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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1530)

[*English*]

The Vice-Chair (Ms. Marilyn Gladu (Sarnia—Lambton, CPC)): Good afternoon. Welcome to the 143rd meeting of the Standing Committee on Health. We are continuing our study on LGBTQ2 health in Canada, and we have quite a number of witnesses with us today.

As individuals, we have with us Andrea Daley, who is an associate professor at the school of social work, Renison University College, and Bill Ryan, who is an adjunct professor at the school of social work at McGill University, We also have with us, from the Edmonton Men's Health Collective, Brook Biggin, who is the founder, and Jeff Chalifoux, who is the coordinator of the harm reduction program. We have, from Healing Our Nations, Arthur Miller, who is the community health educator, and from Our City of Colours, Darren Ho, who is the founder.

Welcome to all of you. You'll each have 10 minutes for your comments.

We'll start with Andrea.

Professor Andrea Daley (Associate Professor, School of Social Work, Renison University College, University of Waterloo, As an Individual): Madam Chair and members of the standing committee, good afternoon. Thank you for this opportunity to present to you on LGBTQ2 health. I commend you on taking this important step in conducting the first study on LGBTQ2 health in Canada.

I'm a social worker with more than a decade of front-line experience in community-based mental health, including providing counselling services to members of Toronto's LGBTQ2 communities. I've also participated in LGBTQ2 grassroots networks in Toronto as a member of the Rainbow Health Network, working collaboratively with my volunteer colleagues to begin to imagine what has now been realized as Rainbow Health Ontario.

Over the last decade or so, I have been an associate professor and director at the school of social work at York University and, more recently, at Renison University College, affiliated with the University of Waterloo. My academic research program has explored health services access and equity, with a particular focus on the implications of institutional policies and practices on high-quality equitable health care for diversely situated LGBTQ2 people. I'm a lesbian/queer cisgender woman.

I have listened to the presentations of witnesses who presented at previous meetings of the standing committee, and I commend my respected colleagues for offering critical accounts of health disparities experienced by LGBTQ people, underscoring the impact of homophobia and transphobia on mental health, highlighting the need to attend to the determinants of health and experiences of discrimination and stigma in health care encounters at the intersections of sexual orientation and gender identity and race, socio-economic status and aging, among other intersections, and finally, for calling for robust structures and methods for collecting Canadian data on LGBTQ2 health inequalities.

Today, I want to focus my remarks and recommendations on the issue of access and equity in health care services. In doing so, I underline one key point and related recommendations that I believe will serve to create change and promote access to high-quality care for LGBTQ2 people. This key point is education and training in health professional programs. To emphasize these points, I draw on experiences of participants from a CIHR-funded, Ontario-based research project on home care access for LGBTQ2 people, of which I was the principal investigator.

Research conducted in Canada, the United States and the United Kingdom has documented barriers to health services that limit access to good-quality care for diversely situated LGBTQ2 people. Health services access barriers include heteronormative practices and policies, including assessment and intake forms that fail to include same-sex relationship status options and that rely on the male-female gender binary. More generally, institutionalized heterosexism, biphobia, transphobia and lack of provider knowledge related to LGBTQ2 health needs and health service experiences have been implicated in the delay of preventative care, the failure to return for follow-up appointments and a general reluctance to report health issues for LGBTQ2 communities.

For example, Trans PULSE reported that 21% of trans participants in their study avoided emergency department care because of fear the encounter would be negative because of their trans status. A participant in the LGBTQ home care access project stated, “I know some folks who’ve had bottom surgeries, who have had friends and family and partners do all that work even if they’ve had fistulas or any kind of infections because they’re terrified”. They didn't want home care to come into their homes.

In response to access barriers, academic and community-based researchers and LGBTQ2 activists, organizations and allies have underscored the need for health provider education and training on the unique health and service experiences of sexual and gender minorities. Such calls for education and training initiatives are focused on providers in hospitals, long-term care and public health sectors. Similarly, literature on the LGBTQ2 learning needs of service providers has addressed health-related professional education programs, such as medicine, nursing and social work.

A review of the literature suggests that education and training initiatives are often conceptualized within a cultural competency framework and delivered in workshop formats ranging from one to six hours, while incorporating different learning components, including small discussion groups, written materials, LGBTQ2-identified speakers and videos. They often include topics such as LGBTQ2-related terminology and concepts, information on barriers to health services and health disparities, and sector-, service- or illness-related information—for example, on aging and long-term care, palliative care, HIV, youth and mental health.

● (1535)

While there appears to be variability in terms of access to education across regulated health professional groups, overall access to repeated opportunities that offer both breadth and depth in terms of LGBTQ2 health and health service access experiences are extremely limited. Repeated opportunities for education and training are crucial. It is not simply a matter of acquiring knowledge, but rather is most often a matter of doing the difficult work of shifting discriminatory beliefs and attitudes, fear and apprehension.

A service user in the LGBTQ2 home care access project described her home care provider's reaction to learning that she was a lesbian and married to a woman. She said, "I was sitting here and [the home care worker] was there and she backed up and, '*Gasp* never heard of that!'." She had never heard of a lesbian. "She didn't say a lot in words, but her body language was very judgmental. She stepped back and sort of put her hands up and then she was very careful not to touch me."

From this point, I offer the following recommendations for federal, provincial and territorial governments to consider with respect to mental health care provider education and training.

Recommendation one is for sufficient funding formulas that adequately provide resources for comprehensive health professional programs.

At a policy level, ministries responsible for both education and health must work collaboratively to consider funding formulas that adequately provide resources for comprehensive health professional programs that prepare health professionals to respond to the diverse and complex health needs and health service experiences of sexual and gender minority service users. This includes resources to fund curricula development in health professional programs that not only address clinical knowledge unique to LGBTQ2 people, but also educational approaches that foster transformative learning, shifting deeply held discriminatory beliefs and attitudes toward LGBTQ2 people.

In the absence of comprehensive health professional programs, LGBTQ2 people are too often put in the position of needing to educate their health care providers, all the while contending with acute, chronic and/or life-threatening illnesses. A participant in the home care project graciously said, "I had to educate, and they actually appreciated the education because they didn't really have much experience with transgender people. They didn't understand what it meant, so I had to explain it."

Recommendation two is on accreditation standards for post-secondary health professional programs.

A systematic review of accreditation standards for all health professional programs through their respective national accrediting bodies is needed to identify gaps in accreditation standards that are specific to LGBTQ2 communities, and then associated standards need to be developed. Ensuring that the curricula of health professional programs include information related to LGBTQ2 communities seems especially important, given the paucity of content in these programs and the paucity of continuing education opportunities once health professionals are in the field.

In the home care project, out of 379 health care providers we surveyed, only 47 had access to LGBTQ2-specific education. Of that 47, 50% attended a half-day workshop. The other 50% attended a workshop that was one to two hours long. Once they were employed in the health care sector, 90% had never received LGBTQ2-focused education.

I'm going to skip recommendation three and go to recommendation four, which is on education and training opportunities for unregulated health providers.

Personal support workers increasingly are providing the bulk of health care to service users. In the home care project, they indicated they have had no opportunities for LGBTQ2 education and training in their training programs or since they had been employed in the home care sector. They have other training opportunities, but not related to LGBTQ2.

My fifth recommendation is a federal accountability structure. There must be an accountability structure to provide oversight and direction for the recommendations identified above. The creation of an accountability structure at the federal level would be well aligned with the Government of Canada's commitment to advocating for the protection and promotion of the human rights of lesbian, gay, bisexual, transgender and intersex persons globally.

● (1540)

Notwithstanding this commitment, it may be that it is more appropriate or feasible to think about accountability structures at the provincial and territorial levels, given their responsibilities for education and health.

Thank you.

The Vice-Chair (Ms. Marilyn Gladu): Thank you so much.

Now we're going to Bill for 10 minutes.

Professor Bill Ryan (Adjunct Professor, School of Social Work, McGill University, As an Individual): Hello, everyone.

I thank you for the opportunity to address you this afternoon, and I applaud your decision to examine more closely the health issues related to gender and sexual minorities.

Permit me to begin by saying that one of the most concrete and practical actions that could be taken would be to ensure that the bill before the Senate forbids conversion therapy as a legitimate reaction to youth and adults coming out. This is still offered to youth. It's condemned by all professional medical and psychological associations, and it has to stop.

The slow movement towards equality is lived asymmetrically depending on what initial in the acronym LGBTQ2I one identifies with. It surely has been noted to you already in your hearings that intersex Canadians have no protection.

After finishing my studies and moving to Montreal, my teaching and research careers focused on gender and sexual minority health. My first research in the late 1980s and everything I've done since then has kept that focus. It’s not uninteresting to note that I'm also a psychotherapist with a large practice composed mostly of gender and sexual minority youth and adults and their parents, who have learned that one of their children is coming out.

I base my presentation to you this afternoon on my experiences as a teacher, a researcher, a therapist and an activist.

