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Chair

Mrs. Karen Vecchio

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● (0850)

[*English*]

The Chair (Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC)): Good morning, and welcome to the 140th meeting of the Standing Committee on the Status of Women. Today's meeting is public as we continue our study of the challenges faced by senior women, with a focus on the factors contributing to their poverty and vulnerability.

For this, I am pleased to welcome, from the Canadian Network for the Prevention of Elder Abuse, Kathy Majowski. She's right there, as you see on your monitor.

From the DisAbled Women's Network of Canada, we have Bonnie Brayton, the National Executive Director. From Egale Canada, we have Helen Kennedy, their Executive Director as well. You'll see her on video conference. From the Native Women's Association of Canada, we have Chaneesa Ryan, Director of Health, as well as Roseann Martin, Elder.

Thank you for joining us today.

I now turn the floor over to Kathy.

Kathy, you have seven minutes for your opening statement.

Ms. Kathy Majowski (Board Chair, Canadian Network for the Prevention of Elder Abuse): Thank you very much. Good morning, Madam Chair, and members of the Standing Committee on the Status of Women. My name is Kathy Majowski, and I'm honoured to be here as a representative for and chair of the Canadian Network for the Prevention of Elder Abuse.

The CNPEA is a pan-Canadian network supported by leaders in aging, research, health care and elder-abuse prevention and response. We connect people and organizations. We foster the exchange of reliable information, and advance program and policy development on issues related to preventing the abuse of older adults. Our work focuses on gathering and disseminating adaptable resources, best practices and current research in policy developed by Canadian expert stakeholders, to increase our collective capacity to address and prevent abuse of older adults.

Our vision is a Canadian society where older adults are valued and respected, and live free from abuse. We have based the following presentation on some of these organizations' recent work.

In this presentation, we would like to focus on intimate partner violence, as it relates to older women; social isolation; barriers to safety, and recommendations to address these challenges; as well as ways to better support older women, in order to enhance their well-being and safety.

Older women's lives are often impacted by the dual effects of sexism and ageism. These barriers can increase if a woman is indigenous or an immigrant, or belongs to other linguistic, sexual and/or ethnocultural minority groups. These factors compound older women's vulnerability to poverty, homelessness, poor health, social isolation and various forms of abuse. Overlapping issues can only be addressed with policies and approaches that override the usual silos between sectors. They will also require understanding and considering the diversity of backgrounds and life experiences of the most vulnerable older women.

With regard to intimate partner violence, safety and abuse are key concerns for girls and women of all ages, and these issues do not improve or disappear as women enter the later stages of their lives. Some have experienced violence and abuse throughout their lives, whether systemic or within the framework of their family and relationships. Others are victims of abuse late in life, at home or in long-term-care settings. Overall, one in three Canadian women will experience abuse or sexual assault in their lifetime. Older women experience rates of violence higher than their male counterparts. The impacts of violence can accumulate, creating compound effects of violence experienced through the life stages.

It's important to recognize that older women are not a homogenized group. Older women who experience violence come from a variety of communities, with diverse needs, backgrounds and experiences of oppression. The term “seniors” tends to be used to describe several age groups, spanning over 40 years. These different groups could benefit from more specificity. A woman's life experience, socio-economic level, race and personal set of circumstances define her more than her age ever will. One does not suddenly acquire a whole new set of personality traits at the age of 60, 70 or 80. It's just one more layer added to a lifetime of experience.

There are some identified barriers to safety, such as providing and receiving care, where a woman who is older and living with violence may be receiving or providing care for a family member, including her abuser. There's the myth of caregiver stress, where a woman who is older may experience violence from her caregiver, who may be a family member, and the myth of the caregiver who is driven to helplessness, rage and frustration, due to overwhelming work and responsibility. These are often used to rationalize violence and abuse against women who are older.

Some women face financial insecurity. There's the need to navigate pensions, benefits and health insurance, which takes resources and time. Some women have not held paid employment, have limited employability or are past working age. There's a fear of losing one's home or community, in particular for remote and rural women. A lifelong commitment to a community, or the thought of losing her home, can make the decision to leave an abusive situation especially hard.

In addition, women who live in remote or rural communities may be faced with geographical isolation, where the nearest neighbour is kilometres away. Isolation in an abusive situation means there isn't a quick way out. This is compounded when a telephone or finances have been made inaccessible. For indigenous or immigrant women, particularly if they speak a language or languages other than English or French, the loss of home or community may be terrifying.

● (0855)

Because of generational beliefs, for a woman who is older and who may have more traditional attitudes regarding marriage, family, gender roles and privacy or loyalty in regard to family matters, discussing personal or family problems with strangers may seem unacceptable. Family dynamics can mean that members of the family may not support their mother or grandmothers if they either do not perceive the abuse to be significant or do not want to take on a caregiving role. A woman who is older may be faced with the shock and disbelief of friends and family who cannot accept her story of abuse.

CNPEA has organized the following recommendations to improve safety.

Support awareness campaigns to help people understand the different forms of elder abuse and the nature of domestic abuse of the aging to dispel the longstanding idea that these are private matters. Support the development of bystander intervention training programs and train-the-trainer programs. Support the development of culturally safe and appropriate, multilingual support services specifically for older women. Support the development of orientation programs to help older women and their loved ones navigate the complexities of the justice, immigration, and health care systems. Encourage the development of support programs that are accessible from home. Improve access to regular and affordable transportation in rural areas. Provide access to benefits for full-time family caregivers and provide greater financial support for senior women who are caring for their children.

The other issue we would like to briefly address is the social isolation of older women. Older women can become more vulnerable due to the narrowing of their social networks over time. Loneliness and disconnection from the community due to mobility or health issues, for instance, can affect service access and utilization and increase their vulnerability to abusive and neglectful situations that negatively impact their mental and physical health and create a vicious circle of poor health, alienation and vulnerability to victimization.

CNPEA would like to put forward the following recommendations to decrease isolation. Support and strengthen community-based groups and programs that play an important role in empowering older women to engage in positive help-seeking behaviours and encourage intergenerational programs and approaches, such as intergenerational housing options that can help curb housing shortages.

The Chair: Kathy, we have to wrap it up. We're already 40 seconds over.

Ms. Kathy Majowski: Thank you.

The Chair: You're welcome. Thank you so much.

I'm now going to turn to floor over to Bonnie Brayton for seven minutes.

Ms. Bonnie Brayton (National Executive Director, DisAbled Women's Network of Canada): Thank you, Karen.

I have submitted a written brief and hope everybody has had an opportunity to read it. It has been rare for DAWN to do this in advance, but I have done it this time. I hope the members of the committee had a chance to review it.

Today I want to quickly go through its points and to add that there are some new things in my speaking notes, including a reminder about state party obligations; intersectional analysis—albeit I feel that with some of the other witnesses we are going to get some good intersectional analysis, as we already have from the first witness—and an end note that I've added on the vulnerable persons standard as it applies to medical assistance in dying.

Just as a reminder to the committee and the Government of Canada, there are state obligations under both the Convention on the Rights of People with Disabilities and the Convention on the Elimination of Discrimination Against Women specifically for women and girls with disabilities—and again, it's to remind us to investigate, prosecute and punish acts of violence and to leave no space for potential abuse or exploitation of persons with disabilities.

That is just a very quick highlight of what's in my speaking notes.

Regarding intersectional analysis, among the things I want to note is that I appreciate the first witness's reference to the labelling of “senior” as a problematic way to see women with disabilities. Women with disabilities are not a homogenous group. There's a very broad range of considerations; again, the intersectional analysis is quite critical here.

In the very limited research we were able to find on black women, for example, with disabilities, there was a study in Ontario from April 2011. Again, rather than go into the details—because I'm very aware of this time thing and want to focus on some other issues—I'd like to remind everyone that there are many barriers that an older black woman with a disability would face that would be very specific to that intersection.

