taxonomy was meticulously applied to variations in human sexuality. Imposition of the pathological label "pervert" upon people with same-sex desire and behavior was not, by contemporary standards, an honest medical appraisal. Rather, as Foucault demonstrates, it was ultimately a political act in the service of a Victorian ideology that is, paradoxically, both repudiated and thriving today. Whatever the motives for discovering and then vilifying the homosexual, it is no wonder that, once branded as sick, homosexuals began to manifest symptoms. And the fact remains that lesbian and gay people, despite the psychiatric profession's change of heart, continue to suffer "distress" over their sexual orientation.

2. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 302.6 (1952).
5. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS [DSM-III] 281 (1978). Gregory Herek recalls that a separate diagnosis describing the content of an individual's dysphoria was an innovation invented for homosexuals; opponents to the classification argued that "ego-dystonic homosexuality" could be treated as well by other general diagnostic categories. Gregory M. Herek, Stigma, Prejudice, and Violence Against Lesbians and Gay Men, in HOMOSEXUALITY: RESEARCH IMPLICATIONS FOR PUBLIC POLICY 60-80, 70 (John C. Gonsiorek & James D. Weinrich eds., 1991).
7. Declassification of gay and lesbian people under the DSM has not been followed by a similar trend for the transgendered, who are strongly implicated under the diagnostic categories of transvestic fetishism and especially gender identity disorder. See Katherine K. in TAKING SIDES—CLASHING VIEWS ON CONTROVERSIAL ISSUES IN SEX AND GENDER 31-38 (E. Paul ed., 2000).
8. See FOUCAULT, supra note 1, at 36-49.
9. Id. at 3-13.
10. See infra Section I.B.
The APA’s revision of its position on homosexuality, then, does not owe to a lack of troubled homosexuals. What actually changed was the placement of blame for those troubles. Among health experts and providers, there has been a gradual, if incomplete, shift from faulting homosexuals as the problem to implicitly faulting society for its problem with homosexuals. Homophobia, not homosexuality, is the obstacle where lesbian and gay health is concerned.

This article uses homophobia’s hazardousness to health as the starting point of an argument that states have an obligation under the international right to health to combat homophobia. Part I sets out the powerful evidence that the stigma, prejudice, and violence directed toward lesbians and gay men constitute drastic dangers to their physical and mental well-being. Because discussion of this problem is virtually absent from legal scholarship, it is described here at some length, with an emphasis on several particular conditions prevalent in homosexual populations, namely AIDS/HIV, substance abuse, inadequate health care, mental disorders, and suicide. Part II outlines the legal content of the international right to health, showing that it can and legally must be interpreted expansively. Application of this interpretation to the public health problem of homophobia illustrates that governments must end a range of state-sponsored discrimination against gay men and lesbians, must afford them substantial legal protection against discrimination by non-state actors, and must combat homophobia through education and other positive efforts. Acknowledging the currently limited possibility of a literal application of this article’s argument, the Conclusion posits a tactical reason for framing lesbian and gay rights as a health issue.

A note on scope: this article seeks to be immediately relevant only in those parts of the world where modern homosexual identity, a distinctly Western construct, is a widespread phenomenon, however varied it may be from one society to another. Even within this limited geographic and cultural range, only a handful of countries have seen sustained public health research on lesbians and gay men. This article’s conclusions about homophobia’s effect on health can be applicable only to those areas—namely, North America, Western Europe, and Australia and New Zealand. In countries where, for example, “men who have sex with men” is a far more useful and accurate concept than “gay men,” a health program based on promoting gay rights would likely hurt, not help, the health of substantial but nearly-invisible populations of homosexually active males.

11. “Men who have sex with men” describes people in terms of their behavior; “gay males” usually denotes a complex combination of identity and behavior.

12. See James Robertson, Neither Health nor Rights: Men Who Have Sex with Men and AIDS in Sub-Saharan Africa (2003) (on file with author) (demonstrating that, because gay identity is highly uncommon throughout much of sub-Saharan Africa and because that identity is vociferously and often violently persecuted at the hands of both state and private actors, identity-based gay-rights approaches to preventing HIV transmission among men who have sex with men would reach pitifully few of its intended targets and might, in fact, spur further persecution of homosexually active men in the name of public health).
Lastly, a note on terminology: writing about homosexuality necessitates a prudent wariness of accepting as givens the labels used to describe gay men, lesbians, and ideas associated with them. Precision is especially warranted when attempting to merge scientific and legal discourses. This article understands “sexual orientation” to be an intricate construct whose dimensions include self-identification; emotional and social preferences; and sexual attraction, behavior, and fantasies. These indicators do not align perfectly in every case, but a documented correlation between them allows us to discuss sexual orientation as a single, underlying construct in our society. For the purposes of this article, the terms “gay men” and “lesbians” describe people whose sexual orientation is primarily or exclusively toward persons of the same sex. Finally, as Heidi Kulkin and others have observed, homophobia is a “loaded term” in our society. This article adopts a definition of homophobia that combines Gregory Herek’s description of individual and institutional prejudice against gay men and lesbians with Richard Friedman and Jennifer Downey’s insistence on the irrationality of that prejudice.

I. Homophobia as a Health Hazard

A. General Observations

It does not come as a surprise to gays and lesbians that homophobia – both atmospheric and targeted—is a serious risk to their health. In the early years of the American AIDS crisis, gay activists made famous the slogan “SILENCE=DEATH.” “Homophobia is a social disease,” asserts another long-popular motto. These ideas were formally articulated to former U.S. Secretary of Health Donna Shalala at a 1993 meeting of the American Association of Physicians for Human Rights. “Homophobia,” according to the

15. Following Ilan Meyer, who studies the effects of discrimination on lesbians and gay men, this article often refers to gay and lesbian “populations” as a reminder that homosexuals are as diverse as the larger populations in which they exist. Ilan Meyer, Why Lesbian, Gay, Bisexual, and Transgender Public Health?, 91 AM. J. OF PUB. HEALTH 856, 856 (2001). It is important to remember, particularly in discussions of mental and physical health, that gay men and lesbians come from all socio-economic, cultural, racial, and ethnic backgrounds. Meyer usefully observes that they “are also diverse in the degree to which their LGBT identities are central to their self-definition, their level of affiliation with other LGBT people, and their rejection or acceptance of societal stereotypes and prejudice.” Id.
16. Heidi S. Kulkin et al., Suicide Among Gay and Lesbian Adolescents and Young Adults: A Review of the Literature, 40 J. HOMOSEXUALITY 1, 12 (2000).
association’s spokespeople, “is itself a disease [that] leads to bad science and inferior health care . . . . As long as gay and lesbian people are oppressed . . . . they [experience] a suboptimal state of health.” Homophobia, like poverty, is therefore what some scholars call a “fundamental cause” of poor health; it is an “underlying social or environmental condition that produces disease through secondary mechanisms.”

