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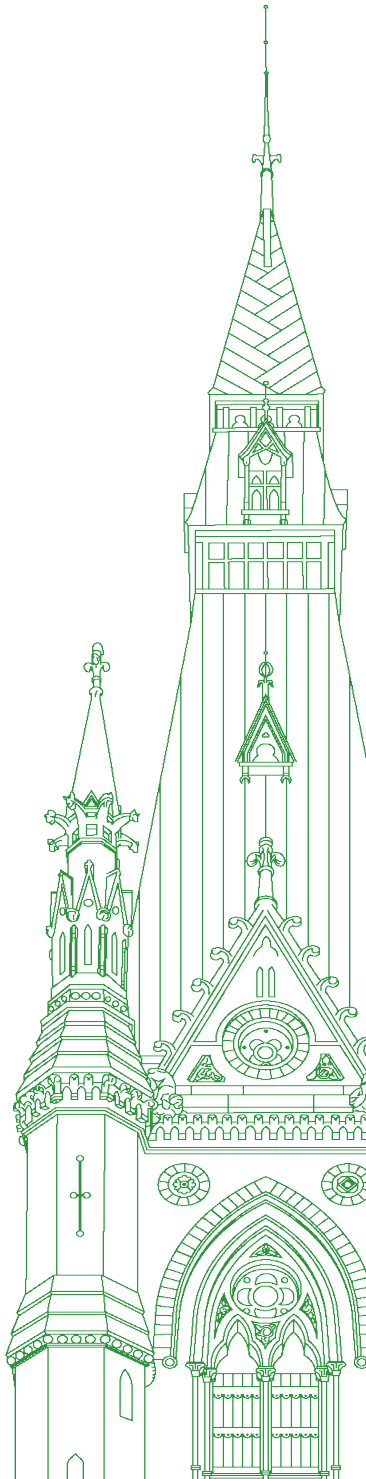

Chair: Mr. Sean Casey

Standing Committee on Health

Monday, November 27, 2023

● (1100)

[*English*]

The Chair (Mr. Sean Casey (Charlottetown, Lib.)): I call this meeting to order.

Welcome to meeting number 91 of the House of Commons Standing Committee on Health. Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders.

I have a few reminders for the folks participating on Zoom. Click your microphone icon to activate your mike, and mute yourself when you're not speaking. For interpretation, you have the choice, at the bottom of your screen, of floor, English or French. Screenshots or photos taken of your screen are not permitted.

In accordance with our routine motion, I am informing the committee that all remote participants have completed the required connection tests in advance of the meeting.

Pursuant to Standing Order 108(2) and the motion adopted on May 16, 2022, the committee is beginning its study of women's health, at long last.

Before we begin, I would like to welcome the officials who are with us today. We have quite a number of them.

From the Canadian Institutes of Health Research, we have Dr. Tammy Clifford, acting president, and Dr. Angela Kaida, scientific director, institute of gender and health, participating via video conference. From the Department of Health, we have Ed Morgan, director general, policy, planning and international affairs directorate; Cindy Moriarty, director general, health programs and strategic initiatives; and Suki Wong, director general, mental health directorate.

[*Translation*]

From the Public Health Agency of Canada, we welcome Annie Comtois, Executive Director of the Centre for Chronic Disease Prevention and Health Equity, Shannon Hurley, Associate Director General of the Centre for Mental Health and Well-Being, and Mark Nafekh, Director General of the Centre for Health Promotion.

[*English*]

Thank you all for taking the time to appear.

We're ready for opening statements of five minutes or less. We're going to begin with the Department of Health.

Who's doing the speaking for the Department of Health?

Ms. Moriarty, thank you for being with us. I understand you're a little under the weather and that there were some near-heroic measures taken to accommodate that. We're glad to see you here.

You have the floor for the next five minutes.

Ms. Cindy Moriarty (Director General, Health Programs and Strategic Initiatives, Department of Health): Thank you very much, Mr. Chair and honourable members.