Specifically, I also wanted to remind us that we are in a time of truth and reconciliation and that it's very important for us to be especially mindful of ways that we can improve our presence on this land today. It's a time for truth and reconciliation and for letting ourselves also consider the needs of older indigenous sisters, in particular, today and consider how we can make reparations and make their lives better for future generations.

To go into the details of DAWN's submission on access to transportation, research indicates that women with disabilities are more likely to be the target of sexual assaults in transit environments. In terms of accessible or specialized transit usage among women with disabilities, the risk increases with the severity of disability. A lack of access to information about transportation and travel, coupled with limited financial assistance, prevents women with disabilities from fully participating in social life. Of the women who report either a severe or very severe disability, 46% report difficulty in using public or specialized transportation. For women in the north, of course, this is particularly true.

In terms of access to health care, the emerging issue that I want to point to, because of the very specific focus of DAWN Canada, is the tension between the Convention on the Rights of Persons with Disabilities and Canada's medical assistance in dying act. Many have argued that the act itself is a violation of Canada's obligations concerning disability and the right to life.

Advocates fear that the act fails to account for the reasons many women with disabilities may seek out assisted dying, which include underfunded palliative and disability support programs, social isolation, a lack of access to needed services and supports—suicide prevention, addictions treatment, trauma-informed services—and because disability still remains stigmatized and undervalued.

In the context of housing and institutionalization, let me add a reminder that the reality is that many senior women who have a disability are homeless, and while women in general are more likely than men to experience poverty, aboriginal women with disabilities, older women, women of colour, and immigrant and refugee women are the most affected by housing issues.

Because of a lack of adequate supported housing in the community, women with disabilities are also at risk for various forms of institutionalization—in group homes, hospitals and long-term care facilities. Additionally, incarceration remains a reality for many women with disabilities who are undiagnosed and therefore untreated. For example, it has been estimated that 40% of Ontario's population of incarcerated women have a history of traumatic brain injury sustained before they committed their first crime.

● (0900)

Access to justice and high rates of victimization against women with disabilities indicate that there are significant gaps with respect to their safety and access to justice. In the review of 120 cases, law enforcement was notified in 96% of these cases, yet only 55% of cases resulted in charges, and only 25% resulted in an assailant being found guilty. In another study looking at sexual assault in nursing homes, only 5% of these cases were prosecuted. Again, for context, we're talking about the low rates of prosecution and the high rates of sexual assault in institutions.

I'll turn to my concluding recommendations, and again there were certainly some excellent ones from the first witness that I really appreciate, which I missed, including focusing on the caregiving piece. I really appreciate that, because unpaid caregiving is something that many older women with disabilities are doing. It's been well documented that there's an overburden of caring for others.

This brief presents research that is relevant to women with disabilities and that has policy implications for older women. In order to ensure that senior women with disabilities, inclusive of race, ethnicity, indigeneity, sexual identity, class and geographic location, are fully included in a social policy and programs, DAWN Canada recommends the following.

We recommend that Canada respect its commitments under the CEDAW and CRPD and other treaties with respect to older women in Canada; that the recommendations of the study focus on the most marginalized seniors using a GBA+ intersectional analysis; that monitoring mechanisms be in place in group homes and institutions to ensure that women are safe and can report incidents of abuse and sexual assault and are supported to do so—I can't emphasize enough how problematic it is that in Canada we do not have institutional monitoring and that we have so much resistance to this idea—that senior women be supported at all stages of reporting sexual assault and abuse; that there be funding for improved availability of adapted and public transportation—

Let's be really clear. In rural and northern communities, this simply doesn't happen; the isolation of seniors in rural communities is a huge and deep concern, and should be for all Canadians.

Furthermore, we recommend that service providers in health care, social services and victim services be educated about the needs across the intersections of senior women with disabilities; that research and policy related to senior women include a disability lens and, most critically, an intersectional lens; that implementation of the medical assistance in dying act be monitored under the vulnerable persons standard to ensure that senior women, in particular women with disabilities, are not subject to coercion.

● (0905)

The Chair: Thank you very much, Bonnie. That was fantastic.

We're now going to turn back to the video conference and speak with Helen Kennedy from Egale. You have seven minutes.

Ms. Helen Kennedy (Executive Director, Egale Canada): Thank you very much for this opportunity.

Egale was founded in 1986 and is Canada's only national charity that seeks to improve the lives of LGBTQI2S people by informing public policy, inspiring cultural change and promoting equal rights and inclusion through research, education and community engagement.

Our mandate encompasses advancing gender equality for LGBTQI2S women—that's lesbian, bi, trans, queer, intersex and two-spirit women—as we recognize that they often experience greater inequalities due to intersectional identities and therefore encounter compounded discrimination on the basis of both sexual orientation and gender identity.

Because we're short on time—I only have seven minutes—I'm jumping right to my recommendations and I'm going to come back, then, to the main piece of the presentation. These are the recommendations that Egale is making to address our concerns.

We recommend the development of a national research and knowledge hub for gender equality, which will facilitate the mainstreaming of LGBTQI2S women within domestic public policy. We recommend that this include the formation of a national steering committee for LGBTQI2S women's rights.

The steering committee, led and organized by a national LGBTQI2S organization such as our own, will identify research and programmatic needs for LBGTQI2S women that align with Status of Women Canada's three priority areas and provide guidance on the research projects that ensures they employ a GBA+ analysis.

We will offer input on the development and improvement of programs/initiatives based on the research findings. We would foster partnerships with local and grassroots organizations to carry out research programs and initiatives and practise results-based management to assess the effectiveness of the programs and initiatives. We would also discuss current issues and policy developments impacting gender equality for LGBTQI2S women in Canada.

We would also recommend a national gender-affirming health care strategy that models the work and approach of Trans Care BC to ensure that there is comprehensive health care for older and aging women trans and gender-diverse non-binary communities that is physically and economically accessible and addresses their wide-ranging health care needs.

We would recommend that we incorporate within the new health accord measures that help to assess and integrate the health care needs of LGBTQI2S women and the broader community, including funding specifically allocated to services that tend to the mental health needs of diverse members of our community.

We would recommend that we ensure that Bill C-81, the accessible Canada act, incorporate measures to address barriers that disproportionately impact members of our community who are living with disabilities, including ensuring that there are safe spaces in health care settings. These include requiring health care colleges—for example, nurses, social workers, etc.—to have frameworks in place to protect members of our LGBTQI2S service users and mandatory competency training in LGBTQI2S issues.

We would recommend a non-discriminatory intake and sign-up forms as well as processes in all health care services in order for our community clients to feel recognized and welcome. More competency and inclusion training in LGBTQI2S issues should be mandatory for all service providers, especially in the long-term care sector.

Jumping back to the reasons why we're making these recommendations, despite the advances in women's health in Canada, significant disparities of equality continue to affect members of the lesbian, bi, trans, queer, intersex and two-spirit older and aging community of women. It's particularly true in the area of access to social resources and the consequences of this lack of access.

There is also an immediate need for intersectional research that currently involves women to include LGBTQI2S older and aging women. The recognition of intersectionality and varying social locations is crucial to facilitating positive aging experiences and good end-of-life care.

● (0910)

Within Canada's aging population, there is significant heterogeneity not only in age, but also in terms of other social determinants and social locations. Sexual orientation and gender identity are key determinants in health, particularly when it comes to discrimination and social inclusion. The intersection of age, gender identity and sexual orientation is an important consideration, given the potential for the layering of ageism with discrimination. In the Canadian context, a need for targeted research with and on diverse groups has been recognized.

Despite efforts to be inclusive, the traditional focus of Canadian health research on women assumes that all women, regardless of age, cultural background, geographical location, socio-economic status, religion, sexual orientation and gender identity and categories of difference, share exactly the same experiences, views and priorities. We know this is not the case. The significant absence of disaggregated data and existing research on experiential and structural impacts of discrimination is felt by LBTQI2S women, both globally and in Canada.