The good news in the last 30 years is that much has changed in terms of law and social policy. The bad news is that, in spite of these landmark changes, the psychological distress experienced—especially but not exclusively in adolescence—is still being felt in ways that are as intense and devastating as they were 30 years ago.

Depending on where you live, who you have been taught by and what kind of work you do, things may have changed enormously or seem to have not changed at all. Until the health indicators, both mental and physical, of this minority are more closely aligned with those of the general population, we have a lot of work to do.

There are two examples I'd just like to invoke as a way to move into a broader discussion. The first is a letter I received from a young person not that long ago. I'll quote from his letter.

It says, “Hi Mr Ryan. I am 16 and I go to high school in Trois-Rivières. I saw you on TV recently and called for your address. I am gay, but have never officially told anyone. Everyone gives me a hard time at school, so much so that I am afraid to go to the cafeteria. Some guys say that they are going to do all kinds of things to me. Nobody, teachers or anyone in the school does anything to stop them…I can’t concentrate anymore. Everything seems hopeless. Please come to my school and talk to them. There is no one here to help me. Please do something before I feel I have no choice but to kill myself. My parents don’t know anything about any of this. I am afraid to talk to them. If they hated me because I was gay I don’t know what I would do.”

Here is another. It says, “ I ran a program for PHAC for several years that developed services for sexual minority youth across Canada, the Safe Spaces Project. Before going to conduct research with the youth who participated I was asked to visit parents whose 16 year old son had just jumped off a bridge and killed himself. He left a note at home, found after the fact, in which he wrote: 'Mom, Dad, I’m gay. I think you’d rather that I be dead, so when you read this, I will be.' I met with the parents. They would have accepted their child. But he, somehow, didn’t know it.”

With those two examples, I'd like to talk to you for a moment about population health. I was a little worried that two faculty members and social workers would talk about the same thing, and I'm glad that we're going to be complementary.

I was asked several years ago by the Public Health Agency of Canada to address the issue of population health as it might apply to gay, bisexual, trans and two-spirit Canadians. I examined the determinants of health as they might relate to sexual minorities. Allow me to review some of the most important factors that my team and I discovered through literature reviews, focus groups and individual interviews.

I'm going to go very quickly, because I'm used to speaking for three hours at a time. Ten minutes is not a lot.

On social support networks, within a population health framework, social support networks are conventionally seen as support from families, friends and communities. Such support assists people in dealing effectively with trying situations and in keeping a sense of control over one's life and life situations. The support of family and friends as well as social participation seem to act as a buffer against health difficulties. Increased emotional support and increased social participation are both tied to increased health. Close intimate relationships are a factor for health and well-being. Lack of social supports or isolation is conversely considered a disease determinant.

Population health interventions cited to strengthen social support networks include programs to maintain strong families, community development that increases social interaction and initiatives that reduce discrimination and promote social tolerance. More generally, social support networks are integral to a person's social environment.

● (1545)

LGBTQI2 adults, and youth especially, often experience significant diminishment and exclusion within conventional social support networks due to homophobia, transphobia and heterosexism. In the face of such degradation and exclusion, they have historically and creatively organized, informally and formally, their own social support relationships and networks. Simultaneously, they often challenge conventional social support networks to be more responsive to their well-being.

Isolation is the most recurring feature in the lives of most sexual minority youth. It includes not just social or physical isolation but also cognitive isolation, which is a lack of knowledge about themselves, and emotional isolation, which is a lack of emotional support as a member of a marginalized group and a lack of social support that is not obvious to them in high school or youth environments.

I'll move now to education and say a few things that have already been said, just to underline their importance. Education equips people with life skills, allows them to participate in their own community and increases opportunities for employment. Historically, schools have been hostile environments for sexual minority youth. Discussion of sexual minorities has been slow to enter the curricula of Canadian schools. When it does, such discussion often faces opposition. Such hostility—due to homophobia, transphobia and heterosexism—ranges from verbal abuse to physical violence. The effects of homophobia, transphobia and heterosexism in school environments contribute to many lesbian, gay and bisexual adolescents dropping out, many becoming street-involved and homeless, high rates of suicide and attempted suicide, and internalized shame and low self-esteem.

Notwithstanding the courageous risks taken by queer youth particularly—and by their allies, as we've seen recently in Alberta with the response to the controversy around gay-straight alliances—they meet tremendous obstacles. Teachers hesitate to come out or be stronger allies because of fears related to public perception and career advancement, depriving youth of role models and support.

I've included a section here on employment and working conditions. You'll be able to see that in the brief I have provided, but I want to move on now to healthy child and adolescent development.

Regarding the general population, positive prenatal and early childhood experiences have a significant positive effect on eventual health, well-being and coping skills. The quality of such early experiences is influenced by socio-economic determinants. Poverty in particular has a wide negative effect. Adolescence for LGBTQI2 youth is a crucial time for their health and well-being. It's during this time of development that they will most likely be dealing intensely with sexual orientation and gender identity issues in their lives, including resisting and surviving homophobia, transphobia and heterosexism.

Access to health and health services is another really important issue. That's been mentioned already. I'll let you consult my brief if you want a little bit more, but I want to talk about the training aspect. Homophobia, transphobia and heterosexism significantly affect the quality of care provided by health care providers within health services. Health practitioners appear insufficiently prepared for interacting effectively with sexual minority clients and patients. Sexual minorities experience both systemic discrimination in health care and individual prejudice by health professionals. Trans folk and those of minority cultural, ethnic or racialized groups may experience compounded systemic discrimination and prejudice. As well, sexual minorities are often rendered invisible within health care systems. These systems are often perceived as unsafe.

The lack of adequate and relevant training of health care providers is a major barrier to the health of LGBTQI2 people. For example, they do not seem to be trained to collect the information necessary to be of assistance. They apparently often confound sexual behaviour with sexual orientation, and generally appear to be ill-equipped to deal with queer patients. Health care providers who are members of sexual minorities often appear to have a better understanding of the issues. That knowledge is usually self-acquired.

I'll make a special mention here related to trans health care. Trans individuals are turned away from services that are in no way connected to their trans identity or their hormone or surgical status. For example, someone was told they could not see a physician for their sore foot because "we don't treat transpeople who take hormones". Another issue is the arbitrary order to cease hormone therapy when the medical issue is in no way related. In this case, the health professional doesn't assess the impact of such an order on a transgender individual's well-being.

● (1550)

Professional schools across Canada need to recognize that the lack of training on issues related to sexual minority health has further marginalized them and has led to their being in situations of greater health risk.

I want to invoke an example from Quebec. For the last 20 years in Quebec, the Ministry of Health and Social Services has funded a training program on gender and sexual diversity. That training program, which I co-authored and am one of the trainers in, has trained 40,000 people. That program has had a huge impact on those who have followed it in terms of the services provided and the comfort level dealing with clients and patients from gender and sexual minorities.

I will stop there. I thank you for the opportunity to address you.

The Vice-Chair (Ms. Marilyn Gladu): Thank you.

We'll go now to Brook Biggin and Jeff Chalifoux, who will be sharing their time.

Mr. Brook Biggin (Founder, Edmonton Men's Health Collective): Hello. On behalf of the EMHC, thank you for addressing this important issue and for inviting us to participate. To provide context for my remarks, in addition to my role with the EMHC, I am co-chair of Alberta's sexually transmitted and blood-borne infections strategy and a national director with the Community-Based Research Centre.

I must admit to the committee that I never really planned to do this type of work. At four, I wanted to be a paleontologist. At 12, I'm pretty sure I just wanted to be Shania Twain. I believed I could be anything, but at the age of 23, when I was diagnosed with HIV, those possibilities no longer seemed endless. I'll never know for certain if I would be HIV-positive if I weren't gay, but I do know that as a gay man, I was 131 times more likely to be infected than my straight counterparts were. As long as Canada has been a country, its queer people have had to start from several steps behind the rest. Whereas others have had the opportunity to thrive, so often we've had to fight to simply stay alive.

Inspired by early HIV activism, the EMHC was founded in response to the extreme health disparities facing our community and the lack of an effective response from the institutions tasked with our well-being. In just three years, the EMHC has grown from an informal gathering of community members in a living room—over a cheap case of beer, because we had no money—to a robust organization with a budget of $250,000, staff and a variety of innovative strategies that address the unique needs of our community. This is despite the fact that up until a few months ago, all of our work was 100% volunteer-powered, with many of our efforts requiring us to circumvent the health system instead of being supported by it.

As I look back on the early figures who inspired our work, I think perhaps they too did not plan to do this work, but they instead selflessly answered the call to serve those they loved, their communities and their country. The impact of their service is apparent throughout every part of Canadian society, not least in the lives they have saved, including the nearly 70,000 people living with HIV in this country who will live and not die, because of their contributions. I am one of them.

Today this committee has the opportunity to honour that legacy and to ensure that someone's sexual orientation or gender identity doesn't require them to start life at a disadvantage, compromise their health or limit their possibilities. This study is not business as usual. It's the righting of an injustice that has robbed us of countless lives and reduced the quality of so many others.