The field of public health has recently begun to address homophobia. In 1999, the American Medical Association issued a policy statement calling for exploration of the connection between gay health and anti-gay discrimination, and the Institute of Medicine published a report on lesbian health. In a significant development, the Gay and Lesbian Medical Association (GLMA) coauthored with researchers at Columbia University a federally-funded white paper entitled “Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns.” The white paper set the stage for recognition of sexual orientation as a social determinant of health in the United States, which came with the inclusion of lesbian, gay, bisexual, and transgender (LGBT) people in the federal government’s ten-year public health plan released in 2000. The resulting document, Healthy People 2010: Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health, nearly 500 pages long, details how stigma, prejudice, and other social factors affect “in myriad ways” both the health of homosexual people and the ability of healthcare professionals to care for them. The white paper and the Healthy People document and identify the major health concerns of gay and lesbian communities, including cancer, HIV/AIDS, mental health and youth suicide, substance abuse, and access to quality healthcare. These sources advocate a national research agenda focused on gay men and lesbians, one that will expose “homophobia, ignorance, and fear” as impediments to health and responsible research on health.

A first look at the unique situation of lesbian and gay youth provides a more concrete understanding of homophobia’s health consequences. More often than not, “such youth are not [even] recognized as . . . existing within . . . society.”

When they are perceived, either through courageous self-identification or the

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23. Id.
24. Id. at 16.
unwelcome aspersions of others, the response often includes “rejection, ostracism, and possibly harm,” even—and sometimes especially—from their own families. Nonrecognition as gay or lesbian does not mean immunity from homophobia’s pernicious effects. In the face of overwhelmingly negative stereotypes and attitudes about homosexuality, unidentified or closeted homosexual youth are sometimes more vulnerable to internalized feelings of stigma and self-hatred than those who are openly gay—feelings that are “almost impossible” for any queer or questioning youth to evade. These gay and “proto-gay”27 young people often have low levels of self-esteem and self-confidence, a legitimate and powerful fear of harassment and physical abuse, and a sense of cultural and personal isolation. Such troubles go far in explaining their high rates of psychological difficulties, substance abuse, unsafe sex, and suicide.28

B. MENTAL HEALTH AND SUICIDE

Mental health, a necessary complement to physical health, is “a state of successful performance of the mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity.”29 It is encompassed in the definitions of health adopted and promulgated by the World Health Organization and other international bodies.30 Severe problems in mental health can be debilitating.

Mental disorders are substantially more prevalent among gay and lesbian people than in the population at large. A New Zealand study of sexual minority youth found higher rates of extreme anxiety, major depression, and conduct disorders.31 Homosexually active men are more likely to experience depression than exclusively heterosexual men, and they are more likely to be bipolar, to have

25. Id.
26. Id.
27. I borrow this useful term from Eve Kosofsky Sedgwick’s, “How to Bring Your Kids Up Gay: The War on Effeminate Boys,” in TENDENCIES 154-164, 163 (1993). By proto-gay, I mean youth—usually children—who do not yet understand themselves as members of a sexual minority. There are any number of reasons why proto-gay youth may not have acknowledged their sexuality to themselves; two of the most prevalent reasons are a lack of consciousness about sexuality generally and a lack of consciousness about homosexuality in particular. Despite such unawareness, proto-gay youth often sense quite acutely their difference from the cultural norms that masquerade as universally shared.
28. See infra Sections I.B-E.
29. GLMA, supra note 22, at 206.
panic attacks, and to suffer most other mental disorders. Depression is more common among African American lesbians and gay men than in the general African American population. It should be noted that mental problems among lesbian and gay people are most prevalent—and often most damaging—in adolescence.

Homophobia is indisputably responsible for homosexuals’ heightened susceptibility to mental illness. The United States government’s ten-year plan for a healthy population states outright: “the widespread prejudice, discrimination, and violence to which LGBT people are often subjected pose risks to [their] mental health and well-being.” Several studies have indicated that homophobic phenomena provoke serious stress in their victims. Gay men are at greater risk for mental health problems and emotional distress “as a direct result” of discrimination and negative experiences in society. Gay and lesbian youth internalize a harsh and negative self-image of being deviant from society, family, and friends. Cultural stereotypes of homosexuals as inherently sick and self-destructive make them believe their low self-esteem and depression are inevitable and deserved.

Suicide is the most serious incursion of mental health problems into physical health. Unsurprisingly, high rates of homophobia-induced mental disorders in lesbian and gay populations translate into correspondingly high suicide rates. Numerous studies have shown what one study modestly calls an “unusual prevalence” of suicide attempts among homosexuals. Suicide is the number-

32. GLMA, supra note 22, at 212.
35. GLMA, supra note 22, at 211.
40. Suicide and attempts to commit suicide usually result from a mental disorder. GLMA, supra note 22, at 206.
41. Kulkin et al., supra note 16, at 3; Friedman & Downey, supra note 17, at 925-26; Ronald F.C. Kourany, Suicide among Homosexual Adolescents, 13:4 J. HOMOSEXUALITY 111, 113 (1987); Stephen G. Schneider, Norman L. Farberow & Gabriel N. Kruks, Suicidal Behavior in Adolescent and Young Adult Gay Men, 19 SUICIDE & LIFE-THREATENING BEHAVIOR 381, 382 (1989).
one cause of death among young gays and lesbians, who attempt it, according to one study, two to three times more often than straight youth. These determinations of suicide’s prevalence among lesbian and gay populations, one should remember, are based on one of two sources of information: either subjects’ personal identification as homosexual or homosexually active; or, in cases where suicide has been completed, conservative determinations of which suicides are attributed to sexual orientation-related troubles. Therefore, the correlation between homosexual orientation and suicide attempts or ideation is probably even higher than the astounding estimates cited here.