It's also of particular concern for research involving LBTQI2S women. Women, seniors, sexual orientation and gender identity minorities continue to suffer from a lack of intersectional research in Canada. An intersectional approach is necessary so the full range of vulnerabilities, experiences and issues of diverse women are not obscured. The issues and priorities of many of our vulnerable women, including members of other groups, are usually excluded from mainstream women's health research.

Older LBTQI2S women are more likely impacted by social exclusion. Social exclusion has been linked to a wide range of issues, including poverty, poor mental and physical health, a lack of education and lack of political participation. There are no—

The Chair: Helen, we are a little over your time. Thank you very much. You've shown great work with the recommendations.

We're now going to turn the floor over to the Native Women's Association of Canada.

You have seven minutes.

Ms. Chaneesa Ryan (Director of Health, Native Women's Association of Canada): *Ullaakkut*. Good morning. Thank you for inviting us here today to speak about the challenges faced by older indigenous women in this country.

Before I continue, I'd like to take a moment to recognize that we are on the unceded traditional territory of the Algonquin people.

Since 1974, NWAC has represented the collective voices of indigenous women, girls and gender-diverse people of first nations, both on and off reserve, and disenfranchised Métis and Inuit.

We're gathered here today to discuss the challenges experienced by older indigenous women and factors that are contributing to their vulnerability. However, it is important to note that vulnerability is cumulative over someone's life course. The welfare of the aging population depends greatly on the trajectories of their various experiences and challenges endured throughout their life course. Adverse childhood experiences—think the residential school system and the resulting intergenerational trauma—combined and compounded by later adversities contribute to poor health outcomes and increased mortality.

It is important to acknowledge that while indigenous seniors are not a homogeneous group, colonial oppression and exploitation have created a commonality of experiences that have impacted a significant number of indigenous seniors' health and well-being. Given the continued effects of colonization, the legacy of residential schools, the sixties scoop, discriminatory policies and ongoing inequities in the health care system, it is clear that indigenous seniors are vulnerable. Indigenous populations have significant differences in their life expectancy compared with their non-indigenous counterparts. In 2017, the projected life expectancy of first nations females was 78. For Métis females, it was 80, and for Inuit females, it was 73, as compared with 84 for non-indigenous women. The drastic gap in life expectancy between indigenous women—which is most pronounced between Inuit women and their non-indigenous counterparts, at 11 years—is reflective of their overall vulnerability.

● (0915)

In general, across all populations senior women are more likely to be vulnerable than men, as they have different, often interrupted, patterns of wage earnings. As a result, they may have fewer opportunities to contribute to their savings and/or pension plan. Women typically earn significantly less then men. Indigenous women fall even further behind in the wage gap.

The current generation of senior women are more likely to have worked within the home as homemakers rather than paid members of the workforce. These factors, all of which may be compounded for indigenous women, contribute to lower income status and increased vulnerability of women. Therefore, it's important to address both income and equality and establish reforms that abolish the gender wage gap in this country.

Due to increased life expectancy and relatively high fertility rates, the Canadian indigenous population is growing nearly twice as fast as their non-indigenous counterparts. As a result, the indigenous aging population is increasing as well. According to population projections, within the next two decades, the fraction of indigenous people aged 65 years and older will more than double in size. Therefore, complacency about their vulnerability and challenges will not only affect the current generation but also an increasing number of people going forward.

First nations, Métis and Inuit seniors suffer from poorer overall health outcomes than their non-indigenous counterparts. Indigenous populations are more likely to have higher rates of numerous chronic conditions like hypertension, heart disease, stroke and diabetes, including at a younger age compared with the general Canadian population. The increased prevalence of chronic conditions, combined with elevated smoking and obesity rates in some indigenous populations, increase the risk of dementia. This complex multi-morbidity at younger ages can substantially impact quality of life and the ability to age well in communities.

Gaps in information exist, making it difficult to understand the full extent of the problematic prevalence of disabilities in indigenous communities. However, due to complex social, cultural and historical factors and the increased prevalence of chronic conditions, mental health issues, depression, substance abuse and rates of violence, it's safe to conclude that indigenous peoples are more likely to experience disability compared with their non-indigenous counterparts.

Due to the intersectionality of indigenous status and disability status, indigenous people with disabilities in Canada represent a marginalized community within a marginalized population. The biggest challenge for seniors with disabilities is economic insecurity, particularly for those whose disabilities affected their employment and in turn their ability to accumulate savings for retirement.

Part of the poor health outcomes and disability rates of this population can be attributed to the increased likelihood of low educational attainment, low employment rates, low incomes and disproportionate and chronic poverty that impact indigenous people across their life course. Research has indicated that indigenous seniors experience substantially higher poverty rates than the national average, with approximately 25% of indigenous seniors living in poverty compared with 13% of non-indigenous seniors.

Despite the growing demand for culturally safe community-based supports and services for older indigenous populations in Canada, the current infrastructure and services are lacking and inadequate. For example, 44% of first nations people aged 55 and older require one or more continuing care services. However, fewer then 1% have access to long-term care facilities on reserve. As a result, some health challenges may go unnoticed until they are exacerbated and complicated, requiring an emergency room visit or hospital admission.

When members of the indigenous community inevitably require more supports and services, they are forced to leave their communities to access long-term care that is often hundreds if not thousands of kilometres away. These individuals are not only forced to leave their homes but are also moved away from their families, their language, their cultures and their traditional country foods. The impact of being forced to move away from their community to access services can be very traumatizing and trigger traumatic experiences from childhood, such as forced relocation, the residential school system and the sixties scoop.

The challenges surrounding continuing care within indigenous communities are partially due to the convoluted and overlapping nature of the responsibilities, policies and jurisdictions of different levels of government. The responsibility for and provision of health care are currently shared by federal, provincial and territorial governments. As the framework is complicated and ambiguous, many older indigenous people experience difficulty navigating the system and accessing adequate support services and care.

● (0920)

The Chair: Excellent. Thank you so much.

Now we'll go to our questions in seven-minute rounds, starting with Eva Nassif.

Eva, you have the floor for seven minutes.

[*Translation*]

Mrs. Eva Nassif (Vimy, Lib.): Thank you, Madam Chair.

I want to thank the four witnesses for their presentations.

I think that Ms. Majowski was in the process of sharing her recommendations.

Ms. Majowski, how should we help seniors reduce their social isolation?

[*English*]

Ms. Kathy Majowski: I will go back and say that we need to support and strengthen community-based groups and programs, which play an important role in empowering older women to engage in positive help-seeking behaviours, and to encourage intergenerational programs. Intergenerational housing options can help curb housing shortage concerns, safety concerns, and loneliness.

I believe that both of those recommendations are already occurring. There are a few different models across Canada that are working on research and seeing how this works. The National Initiative for the Care of the Elderly is working with the City of Toronto on an intergenerational housing program, and I'm excited to see the results.

Mrs. Eva Nassif: Thank you.

[*Translation*]

Ms. Brayton, hello again. We met in 2017 when I made an announcement to your organization.

Have you been informed that you'll be receiving $830,959 for the year 2019-20?

Ms. Bonnie Brayton: Yes. We're very happy about that.

Mrs. Eva Nassif: You also know that we've already started to provide funding to the new horizons for seniors program, and that we'll continue to do so. We've even increased our investments. We created the national housing strategy in 2017. This national strategy will help many women living in poverty.

You said that you submitted a brief, but I didn't have access to that document. I want to know your recommendations. Despite everything that has been invested, there's still a great deal of work to do. However, the national housing strategy and our investments are a good way to start reducing the isolation of our seniors.

What are your recommendations for senior women with disabilities?

Ms. Bonnie Brayton: I'll check with the clerk.

[*English*]

She said she didn't receive the brief.

Mrs. Eva Nassif: I didn't receive it.

Did we?

The Clerk of the Committee (Ms. Kenza Gamassi): Yes. It was a while ago.