Thank you for the last-minute accommodations.

You've already introduced me, so I won't say again who I am, but I'm with the health programs and strategic initiatives directorate at the strategic policy branch of Health Canada.

● (1105)

[*Translation*]

We're here to discuss women's health. Before we begin, I want to make it clear that many trans and non-binary people are affected by women's health issues.

[*English*]

Today I'm accompanied, as you know, by officials who can speak to diverse topics, including sexual and reproductive health, intimate partner violence, women's mental health and well-being, women and aging, women-focused health research, and issues pertaining to gender-diverse individuals and trans women.

In Canada, women's health as a field of care, research and program implementation has made great strides. For example, the national women's health research initiative is advancing a coordinated research program to address high-priority areas of women's health. Funding is also flowing on other fronts. Budget 2021 committed $7.6 million over five years to Stats Canada to develop and implement a national data initiative on sexual and reproductive health.

[*Translation*]

Despite these efforts, gaps remain in our understanding of women's health issues. Compared to men, women and trans or non-binary people have poorer health outcomes, and this is due to misdiagnoses, minimized symptoms, a heavier burden of specific diseases and poorly targeted treatments. This problem particularly affects racialized and Indigenous women, as well as women with disabilities.

[*English*]

Traditionally, the medical system has taken a narrow approach, with health data and research results stemming from male-only studies and clinical trials. However, this is changing. Today, much more attention is paid to women's health, and a greater general understanding of women's health issues exists than was the case even a decade ago.

For example, since 2007, Health Canada has provided approximately $50 million per year to the Canadian Partnership Against Cancer. The partnership convenes and supports the Canadian breast cancer screening network. It has also worked with the radiology and breast cancer screening communities to develop the "Pan-Canadian Framework for Action to Address Abnormal Cell Rates in Breast Cancer Screening".

The Public Health Agency also provides funding and support to the Canadian Task Force on Preventive Health Care, an independent panel of experts that develops robust and evidence-based guidelines on preventive medicine topics such as high blood pressure and certain cancers. The task force is currently undertaking an expedited update of its 2018 breast cancer screening guideline. The recommendations will be based on assessments of available scientific evidence and involve stakeholder input from multiple experts and patients.

[*Translation*]

However, closing the gender gap in health requires more research focused on health priorities that affect solely women either disproportionately or differently. This includes research with trans and non-binary people, as well as better data.

[*English*]

We're fortunate to have a strong public health care system in Canada that is supported by so many dedicated nurses, doctors and other health professionals. However, we also recognize the challenges the health system is facing, as noted in this committee's recent report on Canada's health workforce.

[*Translation*]

We are aware, however, that there is still a great need to address the issue of women's health, to take initiatives and to play a leading role in this field.

[*English*]

I am pleased to say that the government has already begun this work on a number of fronts. Budget 2016 committed $5 million over five years to the Heart and Stroke Foundation to support targeted research on women's heart and brain health, and to promote collaboration between research institutions across the country.

Budget 2019 committed $10 million over five years to help address gaps in knowledge about effective prevention, screening and treatment options for ovarian cancer. At the same time, the government is also supporting a broad range of initiatives and organizations to promote and enhance women's health.

[*Translation*]

That's why Budget 2021 allocated $45 million over three years to improve access to a full range of sexual and reproductive health support, information and services for Canadian women facing the greatest barriers to access. The 2023 budget renewed this investment to the tune of $36 million over a further three years.

[*English*]

Through this funding, partner organizations are empowered to design and deliver programs to address the diverse health needs of women.

[*Translation*]

Many advances have been achieved in women's health in recent years. Behaviours are evolving, and our approach to research and program delivery and policy analysis is changing and continues to change.

[*English*]

For example, the government now broadly applies sex- and gender-based analysis to all of its activities to ensure that the issues experienced by women and gender-diverse individuals are considered when we're developing new policies and programs. This enables us to formulate responsive and inclusive health initiatives to promote greater equity.