While we agree with many recommendations before this committee, we recognize the challenge of trying to address every issue that has been raised. We will reinforce four that we believe could have significant structural and sustained impact.

One, though there are many ways in which quality of life is reduced for queer people in this country, for some people these issues are particularly urgent. This is especially so for trans and gender-diverse Canadians, many of whom experience significant barriers to gender-affirming care, such as hormone therapy or gender-affirming surgeries—care that will not simply improve their lives but in some cases save them. We urge the committee to take comprehensive action, working with all levels of government, to ensure that transpeople across Canada have equitable access to gender-affirming care regardless of where they reside or their financial means.

Two, while we acknowledge the government's current investment in queer health, detailed in several submitted briefs, one glance at the extreme disparities shared with this committee shows us that in terms of both scale and application, the current investment is insufficient. We recommend the establishment of queer-specific funding streams within any department that addresses issues that disproportionately impact the health of queer communities.

Three, deficits in queer medical knowledge and cultural competency amongst health care providers remain primary barriers to queer health access, resulting in many individuals either not disclosing their sexual or gender minority status or delaying access to care. We recommend that the government invest funds in and work with all relevant stakeholders to ensure that health care providers are adequately trained to provide knowledgeable and culturally competent care to sexual and gender minority individuals across this country.

Four, much of our work involves the correction of existing systems that fail to address our needs. However, with the government's new commitment to move forward on three foundational elements of a national pharmacare plan, we have the opportunity to get it right from the beginning. As the government moves forward, it must engage experts in queer health to ensure that our unique needs are addressed, including access to HIV medication for treatment and prevention, HPV immunization and access to hormone therapy.

● (1555)

To conclude, once again I'd like to thank the committee for having us and we are happy to answer any questions you have.

I will now pass it over to Jeff Chalifoux, harm reduction coordinator at the EMHC and co-chair of Edmonton's 2 Spirit Society.

Mr. Jeff Chalifoux (Coordinator, Harm Reduction Program, Edmonton Men's Health Collective): Thanks, Brook.

Tansi. Hello.

Thank you for this opportunity to discuss the health and wellness of our communities. Specifically, on behalf of the Edmonton 2 Spirit Society and other two-spirits across Turtle Island, I wish to thank you.

I am co-chair and one of the founders of the Edmonton 2 Spirit Society, which is a grassroots organization providing safe spaces and supports for two-spirits in the Edmonton area and delivering education to the community at large. I am also a delegate of the International Council of Two Spirit Societies and a member of the Alberta College of Social Workers' sexual and gender diversity committee as an indigenous social worker. I come here as a storyteller to share the importance of identity and culture, which will give you some personal insights into how history and current events are affecting two-spirits.

You have already heard a lot about the disparities faced by the LGBTIQ and the two-spirit community like homelessness, vulnerability, stigma and discrimination; inequalities around access to health care, employment, income and social supports; higher rates of mental illness, suicide, HIV/STBBIs and a plethora of other issues faced specifically by two-spirits; and, as you're well aware, the overrepresentation of indigenous communities in terms of other socio-economic concerns.

I could share statistics and research with you around two-spirit health as well as the challenges and barriers endured by two-spirits, but it would never offer you a true picture. You see, the tradition of two-spirits had nearly been eradicated with colonization, residential schools and the current systems in place for indigenous peoples. I need not recount the treatment and traumas here, but we can at least honour and recognize our history and what we learned during the Truth and Reconciliation Commission.

Two-spirits was once a culture revered and honoured, which held traditional roles such as medicine keepers, care givers and healers. The language and oral history were almost forgotten, and some lost forever. In some tribes like the Plains Cree and Blackfoot, there are seven recognized gender roles, and many tribes across North America understood that it was forbidden to interfere with an individual's expression.

Therefore, traditionally, all genders were respected. Europeans didn't understand our culture, actively condemned two-spirit people, left us out of history and further went on to set up systems designed to eradicate the culture. There began a heteronormative, cis-normative, gender binary. An example was the introduction of gendered spaces in residential schools where children were actively separated according to their genitalia.

Most important to discuss today are the impacts for two-spirits. To do this, I am going to share a bit of my own story. I am two-spirit. I'm a father and I'm a social worker. I have lived those disparities you've been hearing of. I've overdosed many times. I've attempted suicide, self-harmed and I live with ADHD, anxiety and disabilities, and have endured through things no one need ever face.

I was a youth in group homes and I went on to live through over 12 years in Canadian correctional systems, nearly five of those in solitary confinement alone. I either lived homeless on the streets of Edmonton or I was in prison. The first needle I put in my arm was with methamphetamines at age 13. At a time when hormones were high and puberty just beginning, when I should have been exploring my sexuality, instead I was repressing it.

I should have just been a kid at that time, but I wasn't able to because I was lost, confused and I didn't have the traditional knowledge and teachings. I never knew about my culture because, in my family, our indigenous roots were eradicated. I matured into my two-spirit self at 35 years old after nearly 25 years of severe substance abuse. I am now four years clean and sober and about to embark on graduate studies in social work. I walk the red road as a traditional two-spirit helper. I am also an attuned father to a five-year-old son who we raise free of the barriers I faced. My common-law husband and I raise our son with my wife, his mother. We are in each other's homes, we all love and care about each other and we live free from shame and guilt.

My story is not unique. Time and time again I sit with indigenous youth to talk about things no one ever talked to me about. Sexuality and sexual health, substance use and mental health are a huge part of those conversations.

One youth told me that when he was 12, he told his foster mom that he had started kissing other boys. He got a licking, he got grounded and he got his electronics taken away. Another guy shared that he was kicked out of his house and shunned from the reserve. He moved to Edmonton and soon began doing drugs and survival sex with other men. There are many two-spirits who are lost and simply just trying to exist.

You heard from Brook that I am the harm reduction program coordinator with EMHC, and I am lucky and honoured to make my past experiences an asset to those I help today.

● (1600)

I wish to note that EMHC fully recognizes and supports two-spirits. It's my hope that the Canadian government will do the same by reconciling the disparities two-spirits endure in the present day by actively engaging in circles and discussions with two-spirit leaders and elders. Finding ways to effectively address the disparities and to fund practical ways that are rooted in culture and guided by two-spirits will aid in our survival. Events such as two-spirit powwows, two-spirit gatherings and education in first nations are some things that would certainly help.

I wish to thank you for the opportunity to share today. I'm honoured to answer any questions you may have.

The Vice-Chair (Ms. Marilyn Gladu): Thanks so much.

Now we're going to go to Arthur Miller, from Healing Our Nations.

Mr. Arthur Miller (Community Health Educator, Healing Our Nations): Thank you.

I'd like to thank the committee chair and members for inviting me to speak today on LGBTQ2 health in Canada. I'd like to focus on indigenous LGBTQ2 health in Canada.

I'd like to begin by acknowledging the traditional unceded territory of the Algonquin Anishinabe people.

My name is Arthur Miller. I work with Healing Our Nations as a community health educator. We're a non-profit organization. We work in 33 first nation communities in Atlantic Canada in sexual health. It started with HIV, when we saw a need. We saw that our people were dying of AIDS. We started a task force that progressed over the years. Now, we educate on really anything that people need in their communities to live a healthy and happy life. We have different workshops on setting boundaries and on LGBTQ youth.

We do a lot of work with the youth in Atlantic Canada. We have a youth and elder gathering every year, in which we bring in about 10 LGBT indigenous youth to a gathering. We do sexual health 101. There's ceremony, and there are drumming, naming ceremonies, medicine walks and, most important, time spent in getting to know elders. Elders carry the knowledge of where we've come from and the youth will carry it on to where we're going.

This gathering has proven through testimony that indigenous LGBTQ people have gained knowledge, confidence and self-peace. Some expressed that they weren't connected to their culture but that after attending the gathering felt that there was a missing link that was replaced. It's difficult to live your life if you don't know parts of who you are. Culture is very important because it brings balance, and balance contributes to better health.

We have an APHA peer mentoring project, which reaches out to indigenous people who are newly diagnosed with HIV or affected by HIV. We see a really big need for more peer mentors. There's great value in people sharing their experiences with others who may be going through the same thing. For instance, in a community in New Brunswick, we've had youth attend our workshop who are now carrying out sexual health workshops with their peers.

This work is very important to me. I am an indigenous person living with HIV, and I saw a need for better services or more services that were specific to indigenous people.

One of the biggest challenges we see is layered stigma and discrimination. Not only do we see stigma and discrimination because people are indigenous, but we see it also because they're from the LGBTQ community and, on top of that, there may be a diagnosis of HIV or hepatitis C. Added to that is the lack of cultural competency in non-indigenous services. It's hard for some to take the step to speak to their doctors regarding LGBTQ issues for fear of discrimination, but also, at the same time, it's difficult having to explain who they are and the differences they have compared with non-indigenous people.