Mrs. Eva Nassif: Okay, a while ago, because yesterday it wasn't there.

[*Translation*]

There's also Bill C-81 on accessibility.

Can you talk about what more you want us to do?

Ms. Bonnie Brayton: I can reiterate our concerns regarding older women with disabilities. If you'll allow me, I'll continue in English, because my recommendations are in English.

[*English*]

Again, we'd just ask the committee to remember that Canada has obligations under its UN commitments to CEDAW, the CRPD, UNDRIP and other UN treaties. Monitoring is one of the things that we think is quite important for dealing with and trying to address the high levels of abuse that we see in senior care in residences and institutional settings.

We remind everyone that there is a really important issue with and concerns about sexual assault and sexual abuse of older women, particularly older women with disabilities. Again, a lot of information was provided on that by the other witness.

A really important point, one that was very well made by all of the panellists, is that it's very important to see all of these recommendations from an intersectional perspective to understand that we need important policy reforms that look at those things.

DAWN Canada would remind the committee of a project we launched that developed a social media platform called "More Than a Footnote". The reason we developed that message is that we understand that, far too often, many of the things we are talking about today are footnoted rather than understood to be important in fully developing policy recommendations.

I would say again that the vulnerable person standard is something that DAWN Canada and many other national disability organizations feel is critical to understanding the risks that the new legislation—well it's not so new now—on medical assistance in dying poses, particularly to older women with disabilities. While we understand that this is the law, it's important for lawmakers to understand that there is a vulnerabilization of certain communities through medical assistance in dying and that we need to develop standards and that the disability community needs to be involved in this monitoring process.

● (0925)

[*Translation*]

Mrs. Eva Nassif: Thank you.

My next question is for Ms. Ryan and her association. You had to rush earlier to give your presentation.

Since our government took office, you know that we've worked hard to accomplish what could be accomplished. We're continuing to focus on improving the relationship with indigenous people and the situation with respect to reconciliation with indigenous people. My question is very specific. I want to know more about the residential school system that targeted our young indigenous women. These women have now become seniors, indigenous senior women.

What are your recommendations with regard to them? We know that the poverty rate among indigenous senior women is twice as high as the rate among non-indigenous Canadian women. How have the residential schools, where the young indigenous women once lived, affected the isolation and poverty of the indigenous senior women they've become?

[*English*]

Ms. Roseann Martin (Elder, Native Women's Association of Canada): My name is Roseann Martin, and I'm from Listuguj, Quebec. I'm a residential school survivor. I'm also a sixties scoop survivor. In my community, we had 35 members way back when, from 1929, who attended these schools. The majority of our families that eventually came back to the community were affected so deeply by what was done to them. Over the years, it generated a lot of addictions, a lot of mental health issues and a lot of serious problems.

I went through almost 26 years of hell, living a lifestyle that was very unhealthy. It affected my community. It affected my family. It affected my children, mostly. Today, I have grandchildren, and I see the impacts of what happened to me affecting them.

We have 39 families in the community. You can bet that a lot of them are affected, and there's a high rate of suicide. There are high rates of addiction, homelessness and poverty—you name it. There are no jobs. There is nothing available for them. What do they turn to? They turn to things to medicate themselves, and all that.

I see a lot of problems with opiates. Our people are dying left and right, because there is no help for them. Where are they going to go? The detox centres are full. The healing lodges are full. Our people are sent away. When they are sick and dying, they are sent far away. There is no place for them. I went to see my mother when she was in the hospital dying of cancer. I was lucky at that time, when I went to see her, because she was in the bathroom in a wheelchair. She had been knocked over. She had been there for a couple of hours, and nobody had checked on her. We had to take our mother out of there, and put her closer to our area.

These are some of the ongoing factors right now in our communities. There's a lot of homelessness and a lot of.... Addictions are number one.

The Chair: Roseann, thank you so much.

We went a little over time, but your passion was awesome. You really got your point across.

Thank you very much for your time.

We have to take a slight break here. Yesterday, I had the opportunity to table, on behalf of the committee, the committee's 15th report, "Surviving Abuse and Building Resilience—A Study of Canada's Systems of Shelters and Transition Houses Serving Women and Children Affected by Violence".

Because of that, I would like to draw the attention of all members to the presence of some of the founders of the first women's shelters in Canada, and the author who shone a light on their story.

The founders of the first women's shelters in Canada I'd like to introduce are Ardis Beaudry, Janet Currie, Therese d'Allaire-Laplante, Nicole Thauvette, Lorraine Penashuk, Natalie McBride and Lynn Zimmer. Also with us today is Margo Goodhand, author of *Runaway Wives and Rogue Feminists: The Origins of the Women's Shelter Movement in Canada*.

We would like to thank you all for coming.

Voices: Hear, hear!

The Chair: Am I good? Did I say everything fine?

● (0930)

Mr. Terry Duguid (Winnipeg South, Lib.): Madam Chair, I didn't know whether you were going to recognize Margo Goodhand as being from Winnipeg originally. Her father was my family doctor as well, but I would just commend her book. It's very heartwarming. It tells the story of these very brave and inspiring women, and how they began the shelter movement way back in the early 1970s.

Thank you.

The Chair: You're welcome.

I'd like to thank you for all the work you did.

We're now going to turn back to our excellent panellists today. Rachael, I'm going to give you the floor for seven minutes.

Ms. Rachael Harder (Lethbridge, CPC): Ms. Brayton, I'm going to start with you. You mentioned medical assistance in dying and your concerns about the lack of palliative care available to those who might choose it rather than medical assistance in dying. You also talked about your concerns that medical assistance in dying is and could in fact become increasingly available to those who have a disability, and that a decision in that regard could even be made by a family member on behalf of an individual. You commented that this speaks to the value of these people who live with a disability, and that society is perhaps not placing the level of value on these individuals that we should.

I'm hoping that you could comment on that a little bit further in terms of women who live with a disability, particularly as they enter into their senior years, and your concerns based on your experiences in the field.

Ms. Bonnie Brayton: Thank you so much for bringing this back. I really think it's important and appreciate this opportunity very much. I know it's an important discussion for lawmakers because it is a law that I know was passed with concerns and with a real preoccupation going forward for how it would take shape. Indeed, a couple of years in we certainly, in terms of a disability community, know of and are beginning to hear of cases of concern. I'm not going to cite them today because I'm not really prepared to do that, and again, I wanted to bring this forward.

I will say in response to what you're speaking of that the stigma, the devaluation, essentially the isolation, of women with disabilities, particularly senior women, makes them particularly vulnerable. I talked about suicide prevention and how important it is and how rarely we think of that instead of an end-of-life process, and that sort of thing. I think the palliative care issue is one, and I know Dr. Leitch is also here, who knows very well that we have some work to do in our medical system to really improve the care for seniors, particularly at the end of life. That's one of the key ways we can mitigate the risk of somebody being offered medical assistance in dying rather than either palliative care or, indeed, an opportunity to think of something rather than medical assistance in dying as their only option.

I think one of the things that we want to make sure that we do, and again I spoke to this, is the vulnerable persons standard. This is something that's been widely supported by the national disability community and Canadians with disabilities as something that we think would be an important to put in place. I have provided a link in my speaking notes and would invite the chair to share that link with more information for the committee on the vulnerable persons standard. I think the review is next year, 2020, and think that that it would be a good point to look at whether or not the vulnerable persons standard is something that we can actually put in place soon.

I can share, again, not a senior example, but an example of the vulnerability of women with disabilities. In this case I think it's even more compelling because the woman was 24. She was from Newfoundland, a young woman who presented at the hospital with her mother who was in medical distress at the time, but it had not been....

Sorry, I just want to refocus and tell the story properly. She came into the hospital with her mother; she's not a verbal person, so her mother was with her. The physician who received them leaned in to the mother and said, “There's something we can do to help here”, and implied to the mother that medical assistance in dying was something he could offer to her daughter. I'm happy to say that this mother's instinct and reaction was to tell him immediately that she wanted to see another physician, and was referred to another physician. An investigation ensued of this doctor. I want to say this about this young woman and make the point why the medical assistance in dying issue is so important. My point is that a year later she was placed in a supportive living environment, and that's where she is to this day and, of course, she's thriving now.