The gay gene, if it exists, is not coded with fatalist DNA; nothing about homosexuals makes them, more than heterosexuals, inherently suicidal. The homophobia that compels an increased propensity to develop psychological problems also compels an increased propensity to kill oneself. There are no differences between homosexual and heterosexual youth in terms of suicidal tendencies when one controls for stress, social support, and coping resources. Societal discrimination, harassment, and prejudice are the significant variables. As a study published in the American Journal of Public Health urged, “if we cannot change some of the environment in which [gay and lesbian] youths come to maturity . . . alienation, isolation, and victimization” will continue their lethal work.

C. SUBSTANCE ABUSE

There is an unfortunate dearth of statistical information comparing substance abuse in homosexual and heterosexual populations, and what data does exist is not encouraging. Lesbian and gay people are consistently shown to be at greater risk of drug addiction and abuse. Illicit substance abuse is more common

43. Gibson, supra note 38. Kulkin et al. write:

[M]any studies indicate the rate of attempted suicides occur around the age of 20 or younger. According to a study performed by Saghir and Robins, 5 out of 6 gay men who attempted suicide had done so by the age of 20. Bell and Weinberg found that 35% of gay men sampled and 38% of lesbians sampled had attempted or had serious suicidal ideation before the age of 20. Thus, studies which have been able to illustrate suicidality within the population of homosexual youth, have found a high rate of suicidal ideation and behavior that places these adolescents and young adults at a greater risk of taking their own lives than other youths.

46. For example, the National Household Survey on Drug Abuse and the Monitoring the Future study are the two most commonly cited substance abuse data sets, and neither includes sexual orientation as a demographic variable in its data collection or analysis. GLMA, supra note 22, at 331.
among people with same-sex partners than among people with opposite-sex partners. Most studies indicate that lesbians drink substantially more than the general female population. One study of gay men and lesbians in metropolitan areas of the southern United States found significantly higher alcohol, marijuana, and inhalant use.

“Party” drugs are a severe problem among gay men, who use substances like amyl nitrite, ketamine, ecstasy, and crystal methamphetamine at extremely high rates. In one survey, one-third of the gay male participants reported using ecstasy at least once per month; in another, about twenty percent had used party drugs once or twice per year, more than a quarter used such substances once per month, and thirteen percent used them at least once per week. “Crystal meth” abuse among gay men has reached such epidemic proportions that the Washington Blade, the leading gay newspaper in the United States, this year published a four-part series on the crisis.

Substance abuse among lesbian and gay youth presents a special cause for alarm. The 1997 Vermont Youth Risk Behavior Survey found that youth with homosexual experience were significantly more likely to have used drugs and alcohol than other youth, with sixteen percent of them drinking alcohol daily for the past thirty days and nearly one-third having used cocaine in that period. A study of LGBT youth in New York City showed a high prevalence of alcohol and illicit drug abuse, as did a study comparing homosexual and heterosexual students in Massachusetts.

High rates of substance abuse among homosexual populations are widely seen

49. GLMA, supra note 22, at 338.
52. Klitzman et al., supra note 51, at 1162.
55. GLMA, supra note 22, at 336 (citing VT DEPT. OF HEALTH, 1997 VERMONT YOUTH RISK BEHAVIOR SURVEY).
56. Margaret Rosario et al., Exploration of Substance Use Among Lesbian, Gay, and Bisexual Youth: Prevalence and Correlates, 12 J. ADOLESCENT RES. 454, 463 (1997).
as an indirect result of the homophobia they face. People with certain mental disorders are more likely than others to resort to drug and alcohol use, and findings on the mental health of lesbians and gay men make their increased susceptibility to drugs unsurprising. 58 A study comparing high school students who had been threatened or hurt on the basis of sexual orientation with those who had not found that more than half of those who reported harassment or violence had smoked tobacco and marijuana in the past month, almost forty percent had sniffed inhalants, a quarter had tried LSD, and almost a quarter had experimented with cocaine. 59 Another study found that substance abuse among homosexuals is often a coping mechanism to deal with homophobic stigma. 60 And, as the GLMA observes, there is a connection between lesbian and gay substance abuse and the relegation of much of gay life to bars and clubs—especially the part that is most observable and accessible to young people living in a rigorously heterosexual culture. 61

D. HIV/AIDS

For many people, AIDS provided the first and clearest opportunity to understand the nature of homophobia’s effect on health. 62 The impact of homophobia on AIDS policy, especially in the 1980s, was obvious and devastating. Because homosexuals were then the disease’s primary victims, governments were recklessly slow to respond to the growing crisis. Only when it became apparent that AIDS was a threat to mainstream heterosexuals did the disease receive some of the attention it deserved, and by then thousands had died and hundreds of thousands more were infected. 63

Homophobia has affected gay susceptibility to AIDS in more insidious ways than the cruel inattention that typified the early years of the epidemic. Although the link is seldom acknowledged, homophobia is largely to blame for the astonishing rates at which gay men continue to be infected with HIV. 64 While a rigorously homophobic culture has always been happy to admonish gay men to take responsibility for gay health, it has not itself taken responsibility for furnishing the HIV-hospitable environment that gay men inhabit. 65 For one, the closet, a metaphorical space that confines and compromises gays and lesbians by

58. See supra Section I.B.
60. Orenstein, supra note 57, at 11-12.
61. GLMA, supra note 22, at 334.
62. Kenji Yoshino, an important scholar of lesbian and gay legal issues, notes that, “to the extent that homophobia has resulted in government inaction on AIDS... gay ‘health’ cannot be understood without understanding sexual orientation discrimination.” Kenji Yoshino, Assimilationist Bias in Equal Protec-
64. GLMA, supra note 22, at 182.
65. Burris, supra note 19, at 419.
making them socially invisible, is a significant barrier to effective AIDS prevention. AIDS-education efforts are typically directed toward men who identify as gay, a poor strategy if one hopes to reach the vast variety of men who have sex with men. This problem is particularly pervasive among homosexually active men of color, who in the United States today have the highest rates of HIV infection.