The knowledge of indigenous people needs to start at the top. We've made progress in educating others through cultural competency training, but we really should look at making cultural competency training a requirement in our health care services. I work closely with all of the infectious disease doctors in Atlantic Canada, and thankfully, over the years, I've been able to educate around first nations culture; however, this was done at their own will. In addition, a point was brought forward from one of our specialists, who said that they receive little to no information on transgender people.

● (1605)

Many front-line services understand little about indigenous people, which makes it a barrier, then, to treat them and move forward. It's frustrating not only for the patients, but for the professionals too. It's very difficult for many because their health care centres in rural areas don't have the same services and supports as urban areas. One of the issues is that they have to travel to larger cities to receive treatment that they should be able to access in their own communities.

The concern here, for example, is that a person can now get tested for HIV or hepatitis C within their community at their health care centres. We have very high rates among our LGBTQ community. But what happens is, should they test positive for HIV or hepatitis C, they are then referred to a larger facility that, in some cases, can be hours away. We're losing people between diagnosis and showing up for their first specialist appointments. There needs to be more connections and knowledge shared between community health nurses and the specialists. People don't know what they are to expect and, therefore, many times do not make follow-up appointments, which causes a decline in health, causing other health issues.

In Nova Scotia and other provinces, we're lacking family doctors. The concern is that LGBTQ2 people are forced to visit walk-in clinics. They are not comfortable doing so because there is no doctor-patient relationship. On the other hand, if they should be so lucky as to have a family doctor, they have to deal with enforced shortness of visits.

I had a colleague mention that elderly people have concerns that they may have to go back into the closet when they give up fully independent living due to possible homophobia. People want LGBTQ2 elderly assisted and co-housing. We need to work more on normalizing LGBTQ2 and help include them in everything.

Sexual health education—for LGBTQ, rather than just heterosexual health—and additionally, health centres, need to be diverse in gender diversity so that supports are in place if Healing Our Nations is not available to provide education. Also, education shouldn't be limited to just teens in schools. We need to understand that the coming-out process is different at any age.

In closing, we need to build up LGBTQ people and help them be proud of who they are and what they can contribute.

Thank you.

● (1610)

The Vice-Chair (Ms. Marilyn Gladu): Thank you.

Now we'll go to Darren Ho, the founder of Our City of Colours, for 10 minutes.

Mr. Darren Ho (Founder, Our City of Colours): Good afternoon, vice-chairs and members of the standing committee.

I am Darren Ho, a gay may from the unceded Coast Salish territories of the Musqueam, Tsleil-Waututh, and Squamish peoples, also known as Vancouver. I founded an organization called Our City of Colours, an initiative that aimed to increase the visibility of LGBTQ people from under-represented and underserved cultural and linguistic communities.

Like Brook, I currently work for the Community-Based Research Centre, or CBRC, the executive director of which, Jody Jollimore, you heard from a couple of sessions ago. CBRC uses research and intervention development to promote the health of queer men.

In my statement, I will be using the acronym QPOC to refer to queer people of colour, a group I identify as being a part of, being both gay and of Chinese-Asian descent. I use “queer” as an umbrella term to refer to those of us who are sexual and gender minorities, including gay, lesbian, bisexual and trans people.

The importance of intersectionality has been brought up in some previous sessions, but I want to reiterate that viewing health and shaping policies through an intersectional lens is very important for QPOC communities. Oftentimes in racialized communities, our queerness is erased, and in queer communities, our racialized identities are not welcomed.

It's a common experience amongst my peers that we have to hide our sexuality in our cultural communities—for me specifically, the Chinese community. Meanwhile, in queer communities, we face microagressions, discrimination and racism. Understanding intersectionality is crucial when serving queer people of colour.

I want to tell a story about me in the mid-2000s. Imagine me at 18 years old, which I like to think is still how I look now. I was 18 years old, growing up in Coquitlam, B.C. I had just had my first sexual experience with another guy. I went to my family doctor a couple of days afterwards because I was really worried. I hadn't learned anything yet about testing window periods, so I thought I had to be tested for STIs right away. I told my doctor that I had had sex with a guy. To this day, I remember his response, which was to ask two questions: one, had I used a condom, and two, whether my parents knew.

Both questions he asked me were very accusatory and judgmental. My parents did not know that I was gay, and I was worried that even with policies around doctor-patient confidentiality, he would accidentally or intentionally out me to my parents, because he was the doctor for everyone in my family. I felt anxious and worried that all of this would get back to my parents. That was the last time I visited my family doctor.

My point is that this one interaction is all it took to turn me off of seeing a family doctor for over 10 years. This happened when I was 18, and I'm now 30 years old. I only got a family doctor a few months ago.

I also tell the story being conscious of the statistic that if we as gay men are not out to our doctor, we are 10 times less likely to be tested for HIV. Recent studies have looked at how many queer men of colour are out to their primary care providers, with estimates ranging from as high as about 70% to as low as about 24% in some queer men of colour communities.

Regardless of what this number is, the reality is that many members of the QPOC community face a number of barriers in being open about their sexuality. Homosexuality is still very stigmatized in many of our communities. As young gay men, we are often told a narrative that once we come out to others about our sexuality, a world of opportunity to live openly and happily will be available to us. This is true, but not for all of us and not all of the time. It's not always better to come out. For many of us, coming out in our communities can bring feelings of acceptance, but it can also lead to feelings of anxiety, being rejected or even being forced back into the closet. When these realities feel more likely than the supposed promised world of opportunity, the decision to not come out feels compelling.

I'm not advocating that we shouldn't come out to folks like our health care professionals. I'm asking us to reconsider what we think about people who are not out to their families, friends or communities, and then to take that reconsideration to shaping better health care spaces. Confidential and anonymous sexual health options are crucial for the health of many in our community. However, just as important are health care providers who have the competency and training to create environments where LBGTQ patients can feel safe to disclose their sexuality when they feel like it.

My first recommendation is for the federal government to ensure that health care professionals receive comprehensive intersectional education and training to provide health care that accounts for the intricacies of patients from QPOC communities. Working, volunteering and navigating through gay men's health, I've learned that race is a social determinant of health, as is being a sexual minority. The conclusion is, of course, that those of us who are marginalized because we are a racial minority face further marginalization because of this intersection. Bill also just talked about this.

Earlier, you heard from Travis Salway, a post-doctoral research fellow from UBC's school of population and public health. Salway so eloquently explained that minority stress is the cumulative stress experienced due to our minority status. Minority stress is a factor that contributes to health disparities experienced by sexual and gender minorities, and we also know that queer people of colour, being members of multiple minority groups, experience minority stress at higher levels and are more likely to face experiences of discrimination and stigmatization.

● (1615)

We also know through research that minority stress compounded by race-related factors increases vulnerability to mental health challenges and HIV risk. Mental wellness is a critical health care issue for queer men, particularly anxiety for south Asian, east Asian and southeast Asian men, as well as depression for African, Caribbean and black men. I recommend that the federal government invest in targeted intersectional health promotion programs for different communities of queer people of colour.

Closely intertwined with QPOC communities are communities of queer immigrants and newcomers. Accessing health care as a queer individual has its own barriers, and this is more difficult when English or French is not our first language. Many of us who are queer and from backgrounds of racial minorities know of the disconnect often found between our sexuality and our culture. Some of us may not even know how to say the word “gay” in our mother tongues, simply because this word doesn't exist, because our culture never taught it to us, or maybe because colonialism has erased those teachings.

Many leaders in QPOC communities are working hard to advocate against the notion that queerness is only a concept of the western world, against the notion that homosexuality and queer identities only exist in other people's cultures. However, these ideas are reinforced when we only see sexual health information and queer-positive messaging in English and French.

I would like to recommend that the federal government explore options to make health care accessible and available in more linguistic communities that represent our growing populations. Related to that, in consideration of queer newcomers, it is vital to see a greater effort of including queer resources in settlement support services. That would be a very tangible example of an intersectional program.

Another story I want to share comes from working in HIV prevention. In doing this work, I've learned that health promotion strategies work best when enacted by local communities and supported by the federal government.

Today, in 2019, it's becoming more known that the HIV prevention tool pre-exposure prophylaxis or PrEP is covered in most Canadian provinces. However, where this messaging got lost was that PrEP had actually been available free of cost to first nations and Inuit people since 2013. All first nations people living in B.C. receiving benefits through the First Nations Health Authority could access free PrEP, and Inuit people in B.C. and nationwide could access free PrEP through their non-insured health benefits.

We knew that PrEP was an effective HIV prevention tool as early as 2012. In the five years between 2013 and 2018, only 13 first nations people in B.C. were accessing this free drug—only 13. Once PrEP became available to the general population in B.C. over 3,000 people were prescribed PrEP in that one year. Again, in the five years that PrEP was available in B.C. to first nations and Inuit people, we only got 13 people on PrEP. Please consider the number of first nations and Inuit people who contracted HIV during this time because of a lack of awareness of this drug. Somewhere along the way, health promotion messaging on this important prevention tool got lost for a very large community in Canada.