My past president was in an induced coma due to pneumonia, again an older woman with a disability, and when she came out of the coma—and some of you may have actually met Ms. Hutchison when she was our president—the first thing that happened was the nurse leaned in and began implying to her that she might want to consider medical assistance in dying.

What I'm trying to say is that it's not a perfect system and that it's very important we understand that one of the things we have to accept is that there are going to be risks and that our duty is to reduce those risks at this point, because the legislation is in place.

Thank you so much for letting me bring that forward. I appreciate it very much.

● (0935)

Ms. Rachael Harder: Can you go into that a bit further? Having expressed your concerns about medical assistance in dying, the alternative then would be offering an adequate palliative care system or....

Ms. Bonnie Brayton: Quality of life.

Ms. Rachael Harder: Quality of life, exactly.

Can you talk about what could be done, particularly at the federal level, to make sure there is greater accessibility to this for these women? And, of course, with that comes overall quality of life and a higher living standard.

What would it look like if we as a society were to embrace that to a greater extent?

Ms. Bonnie Brayton: I think one thing we heard an awful lot about already from that other panellists is the issue of poverty. The economic situation of older women, particularly older women with disabilities, is something you need to address at a national, provincial, territorial and local level. As a society we need to address income inequality, writ large. I think that's probably one of the first things I would say.

I think we need to understand that we need to begin to address the caregiving issue in this country. It's a critical issue, both on the giving and receiving end. It's critical to understand that the level of stress on families of caregiving is one thing that's not being addressed.

In terms of the overall question, though, I think it would probably require another hour for me to get into all of the different issues we have around social inequality of women and girls with disabilities. But fundamentally the social determinants of health are something that all Canadians are entitled to, and sadly, many Canadians, including women with disabilities, do not have that.

I will remind this panel that as of November 2018, the new statistic for women with disabilities in Canada is 24%. So 24% of women in Canada live with a disability. The idea that we do not and have not inserted disability into every single social and economic policy speaks to the fact that we have yet to really achieve equality for all Canadians.

Ms. Rachel Harder: I'm done.

The Chair: I want to add one thing. We have shown that on April 11 the document you submitted was circulated. We just wanted to clarify that for you as well.

I'm going to pass the floor over to Wayne Stetski now.

Wayne, you have seven minutes.

Mr. Wayne Stetski (Kootenay—Columbia, NDP): I would like to thank you for being here today on this very important issue.

From my perspective personally and from my party's perspective, we need a national seniors strategy that will incorporate many of the aspects we're talking about today. I really do see that as the way forward.

I want to start, though, with Ms. Majowski on prevention of elder abuse, which does relate to a national seniors strategy.

A couple of months ago I attended a training session in Cranbrook on recognizing and dealing with elder abuse. I'm from Kootenay—Columbia in southeastern B.C. At the end of that, I asked the group a question. We have legislation that protects many aspects of Canada, including children and pets, and so I have to raise the question of whether there should be legislation protecting seniors.

I'm interested in whether you have thought about that and what your view is on it.

Ms. Kathy Majowski: Absolutely. Thank you so much.

It's very difficult to paint it as a black and white issue. My day job is working front-line in community health care as a nurse. I've come across situations on many occasions where we suspect and are almost sure there is been abuse, but the individual who is being abused, or potentially being abused, remains cognitively intact and autonomous, so we have limitations.

When we talk about potentially having a seniors strategy for abuse prevention or abuse reporting, we need to be very careful, because there is that really fine balance of autonomy versus somebody else stepping in and making decisions.

It's a little more cut and dried when we have individuals who are more vulnerable, who have cognitive concerns or cognitive impairments. It becomes also a little easier with some of the legislation around the Protection for Persons in Care Act, in particular in Manitoba.

As a health care professional, when I suspect something is happening in a facility in regard to abuse, I have a duty. I have an absolute duty to report. But when it comes to community settings, it becomes much greyer and much less clear.

I would support a standard or a standard communication about what are the roles of individuals who come across these situations. What can you do? This is part of what our organization does. We provide resources on our website for local, provincial and territorial organizations and the kinds of things they do, because, unfortunately, there is no standard across the country. Each province and territory has slightly different things they do and they recommend, and slightly different kinds of resources available.

In my opinion, speaking for the CNPEA, we would like to see more standards across Canada so that the people who are living in Nova Scotia have access to the same services and supports as the people living in British Columbia.

● (0940)

Mr. Wayne Stetski: Would legislation help with that, do you think?

Ms. Kathy Majowski: I would hope so. I believe that standardization has to come from a higher level. Provinces and territories are most definitely free to do what they feel is right and to fund programs that they feel are important, but some direction from the federal government would go a long way, I believe, towards standardizing these types of programs, resources and services, which need to be considered mandatory for our older adults.

Mr. Wayne Stetski: Okay. I'll turn to Ms. Ryan for a minute but will start by recognizing that I come from the unceded territory of the Ktunaxa, Shuswap, Okanagan and Sinixt first nations in southeastern British Columbia.

We often hear of the differences between on-reserve and off-reserve living and life for indigenous people. Could you share with us whether there's a difference for seniors as well?

Ms. Chaneesa Ryan: Certainly there is.

Before answering any other questions, I want to use this as an opportunity to point out something that I didn't get to in my speech. There is a complete lack of data on indigenous seniors and aging, and the data that does exist is often not disaggregated. While I am going to attempt, then, to answer your question, much of it will be based on anecdotal evidence.

At the same time, I know now that 52% of indigenous seniors are living off reserve. That's important to consider as well, when we talk about the need for services on reserve. While this need is certainly there, we need culturally safe supports—gender-based supports and trauma-informed supports—in cities as well, knowing now that over half of the indigenous senior population lives off reserve.

I don't know, Roseann, whether you want to add anything to that.

Ms. Roseann Martin: No.

Ms. Chaneesa Ryan: Could you just ask the question again?

Mr. Wayne Stetski: I'm wondering whether there is a difference for indigenous seniors living on reserve versus off reserve in terms of supports. You mentioned, for example, that there are very few seniors' homes on reserve, so basically you're forced to live off reserve. I'm wondering whether there are other differences and challenges as well.

Ms. Chaneesa Ryan: Yes. While there may be more access to home care supports or long-term care supports off reserve, there is still a lack of access to culturally safe supports. We had an engagement session recently with seniors living in Ottawa who pointed out their experiences of racism in the health care system within long-term care and of not feeling comfortable—not being able to smudge in hospitals and many long-term care centres, for example. Even though they have access to services, this lack of cultural safety within those services is still really an issue. While there may be greater access off reserve in one sense, it's still not necessarily meeting indigenous seniors' needs from a holistic standpoint.

● (0945)

Mr. Wayne Stetski: You released a statement on April 29 announcing the release of—

The Chair: Wayne, you have 20 seconds left.

Mr. Wayne Stetski: —employees as a result of a lack of core funding. What would you like to see from the federal government around securing your future?

Ms. Chaneesa Ryan: With regard to seniors, we currently have no funding. We've applied to ESDC's new horizons program and have recently applied to the Public Health Agency's dementia community investment fund. However, I would really like to see an investment in the aging indigenous population, specifically with a gender-based focus, given that indigenous women are living longer than men and that there are gender-specific needs. I would really like to see a dedicated effort to this area. As well, I would like to see indigenous organizations be involved in the decision making about what funds will become available and how they may be used.

The Chair: Excellent. Thank you.

We're now going to move on, for our final seven minutes, to Rachel Bendayan.