As with suicide and substance abuse, risk of HIV infection correlates with certain mental disorders. The particular mental problems faced by many gay men have been associated in numerous studies with sexual risk-taking practices. Such behavior is sometimes identified as an "emotion-focused coping strategy" employed to reduce the powerful stresses induced by homosexual existence in homophobic society. Substance abuse—particularly the "party" drug use favored by many gay men to relieve themselves of psychological inhibitions, stressors, and torments—is another factor that heightens the risk of HIV-infection. Indeed, the highly dangerous and grossly misunderstood bare-backing trend among many gay men is largely fueled by an intense party drug culture.

These facts on AIDS and gay men painfully demonstrate that homosexuals are taught and induced to so undervalue their lives that they take risks that seem totally irrational. This devaluation theory has been implicitly articulated by Scott Burris, who argues that governmental refusal to legally recognize lesbian and gay relationships is partly to blame for risky sexual behavior among gay men. Burris writes that there has been a failure "to treat sex as social behavior," to address the fact that people make choices, even intimate ones, "based on options, tastes and norms set by their communities and the larger society." Under this view, the health risks of "gay sexual culture" are fatal consequences of, among other things, "limited access to social validation of their relationships."

67. GLMA, supra note 22, at 182.
68. Id. For the most recent statistics and references on HIV infection in this community, and in the larger African American community; see also the Center for Disease Control Fact Sheet on HIV/AIDS among African Americans available at http://www.cdc.gov/hiv/pubs/fa... (last visited Jan. 15, 2005) (listing the most recent statistics and references on HIV).
70. GLMA, supra note 22, at 215.
73. Burris, supra note 22, at 418.
74. Id. at 425-26.
E. INADEQUATE HEALTH CARE

I told my family doctor I was gay when I was fifteen. He asked if I had been having sex with other men. When I said yes he asked me to find another [physician] and phoned my father to tell him why he could no longer treat me. I have never trusted another doctor since. 75

* * * *

The Nurse Practitioner was doing a history . . . and asking about pregnancies, so I thought it was a good time to tell her I was a lesbian. . . . It just took this nurse completely off-guard. She started spelling it out loud as she wrote it in my chart.

"L-E-S-B-I-A-N."

A nervous smile came over her face and she couldn’t recompose herself. She left the room . . . and when she came back in, [another] person was peering in at me from behind the door. I couldn’t believe what was happening. There I was half-dressed. I was humiliated. 76

Like most people, health practitioners tend to operate upon a presumption of heterosexuality in the individuals they treat. Lesbians and gay men can correct that assumption by coming out; but in doctors’ offices, as in many other contexts, such revelations often receive a chilly welcome, as illustrated by the personal stories above. Unfortunately, the alternative—hiding the unique health needs that arise from being gay or lesbian—is not an inviting or harmless option either. 77

Homophobia is prevalent in the medical community. Multiple studies have documented provider bias toward lesbian and gay patients. A 1991 study of American primary care physicians found that thirty-five percent “feel nervous among a group of homosexuals” and believe homosexuality to be “a threat to many of our basic social institutions.” 78 Thirty-six percent of New York City internists, obstetricians, and gynecologists report that “homosexual behavior between two men is just plain wrong,” and sixty-five percent feel that it would not be a “benefit to society to recognize homosexuality as normal.” 79 These trends have long outlived the AIDS-phobia to which they might once have been

75. Sue Turner & Frances Anderson, Barriers to Health Care; Pink Health: Is There a Problem?, Public Health Association conference in Auckland, July 5, 2001 (on file with author) (recounting gay male’s story).
76. Id. (recounting an Australian lesbian’s story).
77. Id.
79. See Gerbert, supra note 78, at 2837.
attributed. The mental health community also continues to be affected by anti-gay bias and ignorance, which are manifested at its worst in so-called reparative therapy.\textsuperscript{81} Despite awareness of prejudice against gay and lesbian populations, medical and mental health professionals often receive little or no training to overcome their homophobia or to learn the necessary “cultural competency-based skills” for effectively treating sexual minority patients.\textsuperscript{82}

Homophobia in the fields of mental and physical health prompts many lesbians and gay men, even those who otherwise openly self-identify as homosexual, to keep their sexual orientation hidden from health providers. One-third of gay men and forty-five percent of lesbians are not out to their doctors.\textsuperscript{83} A number of studies have corroborated this general finding, and further suggest that even those who do tell their doctors about their homosexual orientation nonetheless feel discouraged from being honest or open about their actual sexual practices.\textsuperscript{84}

Benjamin Schatz, former executive director of the American Association of Physicians for Human Rights, believes that homophobia among physicians causes “tremendous harm to patients across America who are not able to talk openly with their [doctors].”\textsuperscript{85} Indeed, homophobic healthcare professionals exhibit decreased empathy and less satisfactory treatment to lesbian and gay clients,\textsuperscript{86} and one study posits that substance abuse counselors’ understanding of gay and lesbian patients’ particular needs has a substantial effect on the recovery of gay and lesbian patients.\textsuperscript{87} The impossibility of coming out to many doctors has resulted in partial or total avoidance of professional care.\textsuperscript{88} In short, disclosure of sexual orientation to medical and mental health providers is “crucial” to the provision of effective, sensitive, and individualized care, and many doctors deprive themselves of this vitally important information.\textsuperscript{89}