So that missed opportunities like this do not happen again, I recommend that when shaping health policies, programs and research, the federal government ensure equity across ethnocultural and indigenous communities.

Finally, since QPOC face barriers to being visible, I often get asked the question, “How many queer people of colour are there in *x* geographical population, according to research?” and then, by extension, “How many immigrants and newcomers identify as LGBTQ2S?”

I do not have those numbers with me today, but even if I did, I would like to remind us that QPOC and indigenous people have historically been under-represented in research. Engaging people of colour in research has often been cited as a limitation to research studies, and this difficulty of engagement stems from the history of research as a colonial tool, as well as the lack of accessibility and representation of people of colour in research conducting research. This is why I want to recommend that the federal government explore innovative research tools, leverage existing research tools and work collaboratively with communities to gain more data beyond quantitative data on QPOC and indigenous peoples.

Thank you for your time. It was a privilege and an honour to speak to this committee.

● (1620)

The Vice-Chair (Ms. Marilyn Gladu): Thank you so much.

Now we're going to begin our rounds of questions, and we're going to start with seven minutes for Mr. McKinnon.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): Thank you, Chair.

Thank you all for being here.

This is the last meeting with witnesses we're having on this study. We've heard quite a number of witnesses and we've heard from a lot of people from a great many different intersectionalities and heard of the kinds of issues, concerns and problems they've had and continue to have in trying to live in a predominantly gender binary and heteronormative world.

I'm going to take a risk here and try to abstract out of all this testimony what I see as a common theme. The common theme, the fundamental problem I'm seeing here, is a problem of acceptance: both by the individuals themselves sometimes, as well as the society in which we live. I think that leads to stress, stigma, fear, discrimination and all those sorts of things. I believe you've all touched on this as well.

It stems from a lack of awareness and a lack of understanding and education. Many of you have spoken about the need for training for different professionals and so forth. Could you weigh in with your thoughts on whether this really is a fundamental problem that we can address out of this study.

Ms. Daley, please start.

Prof. Andrea Daley: Just for clarification purposes, are you suggesting training and education are fundamental pieces?

Mr. Ron McKinnon: I'm saying that acceptance in general, whether of one's own circumstance or how one fits into the society—and the society itself accepting people who are different from what they expect, from the heteronormative gender binary kind of thing—leads to all these other outcomes.

I'm asking if you would agree if that is a fundamental problem that we need to address and how we might address it. I believe you've all touched on this. Do we address it with education, awareness campaigns and so on? That's what I'm driving at, if you would like to weigh in on this.

Prof. Andrea Daley: Sure.

I think there has been an advancement of rights for LGBTQ people in Canada. However, I'm not convinced that gaining rights has been hugely successful in changing attitudes, beliefs and values. In some ways, yes, but in other ways, no. We still see deeply held homophobic, transphobic, biphobic, lesbophobic beliefs and attitudes day to day. I hear it in the classroom when I'm teaching university students in third year, sometimes fourth year, sometimes in a graduate class. I'm still hearing homophobia, biphobia, transphobia, after four years of post-secondary education, understanding the rights that have been gained for LGBTQ communities in Canada.

I think it is a fundamental issue and it's a critical question: How is it that we can engage, not just once students reach post-secondary education, but way before that to start being able to shift attitudes and beliefs? I think Bill speaks to that in the letter he read from the young man who contacted him. It's incredibly prevalent in our schools, in our institutions.

Mr. Ron McKinnon: Bill, would you like to weigh in on this?

Prof. Bill Ryan: Yes. One of the things that I've noticed.... I finished my academic training in 1988, and I think in the 1980s and previous to that, after we started questioning ourselves around sexual minorities and gender minorities and looking at deconstructing many of the things that we'd learned, what happened in university and college training programs was that we just stopped talking about it.

The pathologization of gender and sexual minorities, in terms of explicit content, may have ended. We stopped talking about people as being mentally ill and needing treatments and those kinds of things, but then it was just total silence. I have a foot in training students and I also have a foot in training professionals who have finished their studies years ago, and what I notice is that an awful lot of the content dealing with sexual and gender minorities is optional. It's not transversely integrated into training programs across the board, and there's no guarantee that you can finish studies in health or social sciences in this country and have adequate information given to you during your basic training, unless you went and looked for it yourself in other courses or other programs offered across the university.

There are people who come and take classes that I give at McGill because in their own universities they can't find anything, so they get permission to take a class at another university because there's something being mentioned about gender and sexual minorities. I deal with students who are taking.... I teach optional courses because I teach courses on gender and sexual minorities, and hopefully, at some point that content will be integrated across the board into all classes. It's not the case yet.

Then I meet people who finish their training five or six.... Just Tuesday, actually, I was in the Lanaudière region of Quebec, and one of the people following a course that I was giving for the Quebec ministry of health and social services on this issue had finished her training two years ago, and she said, “I got nothing. I got absolutely nothing.” Other people who had finished 20 or 30 years ago were still trying to figure out if electric shock treatments were still being used or if people should be referred to psychiatrists for potential treatment. We have all of this happening out there in a kind of void of adequate information.

I think the recommendation that you've heard many times, I'm sure—and you heard today—is that somehow we have to put our finger on the scale around accreditation services for programs and around professional associations about accreditation, so that people start to have adequate information. What this translates to is the doctor who says to a trans person, “I can't treat your cut because I don't know anything about trans people”, and ultimately, all that—

● (1625)

Mr. Ron McKinnon: I'm sorry, I'm going to have to cut you off here.

The Vice-Chair (Ms. Marilyn Gladu): You're actually out of time.

Mr. Ron McKinnon: Can I sneak in a quick one? I'm going to discriminate here and I'm going to leap to my Coquitlam friend. Perhaps you can very quickly weigh in.

Mr. Darren Ho: Thank you for the time.

Yes, I do agree that acceptance is an issue, but I also think that, if we continue to work, regardless of whether all Canadians accept queer people, we can still make progress. We don't have to focus on acceptance as the first issue. That's something that will just work itself out as we continue to do queer-positive messaging.

Mr. Ron McKinnon: Thank you.

The Vice-Chair (Ms. Marilyn Gladu): Very good.

Now we'll go to Mr. Webber for seven minutes.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Madam Chair.

Thank you, everyone, for being here today and sharing your stories.

Mr. Chalifoux, I was very impressed with you and the fact that you are sober now for four-plus years. I congratulate you on that. Keep being strong.

Mr. Jeff Chalifoux: Thank you.

Mr. Len Webber: I want to address my first question to Professor Daley and Bill Ryan, two people from universities.

I received a briefing document from Health Canada, the Canadian Institutes of Health Research. It talks about government funding and funding in different areas. It has an annual budget of approximately $1 billion. Through its institute of gender and health, the Canadian Institutes of Health Research fosters research that explores how sex and gender influence health. Its strategic plan identifies research on the health and wellness of individuals who identify as LGBTQI2S as one of its key priorities.

I read about some of the research investments that it is doing. It has $11.7 million going into generating new knowledge and evidence that leads to better health outcomes and improved quality of care for LGBTQI2S Canadians. It has $500,000 for a team of researchers developing interventions for the prevention of human HIV infections among MSM and $750,000 in research for improved screening and treatment of serious cancers caused by HPV.

There is another $21 million for HIV/AIDS research, an annual amount of money to support research and trainees; $3 million for research to address the persistent health gaps faced by LGBT adolescents in Canada; $1.3 million for research on health outcomes of transgender youth undergoing clinical care; and $2.3 million for women's reproductive health in HIV. It just goes on.

Professor Daley, you mentioned that one of your recommendations, of course, is sufficient funding. I am just curious. Can you elaborate on that? Sufficient funding in what areas, and what do you think it should be?

● (1630)

Prof. Andrea Daley: In terms of my recommendation, it was about how to bring the information and knowledge we have into the curriculum. How do we develop a curriculum in a way that isn't just about imparting knowledge but also transforming people's beliefs, attitudes and ideas?

While there may be research being done, I'm not sure that all HIV/AIDS research is focused on queer and trans communities, HPV, women's reproduction and HIV.

The institute of gender and health takes a gender-based lens to the research process, so it's not always LGBTQ-related, even though people might make the assumption around HIV that it's related to LGBTQ communities. That's not always the case.

My main point is this: How do we take what we do know and move it into developing a curriculum that is robust, that is integrated, that is consistent and comprehensive, so that people aren't getting one-offs? Is today the day we lecture on LGBTQ people in social work, nursing, medicine, psychiatry or whatever that is?

What people are getting access to in professional health programs is very limited. It may actually be inadvertently reproducing stereotypes. When we talk about LGBTQ people in social work, we may talk about HIV or depression.

When we do see some of these pieces being brought into the curriculum, it's often, what I call, in a problem framework. It's always reproducing LGBTQ lives as problematic and pathological in some kind of way. We need to take the knowledge that's related to LGBTQ health, that's related to LGBTQ health services and LGBTQ lives, and create a robust curriculum across health professions, so there is a comprehensive, integrated approach to it.