Ms. Rachel Bendayan (Outremont, Lib.): Let me begin by taking a step back. With the remaining time I would like to get into some of the details, but first I would be interested in hearing each of the panellists discuss the issue of language. Everybody touched a little on the labels that senior women face in various communities. I heard reference by some of the panellists to “older adults” and heard words that I think would be interesting for the federal government to hear about, in the hopes of perhaps adopting language that discriminates less and that carries less stigmatism.

Ms. Majowski, perhaps you would like to start.

Ms. Kathy Majowski: Absolutely.

Language is very important. We can communicate discrimination inadvertently by the types of language we use. Ageism is rooted in some of the language and some of the words we choose. Unfortunately, the term “senior” can actually be seen as a derogatory term or a term that conveys less respect than maybe we mean to.

I myself prefer to use the term “older adult”. When I'm speaking of somebody who is indigenous, I say “elder”. I feel those terms convey a little more respect.

That's not to say that “senior” is not an appropriate term or not a term that is widely used and people understand and recognize, but because it has been around for quite some time, it has had the opportunity to develop maybe a less-than-respectful tone to it in some cases.

Ms. Rachel Bendayan: Ms. Brayton, would you like to jump in?

Ms. Bonnie Brayton: I would love to. Thank you.

It's actually a good point. I won't focus on the word “senior”. I'll actually focus on some of the other language we hear around seniors —that is, “vulnerable”. The concept of vulnerabilization is something that is really important to understand in terms of what you do to somebody's person when you vulnerabilize them through language and through the way you treat or see them.

In the disability community, we have the same problem. One of the things I like to do is pivot people from the concept of vulnerabilization to resilience. Especially when you think of seniors or anybody who's marginalized, it means they are facing more barriers and it means they are likely more resilient. Some of the language we need to use is more positive.

While it might not be intuitive for people to think of this, again in a development context, they say there's a continuum between vulnerabilization and resilience. My argument is to take us beyond any of those concepts to empowerment, regardless of what population you're speaking to.

I know it doesn't actually answer the question. The previous witness really addressed the other issue well, in terms of an “older person” or an “elder” being an important way we show respect for older people.

I appreciate the question, and I do think the concept of vulnerabilization is another way we need to think of how we have to stop using language that takes away from somebody's humanity.

Ms. Rachel Bendayan: Ms. Kennedy.

Ms. Helen Kennedy: I agree with Kathy and Bonnie on the use of the word “senior”. “Older adult” is probably the most preferred. However, I also think when you're invisible in this conversation anyway, it's really important to address some of the other issues around intersectionality to be more inclusive. I think most of the LBTI2S seniors or older adults would just like to be included in the conversation in a more positive, empowering way.

If you're looking for a more standardized approach in how you address this issue, I would use the words “older adults” and “elders”—but please include us.

● (0950)

Ms. Chaneesa Ryan: That's a really great question and I'm glad you asked it.

I echo what the other witnesses have said, but it's also really important to make the distinction, at least within the indigenous context, between “elders” and “older adults”.

Roseann could speak to this much better than I could.

Ms. Roseann Martin: Where I come from, we refer to our elders as traditional people, the ones who carry on the language, the culture, the spirituality, and the older people as “seniors”. There's always a misconception, everywhere I go, when they talk about “elders” and “seniors” or “older people”.

Where I come from, we're regarded as “elders”. We are the ones who carry the language. We are the ones who carry the spirituality. We are the ones who teach the next seven generations. This is where the “elder” comes in.

Yesterday, I had the opportunity to sit at another table. When it came dinnertime, in our culture, it's the elders that go first to get their meal and all that, but I was the last one in line. I was mortified, because society doesn't really know that standard yet.

That's all I have to add. Thank you.

Ms. Chaneesa Ryan: Perhaps I could quickly add to that, too.

With 2019 being actually the year of indigenous languages and also in the era of truth and reconciliation, it's a really important question, because it's time to start letting indigenous people use language that they would like to use to describe themselves and not have language assigned to them.

Again, I don't have the answer to the question. We represent indigenous people across the country, and depending on which group you speak to, whether it's first nations, Inuit or Métis, and even distinctions within those groups, they would have a different answer. However, just allowing that space for people to identify how they would like to be identified is a really important question that needs to be considered.

Ms. Rachel Bendayan: Just to follow up on that, would that be something your organization could assist with?

Ms. Chaneesa Ryan: Definitely, yes. It's something we've actually been discussing as well.

Ms. Rachel Bendayan: Okay, wonderful. Thank you.

The Chair: Rachel, your time is over. It's been seven minutes.

We are going to switch over to the second round, but we're going to have to reduce that down to three minutes, I'm afraid, just so that we can get to everyone.

Sonia and Kellie, you'll both have three minutes to ask questions.

Hon. K. Kellie Leitch (Simcoe—Grey, CPC): Thank you, all of you, for taking the time to present today.

I'm a practising physician, and so my questions are about health services. One of the issues that has come up for me many times is the accountability of the system to patients, and in particular to seniors. I'm an orthopaedic surgeon. The number of people waiting months upon months for a hip replacement is ridiculous.

Maybe you, Bonnie and Roseann, could comment with respect to that—palliative care in your case, Bonnie. I'll ask you to be succinct because I only have three minutes.

Roseann, I grew up in northern Alberta surrounded by three Cree reserves where there were issues around infections, whether it be tuberculosis or others. Your comment on opiates was very salient. Maybe you could comment a bit about how the federal government could play a more meaningful role in making sure that your people are healthy, not just seniors but others.

Ms. Bonnie Brayton: Thank you very much. I will jump right in and just say, indeed. The issue of palliative care, for lots of different reasons, is one that I don't feel we have addressed. I think the federal government needs to put a focus on palliative care—

Hon. K. Kellie Leitch: And be accountable.

Ms. Bonnie Brayton: —and be accountable with the idea that we need to set a standard for what has to be available, again, across every province and territory. As we know, with the health system we have, there's a problem with uneven service delivery. Certainly, as you've pointed out, in some places you can wait a very long time, and as a surgeon I know you know that. It depends on where you are. There are those sorts of issues.

Of course, palliative care isn't available in some communities. It's the deepest concern we have because that's the reality.

● (0955)

Hon. K. Kellie Leitch: Roseann, could you comment on the accountability to your people?

Ms. Roseann Martin: Our people need a healing lodge right in our own communities, to be run by indigenous people rather than non-native people because they don't know about our culture. They don't know about our spirituality. They don't know what our needs are.

Hon. K. Kellie Leitch: So it's the direct patient or person accountability for providing care at an appropriate level.

Ms. Roseann Martin: Yes.

Hon. K. Kellie Leitch: Okay.

The Chair: You still have a minute.

Hon. K. Kellie Leitch: Oh my goodness. We're very efficient, ladies.

One of the other items I'll just ask about has to do with the role the federal government can play in health care. Often I find that for patients, people at the federal level say, “This is just a provincial responsibility,” or “This is just the responsibility of a specific group.” Do you find that, whether it be in palliative care or the individuals you deal with, Roseann, in your community? Do you often get that push-back, with no one taking responsibility and ownership but really just passing the buck?

I guess it's almost like a yes or no question. Do you find that's the case?

Ms. Bonnie Brayton: It's absolutely the case, Dr. Leitch. That's exactly what's happening. Again, it's because of the size and the breadth of Canada. One of the issues is that we don't have a national pharma care program, for example. We have all of these issues.

If you're a senior in one place or another, you may or may not be able to get access to certain services. You may or may not be able to get palliative care or caregiving if you have a family member with Alzheimer's. It's all of these issues.

Again, some advocates are trying to piece together recommendations and policy, and its very complex. I've been coming to this committee for a long time. When I first started coming to this committee, I didn't even know how to make a parliamentary brief. I think it's very important we think about these things.

The Chair: Sorry.

Sonia, you get the final three minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you all for being here.

Seniors deserve a better life. Loneliness among adults is a main issue, which leads to isolation. Even though the new horizons for seniors program is here, language and culture differences are the main barrier for seniors to participate in the community and access services.