\begin{itemize}
\item \textsuperscript{80} See, e.g., Allison L. Diamant et al., Implications of Taking a Sexual History, 159 ARCHIVES INTERNAL MED. 2730 (1999); Michele J. Eliason et al., Experiences and Comfort with Culturally Diverse Groups in Undergraduate Prenursing Students, 39 J. NURSING EDUC. 161, 162-63 (2000).
\item \textsuperscript{82} GLMA, supra note 22, at 49; A.E. Harrison, Primary Care of Lesbian and Gay Patients: Educating Ourselves and Our Students, 28 FAM. MED. 57, 57-58 (1996).
\item \textsuperscript{83} Randy Dotinga, Gays Keep the Closet Door Shut at the Doctor’s Office, HEALTH DAY, Dec. 26, 2002.
\item \textsuperscript{84} See GLMA, supra note 22, at 49; DEP’T OF HEALTH AND HUMAN SERV. U.S. PREVENTIVE SERV. TASK FORCE, GUIDE TO CLINICAL PREVENTIVE SERV. (2d ed. 1995).
\item \textsuperscript{85} Cotton, supra note 18, at 2612.
\item \textsuperscript{86} Turner & Anderson, supra note 75.
\item \textsuperscript{87} Tonda L. Hughes & Michele Eliason, Substance Use and Abuse in Lesbian, Gay, Bisexual, and Transgender Populations, 22 J. PRIMARY PREVENTION 263, 289–91 (2001).
\item \textsuperscript{88} Dean et al., supra note 21, at 107–08; Ruth P McNair, Lesbian Health Inequalities: A Cultural Minority Issue for Health Professionals, 178 MED. J. AUSTL. 653, 653 (2003).
\item \textsuperscript{89} GLMA, supra note 22, at 158.
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II. THE INTERNATIONAL RIGHT TO HEALTH

A. SOURCES AND CONTENT OF THE RIGHT TO HEALTH

The AIDS pandemic and the worldwide failure to successfully curb or combat it has been an important impetus for the amplified discussion of health as an international legal norm. The right to health, however, was by no means a novel idea when AIDS appeared; it was already codified in a number of international instruments. The Universal Declaration of Human Rights (UDHR), adopted in December 1948, proclaims that “[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family.” A fuller delineation of the right, and the specific source of most claims relating to it, is Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR), which recognizes every individual’s right to “enjoyment of the highest attainable standard of physical and mental health.”

90. The content of the right to health, as well as state obligations under the right, are not limited to what is discussed in this article, which concentrates on those aspects most relevant to lesbian and gay populations.


92. Universal Declaration of Human Rights (UDHR), art. 25.

93. Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) reads:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

   (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

   (b) The improvement of all aspects of environmental and industrial hygiene;

   (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

   (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

CESCR, art. 12.

A number of other international human rights instruments recognize the right to health. The United Nations Committee on Economic, Social, and Cultural Rights observes:

[T]he right... is recognized, inter alia, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination Against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. Several regional human rights instruments also recognize the right to health, such as the European Social Charter of 1961 as revised (art. 11), the African Charter on Human and Peoples' Rights of 1981 (art. 16) and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988 (art. 10). Similarly, the right to health has been proclaimed...
The meaning and scope of the right to health have long been debated and they remain “mired in confusion” more than thirty years after the ICESCR’s adoption in 1966. Some of this uncertainty was alleviated in 2000, when the United Nations Committee on Economic, Social, and Cultural Rights (CESCR) issued General Comment 14. The Comment’s broad interpretation of Article 12 provides the basis for this article’s understanding of the standards imposed by the right to health. In Part III of the article, the spirit of the CESCR’s approach in the Comment guides the application of these standards to the health situation of lesbian and gay populations.

General Comment 14 begins, “Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.” Early in the document, the CESCR puts an end to one question that had long swirled around Article 12—namely, whether the ICESCR mandates no more than a right to health care. While acknowledging that both the UDHR and the ICESCR reject the definition of health used by the World Health Organization (WHO), which calls for “complete physical, mental and social well-being,” the CESCR lets there be no mistake that both the plain meaning of Article 12 and the intent of its drafters require governments to “promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health.”

The right to health “must be understood” to mandate the wide variety of “facilities, goods, services and conditions” necessary for achieving the highest attainable standard of health.

Thus, the right to health contains both freedoms and entitlements. The right to control one’s health and body and the right to be free from certain interferences like torture and non-consensual medical treatment are cited in General Comment 14 as examples of the freedoms guaranteed by Article 12. Significantly, the Comment explicitly names “sexual and reproductive freedom” as an element of bodily freedom. The entitlements subsumed under Article 12 also include a “right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.”

The existence of entitlements under Article 12 is necessitated by the ICESCR’s unambiguously high standard for human health; only through the existence of positive rights can the underlying determinants of health be reached effectively. Underlying determinants of health may be understood as deeply-rooted social
and economic problems that create opportunities for sickness and death. Identification of these "fundamental causes" and the mechanisms through which they work shows how illness is "structured into our social order" and why changes in that order are "not simply matters of justice but matters of public health." Discrimination has long been recognized as a fundamental cause of disease; in 2001, a senior advisor to the WHO Director-General explicitly took discrimination, for public health purposes, to include homophobia.

A central theme of General Comment 14, which follows from discrimination's role as a fundamental cause of disease, is the nondiscrimination requirement. This principle lies at the heart of the UDHR and the ICESCR, and it applies to all of the rights enumerated in these documents. The CESCR therefore demands that health facilities, goods, and services be "accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds." General Comment 14 specifies sexual orientation as one of the categories upon which discrimination is prohibited under the ICESCR.

The reliance of the right to health on the right to be free from discrimination points to an important characteristic of the right—namely, the necessary connection between the right to health and many other rights specified in international law. As the CESCR observes, "health is a human right indispensable for the exercise of other rights." Lawrence Gostin and Zita Lazzarini in turn write that "promoting human rights is critical to improving health." And as certain scholars have noted, protection of health is an objective in so many areas of international and domestic law that the right to health cannot be fit neatly onto either side of the "civil and political" and "economic, social, and cultural" binary.