Can I make one quick point as well?

Mr. Len Webber: Absolutely, yes.

Prof. Andrea Daley: We can't leave the humanities and social sciences out of this. Equity studies, women and gender studies are the places where nurses, social workers and physicians will get access to much more theoretically rich and engaged discussions around sexuality and gender.

Mr. Len Webber: On that note too, Mr. Ryan, you indicate you teach courses at McGill. Which faculty?

Prof. Bill Ryan: I teach in three programs: the social work program, the couple and family therapy program and in an MBA program in international medical health. In all of those I teach around gender and sexual diversity.

I agree absolutely with everything that's just been said. One of the things I want to mention is that if we didn't have the gender institute at CIHR, we would have nothing. I'm one of those who remembers before, where we could not get funding for any research on sexual and gender minorities except the disease model around HIV, which was important and necessary but it was very limited. The gender institute has opened doors. We're catching up with a lot of research.

There was a time when we could put all the researchers in Canada doing research on this issue around that table. The gender institute has allowed us to expand. We have to get to the point where all studies that look at anything related to human life conditions include sexual and gender minorities. We don't necessarily have to always have specific studies, but those specific studies are filling in pieces that we missed historically for generations.

● (1635)

The Vice-Chair (Ms. Marilyn Gladu): That's your time.

Now we'll go to Mr. Davies for seven minutes.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Madam Chair.

Thank you to all the witnesses for powerful and very helpful testimony.

Brook, I know you've commented publicly about the benefits of PrEP. I think Alberta did a great job in making that available. I was going to ask if that should be covered for all Canadians, but I think I know the answer. We do.

In our last meeting, we found out that HIV self-test kits are available in certain countries in the world, like in the U.K. where you can mail them in. It's delivered to your mailbox. This would be particularly helpful for people who want to test in confidence in rural small towns or places where they don't feel comfortable going to a professional who might know them.

Do you have any thoughts to give this committee on whether Canada should be pursuing those kits?

Mr. Brook Biggin: Yes, for sure. A written brief submitted by the Community-Based Research Centre provides very specific recommendations around that.

I'm not sure if you're familiar with the concept of 90-90-90, but essentially back in 2014, UNAIDS recognized that when people had a suppressed viral load they couldn't transmit the virus to others. Essentially it said that one way we could end the epidemic by 2030 is to get 90% of people who are living with HIV diagnosed, 90% of those diagnosed on treatment and 90% of those on treatment to have a suppressed or undetectable viral load. The last data I was able to see from the Public Health Agency of Canada was up to the end of 2016. They found that 86% of those who were living with HIV were diagnosed, 81% of those diagnosed were on treatment and 91% on treatment had an undetectable viral load.

We see that people living with HIV are doing their job, when they can get diagnosed and on treatment and hit their target four years early, before 2030 when we're supposed to hit 90-90-90. However, we're seeing that in the health system, the two 90s that it's most responsible for, is where we're falling short. Of course, one of them is related to diagnostics. You've heard from multiple witnesses, both through written briefs and oral presentations, about the need to catch up with testing. It's true. I believe Jody Jollimore mentioned that one of these tests is manufactured in B.C., and we can't get it.

Mr. Don Davies: It's in Richmond.

Mr. Brook Biggin: There's been a lot of energy on the ground both in CBRC's and the EMHC's research. The community is ready for it. When you look through the types of testing they would prefer, you have to get down to the third or fourth preference before something is available.

The community is hungry. We know it works in other high-income countries. I think that people on the ground and throughout different provinces are wondering why it's taking us so long to catch up. Definitely home-based testing, different types of point of care testing, we are all for it. We should do it. It works. Why not?

Mr. Don Davies: Thank you.

Darren, I'm from Vancouver. In the Lower Mainland of B.C. we enjoy living in, I think, one of the most multicultural communities in the country. I'm aware of the different cultural and developmental sensitivities in sexual minority and gender diverse communities.

In your view, what types of tools or services or supports would be helpful to promote discussion of these issues within ethnic and racial and linguistic minority families or communities?

Mr. Darren Ho: A lot of these discussions have to happen, as you say, within ethno-racial and racialized communities. One thing that's missing, however, is support from our allies on how to get these conversations going, like space and time and staff and all of these things. There is often a misconception that these conversations have to happen more in racialized communities, because maybe racialized communities are more homophobic or transphobic or against queer rights.

It's also important to recognize that homophobia and transphobia exist across all identities and races and cultures, but maybe in some parts of Canada we see more homophobia and transphobia in certain groups due to the media or due to giving people more platforms. I would say to continue the work of having these conversations in all communities and eventually it will trickle down to people of coloured communities.

Mr. Don Davies: Thank you.

Jeff, first of all, thanks for sharing your powerful story with us. I have to admit my ignorance. When I first started the study, I thought “two-spirited” was an indigenous word for being gay. Through this study I have learned that it's actually a much more complex concept that varies among different nations across the country. I am curious to know what your definition of “two-spirit” would be.

● (1640)

Mr. Jeff Chalifoux: The term “two-spirit” was created in 1990 in Winnipeg at a two-spirit gathering as an umbrella term used by first nations across Turtle Island, many of whom had different gender terms and up to seven gender titles. When it comes to 2S, the concept at that time was that 2S held both the male and female spirit within them, and that correlated with those along the LGBTQI spectrum in those identifying factors.

For me, two-spirits are those who transcend the boundary set by the binary, and the role of two-spirits is to sort of.... It's really difficult because at that gathering in Winnipeg they came up with that term and it's been discussed a lot among indigenous nations and among two-spirit organizations and individuals. Oftentimes there are those who don't feel as if they hold the male and female spirit, or the masculine and feminine spirit, and that just speaks to the different nations and languages and traditions that have been happening among the tribes.

It's hard to really give a definition. For each individual, it's quite different. For me, growing up, I always believed that how I wanted to live is the life that I have now, being able to be a father, to engage in romantic relationships with whomever I chose, and to have the kind of union and family unit I have now in the community surrounding my son. It wasn't something that I had growing up.

The Vice-Chair (Ms. Marilyn Gladu): All right, we're going now to Ms. Sidhu.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Madam Chair.

Thank you to all the panellists for being here. It really helps us to create a good report.

When I was listening to all the panellists, one big thing comes up —intersectional education. We need that. For this type of education, there are four categories: health care providers, teachers, parents and youth. For health care providers, can each of you tell me how we can educate heath care providers, teachers and parents? I'm a parent of three teens.

Thank you, Jeff, for sharing your story.

How can parents know that? I have a son and we don't discuss sexual relationships. How can one parent know what his son or daughter is going through?

Mr. Darren Ho: That's a great question. I definitely think that if we allow this, or if we give space for our parents to ask these questions of their children, and for their children to explain their understanding of themselves to their parents, those would be much more fruitful conversations than any instructional or educational thing I could come up with right now.

Ms. Sonia Sidhu: Are there any educational webinars, or anything else we can learn from? Mostly, in ethnic communities—I'm not talking about me—they don't talk about that relationship. What other tools can they use?

Anyone can answer.

Prof. Bill Ryan: What comes to mind quickly is that we have opportunities where health care professionals and educators meet with parents, either in a health context or in something like prenatal courses. To me, prenatal courses are really rich places, where some subjects can be brought up that might be new to some parents. I would like to think that some day, in prenatal courses, someone asks, “What would happen if in 12 or 13 years, or maybe five or six years, your child came home and said, 'Mom, dad, I have something I need to talk to you about'?” I think if we ask that question before it happens, we're already starting to decide what our response might be.

I think all of us would agree, generally speaking, that most parents love their children and want what's best for their children. Most parents are just not always well equipped to respond, because they don't have the information. In instances like that, we can do it through campaigns. Quebec had a TV campaign against homophobia and transphobia that went into every living room in the province during popular television shows. Those kinds of things start us asking questions we might answer before a certain percentage of parents have a child who comes home and says, “Mom, dad, I have something I have to tell you.”

● (1645)

Ms. Sonia Sidhu: Thank you.

Ms. Daley, you are working on the LGBTQ2 home-care access project. In your view, is there a need for separate LGBTQ long-term care facilities?

Prof. Andrea Daley: I think other people on the panel may have some views on this, as well.

I have one point of clarification. The home-care project focused on in-home care. Residential facilities would be considered in-home, although we didn't include them in our study, because we felt they were different, in terms of the institutional context.

I believe in a multipronged approach and that existing long-term care facilities need to think about access and equity, and access and equity frameworks that explicitly address LGBTQ2 people moving into those spaces. I also feel there is perhaps a need for separate places for people to live, at this point. Many of the facilities aren't looking at LGBTQ policies and practices.