How can the federal government help more seniors with the right kind of infrastructure to keep older adults happy? I know that access to health services is not in the federal jurisdiction, but even the social climate, as Roseann Martin said, is changing.

Before, we were aiding and would provide for the elders. I know that in some cultures they do, but how can we help give infrastructure so that seniors can get more services?

I want to give everyone the chance to jump in.

Ms. Chaneesa Ryan: Concerning what you just said, I would point out that for indigenous people on reserve specifically, the federal government has responsibility to provide health care services —for all people on reserve, but for seniors as well. Making a sustained effort to invest in additional continuing care supports, home care, long-term care, so that people don't have to leave their communities and be vulnerable to a lack of access to culture and language and then don't have to deal with as much social isolation, is really important.

As well, off-reserve....

Do you want to add to that?

I'm sorry, I lost my train of thought, to be completely honest, so I'll transfer my time to someone else.

Ms. Bonnie Brayton: Please, go ahead, dear.

She has her hand up.

Ms. Kathy Majowski: Thank you.

As I mentioned in my presentation, breaking down the silos, encouraging communication across provinces, and looking at a repository of best practices and programs that are working in areas of Canada and making sure those program guidelines are easily accessible is very important.

It's actually the mandate of our program to be that knowledge-sharing hub. We search out all kinds of different programs and reports and research so that the expert stakeholders in the field are able to develop programs based on evidence rather than try to reinvent the wheel with a brand new program every time.

The Chair: We have about five minutes left.

Ms. Helen Kennedy: Let's just say that we don't respect our older adults in Canada at all. We don't treat the care and needs of older adults as a priority, and I find that fascinating, because nobody is getting any younger: We're all going in the same direction.

I think a national seniors strategy leading to one of my recommendations, on forming a national steering committee, would go a long way towards making older adults and the care and the issues of older adults a priority for any government. In Canada we are sadly lagging behind other jurisdictions around the world.

● (1000)

The Chair: Excellent.

I recognize we didn't get around to everybody, but it's 10 o'clock.

On behalf of the committee I'd really like to thank the Canadian Network for the Prevention of Elder Abuse, the DisAbled Women's Network of Canada, Egale Canada and the Native Women's Association of Canada.

There are murmurs that there may be a vote coming up very shortly, so I'm going to ask that we immediately switch panels, have about a minute break here and flip things over so that we can get to the next panel.

We will suspend for one minute.

● (1000)

(Pause)

● (1000)

The Chair: Welcome back to the 140th meeting of the Standing Committee on the Status of Women.

For the second hour I am pleased to welcome, as individuals, Shirley Allan and Arline Wickersham.

What we are going to do is see how far we can get. We'll get your testimonies done and will see when we can get to rounds of questioning.

I'm going to turn the floor over to Shirley.

Shirley, you have seven minutes.

Ms. Shirley Allan (As an Individual): Good morning.

Thank you for the opportunity to speak to you this morning and to share my story for your study on challenges facing Canadian senior women.

My story outlines the path that refined me into the woman I am today. My choices and experiences over 62 years moulded me into who I am and what I hold dear.

As a newly married woman I chose to remove myself from the full-time paying workforce in order to stay at home with my children. Even though society does not seem to place value on the choice I made, I feel that this decision was of great value to me, my family and society as a whole.

I was born in Scotland, and my parents and I immigrated to Canada. I also lived in the United States for seven years and returned to Canada at age 17. I graduated from Queen's University in 1980 with a Bachelor of Commerce degree. While at Queen's I met an officer cadet at the Royal Military College of Canada. My husband and I were married in 1981.

We knew we wanted to have children and we felt very strongly that, as a result of our expectations of the military lifestyle, it would be wise to have a parent at home. Part of my decision was based too on my understanding that reasonable gainful, continuous employment would be difficult as part of a military lifestyle. Together—

● (1005)

The Chair: I'm going to have to interrupt for just one moment. I'm sorry about this. We do have votes. Looking at the time—we're in the same building, and the votes will be at 10:35, in 20 minutes—what I would like to do is finish your testimony and then have one question from each party.

I will need unanimous consent to continue.

Some hon. members: Agreed.

The Chair: Please continue, Shirley.

Ms. Shirley Allan: Thank you.

Together we made the decision that I would stay at home with our children. I would like to emphasize that this decision was made together. My husband is my number one supporter.

When I married, I became a D/W, dependent wife, in the eyes of the armed forces. In 1981 there were no supports for families: no military family resource centres, no supplementary health plans and no dental coverage. When we were posted to Calgary in 1986, D/C, dependent children, were not allowed to accompany their parents on house-hunting trips. We had to make arrangements for our two-year-old to be cared for by family members. Our four-month-old was allowed to accompany us because he was still being breastfed.

My husband was away on a six-month course when we were to be posted to Halifax. I had to go myself, to a city I had never been to, and in five days find a home for our family. Again, our children were not allowed to go, and I had to make arrangements for them to be cared for.

Over the course of the first 22 years of our marriage, we were posted 10 times. We lived in the west and down east. We lived outside of Canada twice. We were blessed with two children. We had no family living near us at the time of their births. In the first five years of marriage, my husband had been away from home on courses and exercises more than half of that time.

Before the birth of our first child, I worked full time. I stayed out of the paying workforce from 1983 until 1997. In 1997 I returned to the workforce on a part-time basis. I returned to full-time work in 2005, with a break from 2011 to 2015 when we were posted. I worked in administrative positions in churches, a private school and a community sports organization. I retired from paid employment in 2018.

One of the losses of not working full time is the loss in status in the eyes of society. The first thing people ask when they meet you is, “What do you do?” I told people that I had the privilege of staying at home with my children. I did, and still do, see it as a privilege. Many of my university peers are now retiring from powerful, well-paying positions in the private and public sectors. I gave up this opportunity when I chose to stay at home.

Other losses are financial. Our family income was smaller than it could have been. We had one car, other than for a few years when our children were learning to drive. We did not travel for vacations. We owned a small home in Ottawa, which we rented out when we were posted elsewhere. Many times we anxiously awaited payday.

I do not have a private pension. My CPP payment is just over $375 per month. If my husband predeceases me, I will receive approximately half of his government pension.

In the eyes of society, I may be viewed as a failure or my choice as folly. However, I see much value in the choice I made. Because I stayed at home, I was able to volunteer extensively. I volunteered in my children's schools, at my church and in homeless shelters, and I served on the boards of directors of a number of not-for-profit organizations. I helped mobilize two churches to support refugees new to Canada. I was able to donate many hours of time and expertise to organizations and I know that I made a difference to those organizations. I currently mentor four young women, and I know that my experiences provide especially relevant support to two of them, who are stay-at-home mothers. I still volunteer in my church and at a seniors health centre.

I believe that staying at home as the stable rock in my family has, in some part, resulted in a still vibrant marriage of 38 years. Most importantly, my choice enabled me to be a central influencer in the upbringing of my children. I was the reliable parent who was always there when their dad was away on course, on exercise or deployed to Afghanistan.

My children are both well-adjusted adults who are contributors to society. Both of my children completed the rigorous international baccalaureate program in high school. My daughter holds a master's degree and has educated children in five different countries in her role as a math teacher in the international school community. My son is an engineer, a pilot, and a major in the Canadian Armed Forces. He recently returned from a deployment overseas.

I believe the family is an important foundation of society. I feel it is important for a parent to have the choice to stay at home with their children and to be supported in this choice.

The government could support families by allowing income splitting for tax purposes; providing a stay-at-home parent tax benefit; financially supporting senior women who never have engaged in paid work; and changing pension legislation for surviving spouses who do not have a private pension.

● (1010)

If I had a chance to go back and to change my decision to stay at home, would I? I would not. Do I see myself as a failure because of my choice? I do not.

Thank you again for this opportunity to share my story.

The Chair: Thank you very much, Shirley.

We're now going to turn the floor over to Arline.