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101. Fidler, supra note 91, at 11.
102. Burris, supra note 19, at 421.
104. CESCR, supra note 30, ¶ 12.
106. CESCR, supra note 30, ¶ 1.
More specifically, General Comment 14 explains that the realization of the right to health is “closely related to and dependent upon” the fruition of other human rights contained in the International Bill of Rights,\(^ {109}\) including “the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement.”\(^ {110}\) Similarly, Executive Director of the Joint United Nations Programme on HIV/AIDS Peter Piot calls respect for human rights “indispensable” to public health, noting that such respect is “the surest way” to persuade populations and individuals “to participate in public health programs . . . counseling, education . . . and treatment.”\(^ {111}\) Failure to protect or the outright deprivation of human rights “drive people away” from necessary and otherwise available health measures.\(^ {112}\)

**B. STATE OBLIGATIONS UNDER THE RIGHT TO HEALTH**

Fulfillment of the right to health is not expected to be achieved immediately. The fact that progressive realization is foreseen and sanctioned by the ICESCR should not, according to the Committee that interprets the Covenant, “be misinterpreted as depriving the obligation of all meaningful content.”\(^ {113}\) Indeed, the very purpose of progressive realization is to prevent inaction; holding governments with meager resources to an impossible standard contains the danger of an all-or-nothing approach, whereby an inability to accomplish some things becomes an excuse for not doing anything. Rights that require at least progressive realization establish a goal; states have a “clear obligation” to move “as expeditiously and effectively as possible toward that goal,”\(^ {114}\) and they must “take steps” to effectuate the rights that are “deliberate, concrete, targeted,” and “exercised without discrimination.”\(^ {115}\) Finally, there is a kind of Hippocratic assumption in even a progressive realization of the right to health; retrogressive measures are almost never permissible.\(^ {116}\)

The CESCR’s determination that Article 12 requires treatment of health’s underlying determinants dictates aggressive, proactive, and systemic policies and practices. If health and illness derive largely from social and material circumstances, then those circumstances must be shaped to produce more health and less illness. For example, in the context of AIDS prevention, campaigns to voluntarily

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\(^ {109}\) The International Bill of Rights consists of the Universal Declaration of Human Rights (UDHR), the International Covenant on Civil and Political Rights (ICCPR), and the International Covenant on Economic, Social, and Cultural Rights (ICESCR).

\(^ {110}\) CESCR, supra note 30, ¶ 3.

\(^ {111}\) Peter Piot, Introduction, in GOSTIN & LAZZARINI, supra note 107, at xv.

\(^ {112}\) Id.


\(^ {114}\) Id.

\(^ {115}\) CESCR, supra note 30, ¶¶ 1, 2, 30.

\(^ {116}\) Id. ¶ 32.
change individual behavior must address the conditions that give rise to individuals' behavioral choices. Because attacking fundamental causes means transforming the social environment by altering practices, beliefs, and conditions that dispose people to sickness, such efforts are often called "ecological interventions." The right to health begins to take on a particularly powerful bite when these interventions are conceived and carried out without discrimination.

The right to health demands that governments do more than provide medical care; they must assure an array of services to promote the health of their populations. The idea that states "possess the power to ensure the conditions under which people can be healthy" is a guiding principle of the 1978 Declaration of Alma Ata, jointly written by UNICEF and the World Health Organization, which states that effectuation of the right to health requires action, government-mandated if need be, within many social and economic sectors aside from just the health sector. General Comment 14 resoundingly affirms this obligation.

There are several tenets established in the foregoing study of the right to health to guide this article's application of it to gay and lesbian populations. First, because states must strive toward realization of the highest attainable standard of health, they have an obligation to address and ultimately eliminate the underlying causes of illness. Second, because many such causes are deeply-rooted societal conditions, governments can and should address them using all legitimate means at their disposal; oftentimes these efforts will necessarily entail the coincidental enforcement of other rights. Third, state efforts to effectuate the right to health must conform to an obligation not to discriminate on the basis of a number of protected categories, including sexual orientation.

117. Burris, supra note 19, at 418.
118. Id. at 419.
119. Fidler, supra note 91, at 47.
120. Id.
121. GOSTIN & LAZZARINI, supra note 107, at 29.
123. The Comment reads:

The right to health . . . imposes three types or levels of obligations on State parties: the obligations to respect, protect and fulfill. In turn, the obligation to fulfill contains obligations to facilitate, provide and promote. The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires States to take measures that prevent third parties from interfering with article 12 guarantees. Finally, the obligation to fulfill requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.

CESCR, supra note 30, ¶ 33.
III. STATE DUTIES TO LESBIANS AND GAY MEN UNDER THE RIGHT TO HEALTH

   A. GENERAL OBSERVATIONS

   Part I demonstrated that homophobia is an underlying cause of ill health among lesbian and gay populations. Part II showed that the international right to health demands aggressive governmental pursuit of underlying causes of ill health without discrimination on the basis of sexual orientation. This Part will argue that a wide range of anti-gay policies, actions, and inactions must be identified as violations of homosexuals’ right to health because they constitute state sponsorship of the homophobia that is so profoundly detrimental to gay and lesbian well-being.

   The aggressive approach recommended here is based on the conception of state obligations discussed previously and on two further considerations. First, the particularly powerful effect of homophobia on the health of lesbian and gay youth makes it imperative to follow international law’s mandate that states have exceptionally stringent obligations toward their youngest citizens: “In all policies and programmes aimed at guaranteeing the right to health of children and adolescents their best interests shall be a primary consideration.” Second, there is an intimate relationship between the right to health and the nonderogable right to life. The connection is obvious but important: life is a predicate for the enjoyment of health, and good health in turn promotes life’s continuation. We saw earlier how poor mental health among lesbians and gay men leads to disproportionately high suicide rates, that gay men’s higher susceptibility to HIV contraction leads to correspondingly higher rates of AIDS deaths, and why lesbians and gay men are less likely to seek life-saving treatment from the health professions. The demands of the right to health, outlined below, derive part of their force from the fact that these problems, like many others that are caused or exacerbated by homophobia, seriously endanger lesbian and gay lives.

   B. HOMOPHOBIC ACTS AND OMISSIONS DIRECTLY RELATED TO HEALTH

   One of the most pressing issues in governmental public health policy as it relates to lesbians and gay men is that, far too often, in practice, it does not relate to them at all. When programs, services, and benefits are offered to the general population, they often reflect an assumption of universal heterosexuality, a denial of homosexual existence, an ignorance of the sometimes different needs of homo- and heterosexuals, or a combination of these faults.