Tamara Sussman, from the McGill University school of social work, did what I would consider to be a bit of a scoping review. I was part of that work, more marginally. They called a number of different long-term care facilities—and you'll have to excuse me, I can't remember right now whether it was in Quebec or beyond—to ask about the policies they have related to older LGBTQ people moving into those spaces. I don't think there was one institution that had a policy, so in the absence of existing institutions expanding their ideas around access and equity, I think separate spaces are probably very much needed.

Other people probably have some ideas around that, as well.

Prof. Bill Ryan: I've been involved in elder care research for awhile, and there are two models. The American model is a private system, and you pay for yourselves. All kinds of communities have developed their own services, but to be honest with you, when I get to need elder care, I'm going to say, “I paid taxes all my life for public services, and I want public services to be adapted to my needs.” I shouldn't have to pay $10,000 more a month for a service that respects me and is adapted to me, after I've paid, like my neighbours have, my entire life for these services to be provided to me. I think there's a debate within the community about that.

I come from Montreal, which has elder care facilities where the language is Italian, the TV is in Italian and the cuisine is Italian. Some people might prefer that, but other people don't want to be put in those kinds of closets again. They want to be out there as they live their lives, with the general community. I think we'll see both. Primarily, I think Canadians generally feel that public services should be adapted to us and should be respectful of us. If not, there are human rights commissions that will redress that.

Ms. Sonia Sidhu: Thank you.

The Vice-Chair (Ms. Marilyn Gladu): Very good.

That's the end of our first round. We're going to go into our second round for five minutes.

Mr. Lobb.

Mr. Ben Lobb (Huron—Bruce, CPC): Thanks, Ms. Gladu.

I'm sure our analysts here have all this information, but I'll ask any of you folks here. If you are HIV positive, which provinces will pay for your medication? Do they all pay for it? Do none of them pay for it? To be honest, I'm unsure, and I don't know if anybody else on the committee actually knows this.

Mr. Brook Biggin: I don't have an exact list of provinces, but I can tell you that it does differ. Right now, if you're living with HIV in Canada, if you live in a province like Alberta, you're covered through the provincial public program. If you live in other provinces, like Manitoba or even Ontario, it's not done in that same way. It does definitely place a disproportionate burden on people living with HIV.

That's why one of the recommendations that has come through different people—either through pharmacare or looking at a different mechanism, which I believe the federal government has done around hep C cure drugs—is some sort of mechanism where Health Canada or the Public Health Agency reimburses certain provinces for that. Definitely HIV medication is something that should be looked at—especially for treatment but also for prevention.

● (1650)

Mr. Ben Lobb: Right.

Obviously, this study is talking about health, and we've had a whole bunch of different things and it can all funnel in. The government's looking right now at a pharmacare program. At the end of the day, do you think that should be covered in a pharmacare program, at minimum?

Mr. Brook Biggin: Yes.

Not only because people living with HIV are people who should be cared for, but also it's a good public health strategy. We know that when people living with HIV are undetectable, they do not pass the virus on to others, so wouldn't we want people living with HIV to have access to medication? Do we want to impose financial barriers on them? I don't believe we do. Remember, we say we can effectively end the HIV epidemic in this country by the year 2030 if we take on some of these good public health strategies. We should definitely not be putting barriers in people's way.

Mr. Ben Lobb: To be honest, I can't remember if it's been brought up at other committees or not, but seeing as this is our last meeting, it probably should be put on the record. I can't remember if any of the other people or groups have commented or have been consulted by Dr. Hoskins on that, but we'll probably put that in our committee.

The other thing I want to ask you about is PrEP. I don't know anything about it, but I understand it suppresses and prevents all this. Is it covered? Should it be covered? It sounds like it should be covered. What does the panel think?

Mr. Darren Ho: PrEP is an HIV-prevention drug that's based on ARVs—antiretroviral treatment or HIV medication. We know it's an effective drug and it is covered in most Canadian provinces, such as B.C., Alberta, Ontario, Quebec and some others, I think. I can't think of them off the top of my head.

In all of these provinces, there was huge advocacy that had to happen for PrEP to get covered provincially for each province, and it's still something that has to happen in some provinces and the territories. We know that PrEP is an effective tool, so yes, it should be covered.

Mr. Brook Biggin: You really need a multipronged strategy. There's no magic bullet when it comes to HIV, but if we do PrEP, get people diagnosed and linked to care, make sure they can afford and access their drugs and get their HIV undetectable—if this committee made sure those things in combination were covered—we would end the HIV epidemic.

Mr. Ben Lobb: I have a number of different notes here. Is hormone therapy covered now? I want to make sure that we have a good, broad range of opinion here for the report. I didn't know if anybody had a comment on hormone therapy. Should it or shouldn't it be covered? I don't know.

Prof. Bill Ryan: It depends on the province. As you know, in Quebec we do have pharmacare, so in Quebec it's covered. My understanding is that there are several provinces where it's not covered, or at least the requirements are stricter than in other places in order for it to be covered.

That's certainly something that I think, in terms of health, should be looked at very seriously as something to recommend.

Mr. Ben Lobb: I have one other question, probably on a broader range, on the HPV vaccination. I know two individuals who have ended up getting throat cancer from that. Is that something that your general practitioner should be suggesting or should public health be suggesting it? What should we be doing for HPV?

Mr. Darren Ho: I think that's something I would put on a list of competency training things for health care practitioners. If you're talking to a patient who is a young gay man who has sex with men, you should talk to him about HPV vaccines.

The Vice-Chair (Ms. Marilyn Gladu): That's your time.

Off we go then to Mr. Ayoub for five minutes.

[*Translation*]

Mr. Ramez Ayoub (Thérèse-De Blainville, Lib.): Thank you, Madam Chair.

● (1655)

I will continue by speaking about training, particularly of professionals.

Mr. Ryan, you were in the Lanaudière region of Quebec recently, if I understand correctly.

You mentioned that you had heard about electroshock therapy as a treatment method. I don't want to make a bad pun, but I was a little shocked to hear about electroshock therapy being used as a medical treatment in 2019. In fact, if you, Mr. Ryan, or Ms. Daley, have any information on that, I would like to have it.

Could you give a brief overview of the situation regarding the training professionals already working, who are already in the field and whose training dates back a few years? We know, of course, that they take refresher courses throughout their careers, but what is your assessment of the training situation with regard to the LGBTQ community?

I'd like to hear your opinion, Mr. Ryan, particularly on the issue of the training of professionals already working in Quebec, if you are in a position to do so.

[*English*]

Prof. Bill Ryan: We have a program that is accredited through the Université de Montreal. It's run by the province. It's called “Sexes, genres et orientations sexuelles : comprendre la diversité”.

It's offered free of charge to any health care professionals, community organizations or educational establishments that want to ask for training. It's voluntary, which means that someone is not obliged to take it, and it's voluntary mostly in terms of registration, so the people who come are generally people who want to follow it. One of the problems we have in promoting it is that it's often seen as being soft. Some health care professionals will take training on pharmacology, for example, but they won't agree to take training on sexuality or gender diversity because they see it as being much less important to their practice.

It's a two-day training. Depending on how long ago they were trained, they often come with worries about the notions that they have, knowing or thinking that these notions are incorrect, but they don't know what to replace them with so they just stay silent. They'll often say to people who say they're gay or lesbian or trans, “I don't deal with that. I can't work with that. I don't know anything about it.”

What we try to do is to reassure them that it doesn't take an awful lot of training to become more comfortable with these issues. It's a question of motivation. What we hear back from the community is that people educate their health care professionals. It's hard to educate your professional when you're in a vulnerable situation and when you don't necessarily have all the answers yourself.

It would be really important to make sure that at the college and university level this content is integrated across the board in health and social services, and education.

Mr. Ramez Ayoub: Go ahead, if you want to add something. I maybe want to respond to that.

Prof. Andrea Daley: I want to think about intersectional education and training as well.

In the social work context, we're taking up the calls to action from the Truth and Reconciliation Commission, and part of this is thinking about how we decolonize education.

I have a million thoughts right now, because I think one of the things that happens around sexuality is that our lives get reduced to sex. The whole issue of how we talk to our children about sexuality is loaded because people think only about sex. Our lives are so much more than that. I think when we think about how we train and how we educate health care providers, we have to think through multiple lenses: a decolonial lens and—

● (1700)

Mr. Ramez Ayoub: I'll need to interrupt because I want to ask another question to Mr. Ryan.

Would it be fair to say that you would recommend that the courses be obligatory?

Prof. Bill Ryan: Yes. I would recommend that it be obligatory for an accreditation in health, social services and education.

The Vice-Chair (Ms. Marilyn Gladu): Great.

Now we're going to go to Mr. Webber, for five minutes.

Mr. Len Webber: I want to get back to funding.

Brook, you had mentioned in your presentation that the current investment in queer health is insufficient. We have another briefing here that we got from Health Canada and the Public Health Agency of Canada. They've indicated here that there are a number of community-based grants and contribution programs specifically designed to address the needs of the LGBTQ populations, and they've come up with a number of different programs.