Arline, you have seven minutes.

Mrs. Arline Wickersham (As an Individual): Good morning.

I am honoured to be here, but it surprises me that you think my story is worth sharing. All I did was go on a ride and I didn't quit. I have been asked to share my story in the context of your study on the challenges facing senior women in Canada.

To offer an honest reflection of my life now, it is important for me to reflect on the journey that has brought me to where I am today. We don't become seniors overnight; there is an entire life course that needs to be considered.

My father died when I was eight, and I never thought twice about doing jobs that some people would label as a man's work. If I saw something that needed to be done on the farm, I did it. If the cows needed to be brought in from the field, I brought them in, even though I was afraid. Fear and inability were not obstacles that would hold me back.

When I was 17, I got married. It was a challenging time. Our faith in God and searching to understand our purpose in life has helped us through the difficulties. In the beginning, I thought that when I got married I was going to have a Cinderella story and that my knight in shining armour would come along on a white horse and swoop me off my feet. But I soon realized that where fairy tales end, real life begins.

As a young newlywed I never could have imagined the journey I was heading on; in my mind, I would be a stay-at-home mom and eventually find a conventional job. As my children grew older, I found there were unique opportunities as a stay-at-home mom. I had found my place.

Being at home was meaningful to me, and I knew there was value in what I was doing and whom I was reaching. I loved raising my babies, and by the time I was 24 we had four children. I was there to participate in the growth of the children through the stages from baby to childhood to adulthood.

Kids don't always see the sacrifices a parent makes, and some of those years were harder than others. Often a mom is left cleaning up the messes and preparing the meals while the rest of the family is out exploring the world around them. At times I wasn't even aware of the sacrifices I made. When I did recognize them, I felt that it was a hard and thankless job.

I was happy to be a stay-at-home mom. It allowed me to send my kids off to school each day and to be there for them when they arrived home. I was not only present in my kids' lives, but also in the lives of their friends. Often, over a fresh plate of cookies, I would find teenagers opening up about their lives. One girl came to me in her twenties to thank me for being a listening ear. She told me that I was a lifesaver for her at a time when she felt there was no one else she could talk to. Our door was always open. Some stayed the day, and others stayed the night. Our house was a home away from home for many. There are countless stories I could tell about the people who came into my home. I hold each person and their story near to my heart.

When my children were teenagers, I thought I would like to try working outside the home. I worked some part-time jobs, but I found they interfered with our family's priorities and weren't as satisfying as I thought they would be—but I had some extra spending money. At home I found myself busy sewing, cooking, baking, cleaning, canning, doing yard work and gardening. No task was too big for me, and when my husband and I decided to build some houses, I was actively involved in the process. I worked like the man and loved it. The physical activity was rewarding for me.

In 1991 we purchased a broiler farm. We raised up to 30,000 chickens at a time. This meant that I was a full-time farmer making sure equipment was functioning properly, and I became the chief problem-solver. I took care of the chickens and did much of our yard work. Much of the work was mine, since my husband was employed full-time in the city. We stayed on the farm for 10 years.

For 20 years my mother struggled with severe health issues, and I was very involved in her care at her home, in our home and ultimately in palliative care. A few years later, we were providing the same care for my in-laws, and in more recent years we helped provide care and support to our son along with our daughter-in-law. It was important to me that the people I loved were able to die with dignity.

I wanted to be there for my children as they raised their children. I was not one to parent my grandchildren, but I wanted to support them and help them feel loved. We have always been there for our grandchildren, offering them love and support through the good and the bad. Even now we support our grandchildren as they raise their children.

Throughout my husband's career I have had many opportunities to volunteer in our community. We have hosted and supported a variety of events. Even after my husband retired from his position, we have continued to be involved. Throughout my life I have accomplished many things, but it was nothing that I did alone. My husband of 57 years has always supported me. He recognized my contribution to our family and encouraged me. We have worked side by side to achieve great things together. Through the many thankless, messy, hard times, we worked tirelessly to overcome many obstacles.

Something we wanted to instill in our children is that determination to work through obstacles is important: don't just give up. We wanted to teach our kids to be independent thinkers, to be people who sought truth and who in finding truth had a solid moral foundation and value system. For my part, I had four children, and it was my responsibility more than anyone else's to raise them. That was my choice.

For women who make this same choice, respecting their choice is important. Family income-splitting is important. Letting women keep more of their money by decreasing taxes is important, and financial support for seniors who haven't paid into CPP is important.

Looking back on my life, I can see the great impact I have had in the lives of family, friends and community. I was once asked whether, if I had the chance to do it all over again, I would. Yes, I would.

● (1015)

The Chair: Excellent. Thank you very much.

As I indicated, we're going to do one question per group. Try to keep your preamble extremely short, because it's going to be about a minute.

Bob, you have the floor.

Mr. Bob Bratina (Hamilton East—Stoney Creek, Lib.): That's a shame, because they are both wonderful stories and we could elicit so much good information, but I'll stick to one question.

What do you tell your daughter, or have you talked to your daughter, about the kind of choices she might have to make in her life? Is she married?

Shirley.

Ms. Shirley Allan: My daughter is not married. At this point in her life she certainly doesn't have the choice to make that I made, but she certainly knows—I've discussed with her—how my husband and I came to the choice we made. She knows, though, that she's free to make her own choice, if that time ever comes.

Mr. Bob Bratina: What I'm getting at is that some young women I've talked to really want to do it all, and I'm not sure.... My wife couldn't do it all.

Ms. Shirley Allan: No, I don't believe you can do it all. I don't believe that; something has to give. If you choose to devote yourself to your career, then I believe your personal life has to take some hits and, vice versa, that if you choose to stay at home as I do, your professional life takes a hit. I don't believe you can have it all.

The Chair: Excellent. Thank you very much.

I'm going to move over to Rachael, for one minute and a couple of seconds.

Ms. Rachael Harder: Ladies, thank you so much for taking the opportunity to be here and to share your personal stories with us.

In the midst of a whole lot of data and theory, it's really important to settle into personal, lived experience. You've certainly provided that within the context of this study, so thank you for being willing to do that.

One of the things I hear in both of your stories is the importance of respecting a woman's choice, whether that is to be in the workforce, and both of you spent some time there, or to invest time and energy into the home. One of the advantages I see of having invested in your family and having made that your priority is that now on the other side your children are returning that favour and they're able to invest in your lives as seniors, which decreases, then, the chances of being isolated or lonely.

Starting with Arline, I wonder if you can talk a little about the value in raising your own children rather than working at a full-time job and sending them off to day care.

● (1020)

Mrs. Arline Wickersham: Well, I wanted to raise my kids. I wanted to be there. I saw a lot of situations where, if a kid is sick, who is going to look after the child? Your day care won't look after them. I just wanted to be there to raise my kids.

The Chair: Excellent. Thank you very much.

I'm going to now move over to Wayne for a minute and a bit.

Mr. Wayne Stetski: Thank you.

My mom was a stay-at-home mom as well.

I'm just curious. How beneficial might it have been to be able to contribute to CPP as a stay-at-home mom, in terms of financial security as an older adult? Do you think that would have been helpful?

Mrs. Arline Wickersham: Yes, it would.

The Chair: Wayne, you have 40 seconds left.

Mr. Wayne Stetski: You'd like to see the federal government move in that direction, then, and therefore put more value on stay-at-home moms going forward.

Ms. Shirley Allan: Yes. If women or parents who stay at home are able to contribute to CPP, even if they don't work in a paid job, that would be great.

Mr. Wayne Stetski: I just want to get that on the record.

Ms. Shirley Allan: It helps at the end of the lifetime.

Mr. Wayne Stetski: For sure.

The Chair: Excellent.

On behalf of the committee, I would really like to thank Shirley Allan and Arline Wickersham. I'm sorry our time was so short. You did have a lot to offer, but we must vote.

Therefore, I'm going to adjourn today's meeting.