124. Id. ¶ 24.
125. UDHR, art. 3 (“Everyone has the right to life, liberty and security of person.”); International Covenant on Civil and Political Rights (ICCPR); art. 6 (“Every human being has the inherent right to life.”); art. 4 (“No derogation from [article] 6 . . . may be made.”).
126. For example, many federal health care programs for American women are focused on reproductive care; because this is not as relevant to most lesbians, they have less access to the other kinds of medical care offered in conjunction with reproductive services. GLMA, supra note 22, at 49-50.
In the field of public health education, there are often startling refusals to provide information that is relevant and sensitive to sexual minorities. In breach of Article 12's condition that the right to health includes a right to "to seek, receive, and impart information and ideas" about health issues, "including sexual health" issues, many states withhold, censor, or intentionally misrepresent health-related information germane to gays and lesbians. These omissions usually go unacknowledged and unremarked, a possibility abetted by the hiding into which many lesbian and gay people are forced. Sometimes, however, the appearance of openly homosexual people pushing for appropriate health information and services forces governments to formally admit, or even formalize, their homophobic approaches to public health. This happened in the United States at the height of the AIDS epidemic among gay men, when the 1987 Helms Amendment barred federal funding for any sex- or health-education materials that might "promote or encourage, directly or indirectly, homosexual sexual activities."

A first step, then, that states should take to fulfill their obligations under the right to health is acknowledgment of the special needs of gay men and lesbians in health-related laws, programs, studies, services, and benefits. Several governments, mostly in Western Europe, have undertaken such measures. In the United States, federal dollars funded the creation of the Healthy People 2010 Companion Document for LGBT Health, which delineated the most important health problems among American lesbians and gay men and offered recommendations for handling those problems.

A second way for governments to promote gay and lesbian health in accordance with Article 12 is by implementing extensive, intelligently designed community-based education programs. These can play a vital role in improving the health of the community's members, and particularly in reaching those who are outside traditional health settings. Unfortunately, one major obstacle to targeting such programs at gay men and lesbians is sexual orientation's absence from most countries' nondiscrimination laws. In the United States, for instance, this means that federal and state agencies, which shoulder much of the responsibility for formulating and implementing health policy, operate under statutes that do not oblige them to give due attention to the specific health needs of a substantial portion of the population.

129. GLMA, supra note 22. The actions suggested by the Healthy People Companion Document are too numerous to be included here in anything resembling their entirety; the report is an excellent resource for any government seeking to comply with its right-to-health obligations to homosexual populations.
130. Id. at 112.
C. HOMOPHOBIC ACTS AND OMISSIONS INDIRECTLY RELATED TO HEALTH

The importance of sexual orientation's protection from discrimination under the right to health cannot be overstated. Taken seriously, the principle of nondiscrimination extends from the most basic expectation that government-run health services cannot be denied because of sexual orientation to the obligation of states to formulate policies, and not only explicitly health-related policies, with lesbian and gay health in mind. A similar approach to gender discrimination has already been applied to the right to health and other rights enumerated under the ICESCR.131

It should be emphasized that governments have a responsibility, firmly grounded in international law, to act in parts of the so-called private sphere within their legal reach. The CESCR finds a violation of the right to health when a state fails "to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties. This category includes such omissions as the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others... and the failure to discourage the continued observance of harmful traditional medical or cultural practices."132

The foregoing discussion of ecological interventions demonstrates that the ICESCR mandates a bold assertion of governmental responsibility for addressing all forms of homophobia. Explicitly health-related efforts alone cannot come close to solving the health problems caused by homophobia. As Kulkin and colleagues write in their review of the public health literature on gay teen suicide, only fundamental societal changes can truly correct the problem of homophobia's toll on health.133 There is a pressing need for homosexual orientation to be understood as a benign human variation. This discursive shift, already well underway, bears the potential to remedy the alienation felt by so many gay men and lesbians.134

Governments are complicit in societal homophobia through their own actions and through failure to regulate and influence the actions of others. The law figures powerfully in this complicity. In many countries, including the United States, lesbians and gay men are not protected in general nondiscrimination statutes, leaving them open to unequal treatment in every area of life. In only two countries may they legally wed,135 and in just a handful more do their...
relationships receive any legal recognition. Many nations even continue to
criminalize sexual activity between partners of the same sex. This last indignity
directly contravene the right to health, which assures a “right to control one’s
health and body” that includes “sexual and reproductive freedom.”

Each of these acts and omissions are manifestations of homophobia, an
underlying cause of disease, and as such they contravene the international right to
health. Of course, each violation does not impinge upon Article 12 alone. Human
rights are interconnected and mutually reliant. It should come as no surprise that
assuring nondiscrimination in lesbian and gay people’s right to housing, for
example, would have positive consequences, directly and indirectly, on their right
to health. Indeed, the formal and far-reaching disenfranchisement of lesbians
and gay men in many countries, coupled with their significant and particular
health problems, provides a compelling illustration of the argument that
promoting civil rights enhances physical and mental well-being.

Take marriage, for example. Exclusion from this fundamental societal
institution, entry into which is enumerated as a right in the UDHR and the
ICESCR, is a startling example of state-sponsored discrimination against
homosexuals that perpetuates the homophobia that debilitates and sometimes
kills. There is an intuitive understanding of this connection among many lesbian
and gay people. Critics of same-sex marriage, especially those who are
themselves homosexual or nonhomophobic, sometimes soften their stance when
asked to imagine the experience of a gay or proto-gay child living in a community
where same-sex couples are legitimately and visibly married. Children who grow
up around such examples—role-models for “well-adjusted” living, as much as
for the problematic institution of monogamous coupledom—seems less likely to
commit suicide when they struggle during adolescence to understand the effects
of their own sexuality on life’s possibilities.

This hunch about the good of gay marriage for gay health is confirmed by
social and scientific research. Helplessness, depression, and disruption of healthy
grieving processes have been shown among older gay men and lesbians to result
from a lack of legal rights and protections in medical emergencies and from a
lack of social acknowledgment of their relationships, especially following the

marry in Belgium and the Netherlands. Id. At the time this article was published, Canada was well on its
way to becoming the third nation to recognize same-sex marriage as a matter of federal law. Id. In the
United States, whose federal government does not recognize same-sex marriage for its own purposes, see
U.S.C. § 1738C (2000)), only the state of Massachusetts allows same-sex couples to marry. See
Goodridge v. Department of Public Health, 798 N.E.2d 941 (Mass. 2003), In re Opinions of the Justices
to the Senate, 802 N.E.2d 565 (Mass. 2004).