Again, there's $112 million and an additional $92 million of non-government funding in areas that “aim to increase the reach and impact of evidence-based approaches that support healthy choices and behaviours” in the LGBTQ community. There's $30 million to support community-based harm reduction projects across Canada to enhance street outreach, build capacity among service providers to expand mobile outreach, and reduce rates of HIV and hepatitis C. There's $5 million for a new centre of innovation in infectious diseases. There's $37.5 million over five years for STBBI programs and services for first nations and Inuit. There's $26.4 million to support communities across Canada to implement innovative and evidence-based STBBI prevention interventions. It just goes on.

There's $7 million for an increased access for gay, bisexual, two-spirited, transgender populations to the equitable and efficient health services that they need. There's $550,000 to reduce stigmatization attitudes towards people living with HIV. It continues to go on here. There are a number of programs through Health Canada.

For you to say that their current investment is lacking, I just want to maybe get some more clarification on that. Are you accessing those grant applications?

This is a question for all of the community-based individuals here. How is your funding?

Mr. Brook Biggin: To that point, I read through the brief and a lot of the funds that they mention don't necessarily deal specifically with queer populations but other issues. Of course they consider LGBTQ populations, but if you actually went down to how the money was divvied up, very little of some of these funds went toward studying sexual and gender minority communities.

I think there's a scale and application when we talk about funding. Yes, of course, having more money to work with is never a bad thing, but there's also looking at it's application, which is why our recommendation was specifically around establishing queer funding streams. It was not so much about giving more money to all of these different things, but ensuring that—similar to other populations who are disproportionately impacted, like with the mental health fund for black men and often within HIV there are specific funding streams for indigenous communities—queer communities have some kind of money that is definitely set aside. Otherwise, once your review committee changes or the government changes, or this or that, you're competing with everybody else and sometimes we see, even though there's lots of money, very little of it is going to this population in so much need.

Mr. Len Webber: I see.

Are there any other comments?

Mr. Jeff Chalifoux: In terms of the Edmonton 2 Spirit Society, I know that we've made several applications—and not just E2S. E2S is short for Edmonton 2 Spirit Society. There's the 2 Spirits in Motion Foundation, which has made several grant applications to Canadian Heritage, as well as to Women and Gender Equality Canada. At this point, I think that all have been denied because of certain—I'm just looking at this....

Apparently they didn't fit the criteria. It's trying to address the health of two-spirits, but it's a heritage grant looking at cultural aspects or vice-versa. It's hard for us, at E2S specifically, to incorporate our cultural practices within the western paradigm of how to structure these kinds of things because when you apply for these grants, you have to spend the money and do it in a certain way. Sometimes that doesn't recognize the culture, the way the story-telling happens or how we come together in ceremony.

We don't have a lot of two-spirit elders and knowledge keepers left. We know that there is a lot of funding that does go to indigenous organizations. I know that in Edmonton alone there are Bent Arrow and other organizations, but they don't have two-spirits on staff. They don't have that knowledge of the language there, and some of them are not bringing in two-spirit elders and knowledge keepers to actually share that with the youth and others.

● (1705)

The Vice-Chair (Ms. Marilyn Gladu): Now we're going to go to Monsieur Ouellette for five minutes.

Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.): Thank you very much, everyone, for coming to testify today. It's much appreciated.

Actually, I'd just like to have a conversation with Jeff Chalifoux. I was speaking with Albert McLeod, whom I guess you must know, in Winnipeg. We were talking quite a bit—because he was here in Ottawa getting an award for mental health and his work related to that—about the term “two-spirit”. The discussion revolved around the fact that when children are born, gender is not the most important thing in the Cree, Anishinabe or Ojibwa languages.

We all have a spirit. The question that I guess we were asking each other was whether you can have two-spirits, and that supposes that our spirit is sexual in nature.

Is our spirit defined by sexuality, or are we defined by something that goes beyond that?

Mr. Jeff Chalifoux: For me, I think our spirit is defined by our own sense of self and our space and place in our community. There was a point for me where I thought.... As I say, I just matured into my two-spirit self five years ago to learn more about the culture and get those kinds of teachings. However, I once viewed it as where I wanted to have romantic relationships with men and then with women. Then I came to realize that there are other genders and that —as I started to grow my own knowledge—for me, being two-spirit is not based on our sexuality.

It's really hard to explain. Auntie Albert would be the one to talk to on that one, yes.

Mr. Robert-Falcon Ouellette: If it's not defined by sexuality, it's defined by something far greater.

Mr. Jeff Chalifoux: Yes, and for me, it's that sense of self. Again, two-spirit was an umbrella term created not long ago. It's not the actual traditional name within each cultural language.

Mr. Robert-Falcon Ouellette: Also, in the traditional Cree world view, a spirit wouldn't be like a person, per se. Spirits are something much more amorphous. They could change at any time. It's more like energy. It's not specific. It's not like we're the face of God. God is something completely different.

You're agreeing. Okay.

Mr. Jeff Chalifoux: To each their kind of understanding. Two-spirit, like I say, was just a term created at a point to encompass those who were lesbian, gay, bisexual, transgender or intersex. That's where that term was created.

Why? I wasn't there. I don't know the discussion that happened when the term “two-spirit” was created and why “spirit” was actually put into that. That's not something that I've learned yet in my brief five years of coming to understand myself and of identifying as two-spirit.

I have still much learning to come.

Mr. Robert-Falcon Ouellette: I have just one more question, surrounding supports on reserve and in smaller rural communities.

What supports are there for people who are two-spirit or LGBT2Q peoples on reserve, and what are the health issues that come out of that?

● (1710)

Mr. Jeff Chalifoux: I have no lived experience in terms of living on a reserve, but having worked with a lot of others and a lot of members of our society, I do hear through their experiences what it's like. As I shared in my discussion, not just in the one particular incident with that individual, but when they do share about their sexuality or how they wish to express themselves or engage in romantic or sexual relationships, they are shunned from their communities and are forced to move, and do not get that support.

However, there are some nations out there that are very supportive. We look at Dr. Makokis in Enoch, close to Edmonton, who does provide that trans support, or support for the trans community, and has educated themselves and is two-spirit themselves and a lodge keeper.

Mr. Robert-Falcon Ouellette: Does that mean the institutions of the reserve are also engaged in that discrimination, the service providers, and would that be a human rights violation?

Mr. Jeff Chalifoux: My belief is that it is happening.

The Vice-Chair (Ms. Marilyn Gladu): Now we're going to go to Mr. Davies for three minutes.

Mr. Don Davies: Thank you.

I know what has become a bit popular in the last couple of years has been this concept of taking a gender lens through legislation. Maybe you've heard of that federally. The idea is that sexism is so baked into our culture that we need to put every piece of legislation through that lens. However, it was just occurring to me that a gender lens is much more than binary. I just wonder what your thoughts are about expanding, say, the federal government's gender lens to be basically a sexual and gender minority or actually a gender and sexuality lens writ large. Has there been any work or any thought given to that?

It seems to me that the issue permeates all aspects of society and almost everything we do, yet I think we have a lack of awareness.

Mr. Ryan, I'll throw this to you.

Prof. Bill Ryan: You can see me getting ready.

Mr. Don Davies: Yes. Well, it's a tough one.

Prof. Bill Ryan: I'm going to come back to an experience in Quebec. Since 2007, for the last 12 years, we've had what's called *Lutte contre l'homophobie et la transphobie*. It doesn't translate well, but it's a centre to confront homophobia and transphobia, and it's within the ministry of justice.

The legislation governing that particular centre says that it is to provide a mirror to look at legislation, programming, funding and policy related to gender and sexual minorities to make sure those are included in government initiatives, legislation, programming and funding.

It doesn't always work perfectly but it's a really important step, much like Status of Women or something such as that, that just keeps an eye on things and makes sure that when funding is announced or programs are announced, this reality is not overlooked. I think that's what you're talking about.

Mr. Don Davies: The other thing is a real messy question, but it strikes me that in our awakening sense of gender and our awakening sense of sexuality, this begins when we're three, four, five or six years old and it continues. Puberty hits us at around 11, 12 or 13 years of age. One thing that I've believed for a long time, but this study has cemented it with me, is that we need age-appropriate, mandatory sexual and gender education in our school system, starting in kindergarten, if we are to sensitize.

I mean in kindergarten, for four- and five-year-olds it's the boy-girl thing. It would seem to me that we have to address the sense of isolation and sense of belonging right then and there, and then as it develops through, as we get older and age.

Do you have any suggestions?

The Vice-Chair (Ms. Marilyn Gladu): Unfortunately, you're out of time.

If you want to submit your answers to the clerk, that would be great.

Mr. Don Davies: Sorry.

The Vice-Chair (Ms. Marilyn Gladu): I could listen to more testimony, but we're at the end of our time. We have some remaining committee business to do.

Thank you to all the witnesses for really excellent testimony.

We're going to suspend. That means we have to clear the room of every non-committee person rather quickly. Again, thank you for your testimony.

[*Proceedings continue in camera*]

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