136. ICESCR, supra note 30, ¶ 8.

137. See supra Section II.A.

138. UDHR, art. 16; ICESCR, art. 23.
loss of a partner. The lack of legal recognition for same-sex couples means reduced access to insurance and other health-related benefits, not to mention negative or poor-quality treatment in many health care settings. And, as noted earlier, it has been suggested that a fundamental cause of HIV-infection among gay men is "limited access to social validation of their relationships."

Ending all forms of state-sponsored and state-sanctioned homophobic discrimination, though admittedly an improbable aspiration in the near future will not be enough to fulfill state duties to homosexual citizens under the right to health. Just as governments develop education efforts to combat racism, sexism, and other prejudices, so too must they combat homophobia. They must proactively reach out to their populations, both hetero- and homosexual, with messages, programs, and services that promote lesbian and gay health by fighting anti-gay prejudice.

Public schools provide one context where such efforts should be undertaken. The Healthy People 2010 Companion Document for LGBT Health, providing recommendations to reduce suicide among lesbian and gay youth, states that these populations "experience unique stressors that the school system must address in an affirmative manner." Due to the common threat of physical and verbal violence in the school setting, children who either are, or are perceived to be, lesbian or gay fear for their mental and physical safety. This fear alone can have serious negative effects on mental health; because education is mandatory for young people, feelings of powerlessness, of being trapped within a hostile institutional setting, are common and they correlate strongly with suicidal contemplation.

Other problems abound. Sex education in the school system typically lacks unprejudiced or affirming information about homosexuality. Schools rarely have counselors willing or knowledgeable enough to discuss sexual orientation issues and development. At the most basic level, the policies of most schools do not prohibit discrimination on the basis of sexual orientation. Moreover, so long as being homosexual—or even suggesting the legitimacy of gay and lesbian lives—endangers educators' job security, homophobic classroom environments will remain the norm.

140. GLMA, supra note 22, at 284; Dean et al., supra note 21, at 106–107.
141. Burris, supra note 19. Whatever else may be said about monogamy, see, e.g., LAURA KIPNIS, AGAINST LOVE: A POLEMIC (2003), it is relatively safe from a medical standpoint.
142. GLMA, supra note 22, at 120.
143. Kulkin et al., supra note 16, at 11.
146. Kulkin et al., supra note 16, at 11.
The GLMA advocates that administrators, teachers, social workers, and counselors should be trained to identify issues that put gay and proto-gay children at high risk for suicide, and that quality counseling should be provided for queer and questioning youth who need and want it. Just as schools have sought instructors from diverse racial, cultural, and ethnic backgrounds to provide positive role models for all their students, so too should openly lesbian and gay teachers be sought for the same purpose. Heterosexuals in the school context must also be targeted. Education of parents, students, teachers, and mental health professionals should be undertaken to change homophobic feelings and at least reduce homophobic behaviors.

States should implement in their public school systems guidelines resembling those of the American School Health Association (ASHA), which in 1990 issued a resolution, since updated, on “Gay and Lesbian Youth in School.” Echoing the National Association of School Nurses’ statement that schools should foster “a safe environment, demonstrating an acceptance of diversity” to help all students, regardless of sexual orientation, to have equal opportunities in the educational system, the ASHA recommends a number of specific undertakings to improve the climate of schools for lesbian and gay youth.

Relationship recognition and school-based efforts have been used here to demonstrate the nature of state obligations under the right to health as they pertain to negative duties (involving adherence to a principle of nondiscrimination) and positive duties (involving active promotion of that principle). The kind of ecological interventions necessary to deal with the health hazard of homophobia are, as these examples suggest, far-reaching and controversial. And it is for

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148. GLMA supra note 22, at 120.
149. Morrow, supra note 147, at 658.
153. For example:

- Curriculum materials, teaching strategies, and school policies that do not discriminate on the basis of sexual orientation should be implemented in schools.
- Sexual orientation should be addressed in the sexuality component of a comprehensive health instruction curriculum.
- School personnel should discourage any sexually oriented deprecating, harassing, and prejudicial statements injurious to students’ self-esteem.
- Every school district could provide access to professional counseling by specially trained personnel for students who may be concerned about sexual orientation.
- Schools must protect LGBT youth from harassment and violence.

ASHA, supra note 151.
CONCLUSION

Gostin and Lazzarini argue that applying human rights language in the context of AIDS/HIV policy will be good for public health: "Raising the profile of health issues on governmental agendas by linking them to human rights could enable individuals or groups to initiate more effective government health policies." This article derives inspiration from that observation, but is premised on its inversion. To use Gostin and Lazzarini's terms, raising the profile of human rights issues by linking them to health could enable individuals or groups to initiate more effective government human rights policies. Indeed, the fact that human health may be improved or diminished by the granting or withholding of other human rights helps to explain why the former are human rights in the first place.

The right to health is hardly taken as seriously as other entitlements under international law. Furthermore, homophobia remains a widely accepted social and political norm, which means that lesbians and gay men would probably not be among the first beneficiaries if and when the right to health receives greater caché. This article's primary motivation for exposing homophobia's hazardousness to health in the context of a legal argument on the right to health is to suggest a change in the rhetoric of gay and lesbian advocates. The fact that health is diminished, sometimes to the point of extinction, by prejudice and concomitant denials of civil rights should assume a prominent place in these advocates' arguments.

Gay rights are controversial. Health, as an abstract ideal, is not. Most people, even those who might be opposed to the idea of same-sex marriage or gay-friendly education in public schools, probably do not believe that lesbian and gay people deserve the ravages of substance abuse or epidemic youth suicide. This article posits that there is a contradiction in these positions, one that should be explained and exploited.

The abortion issue provides a useful analogy. Many people who favor the right to choose nonetheless struggle with the morality of terminating a pregnancy; their reasons for supporting abortion rights may include a fear that restriction will send women back to the infamous back-alleys. For such individuals, it is respect for women's health that allows a difficult ethical question to be answered, or even left unresolved, in a way that protects the right to choose abortion. Similarly, a

154. GOSTIN & LAZZARINI, supra note 107, at 47.
person who questions the morality of marriage between two women may think
differently if asked to see the question from the perspective of a teenage lesbian
contemplating suicide. That a young woman’s right to health—indeed, to life—
may decide the matter powerfully suggests why health can and should enter the
discourse of lesbian and gay rights.