[*Translation*]

More broadly, awareness of the importance of women's health issues continues to grow, affording us a number of opportunities to address the aforementioned gaps and gender inequalities in health care.

● (1110)

[*English*]

This study you're launching now is one more contribution to this important conversation, and we look forward to today's discussions and to answering your questions.

Thank you.

The Chair: Thank you, Ms. Moriarty.

Next, from the Canadian Institutes of Health Research, I believe we're going to hear from Dr. Clifford and Dr. Kaida.

You have the floor. Thank you. Welcome.

Dr. Tammy Clifford (Acting President, Canadian Institutes of Health Research): Thank you so much.

[*Translation*]

As Acting President of the Canadian Institutes of Health Research, or CIHR, I am pleased to appear before your committee to discuss women's health research, alongside my esteemed colleague Dr. Angela Kaida, Scientific Director of CIHR's Institute of Gender and Health, who will also be speaking today.

[*English*]

As Canada's health research funding agency, we at CIHR understand the power of research to improve the health and well-being of all Canadians, including women and girls. We know that sex and gender influence our risk of developing certain diseases, how well we respond to medical treatments and how often we seek out medical care, yet, as recently as 2010, fewer than 20% of basic scientists, 25% of health systems researchers and only a third of clinical and population health researchers in Canada accounted for sex in their studies. This meant that research results often stemmed from male-only studies and clinical trials, limiting our understanding of women's and gender-diverse people's health, which obviously impacted the quality of the care they received at that time.

It's in this context that, over the last decade, CIHR has taken action to promote the integration of sex and gender in research, including offering training modules for CIHR funding applicants and peer reviewers, and requiring researchers to integrate sex and gender into their research design when possible.

Thanks to leadership from CIHR, along with federal funding investments in sex and gender science, today, the integration of sex in health research proposals in Canada exceeds 90%, and gender is addressed in the majority of human research studies. Canada is now recognized as a world leader in sex and gender science, and a review that was published in the journal Science ranks CIHR as the number one agency in the world for the appropriate integration of sex, gender and intersectionality in funding policies.

In addition, CIHR is driving research in key priority areas of women's health.

[*Translation*]

I'll now turn to my colleague Dr. Kaida, who will tell us more about these fascinating initiatives.

[*English*]

Go ahead, Dr. Kaida.

[*Translation*]

Dr. Angela Kaida (Scientific Director, Institute of Gender and Health, Canadian Institutes of Health Research): Thank you, Dr. Clifford.

As my colleague indicated, the Canadian Institutes of Health Research's policy changes have significantly increased the integration of sex and gender into health research.

[*English*]

These policy changes are helping to make CIHR-funded science more rigorous and more inclusive to increase research impact.

As the scientific director of CIHR's institute of gender and health, I am committed to advancing research that will further help to close the gender health gap. This is why I am thrilled to help deliver on a budget 2021 investment of $20 million for women's health research.

With this important investment, CIHR, in partnership with Women and Gender Equality Canada, and in consultation with researchers, clinicians, communities and trainees across Canada, is leading the national women's health research initiative. This initiative is advancing a coordinated research program to address high-priority and under-researched areas of women and gender-diverse people's health. By embracing a community-engaged approach and committing to the principles of equity, diversity, inclusion and indigenous rights, this initiative will support the creation of research evidence to improve women's health care and women's health policies and practice in Canada.

As the first phase of this initiative, in August 2023 the Minister of Health announced an $8.3-million investment to support the creation of 10 women's health hubs. These hubs will focus on mobilizing research evidence in key priority areas of women's health, including sexual and reproductive health, HIV care, the prevention of violence and equity in health services access, to name a few. For example, the women's cardiovascular health hub, led by Dr. Kerri-Anne Mullen and Dr. Thais Coutinho and their team at the Ottawa Heart Institute Research Corporation, will leverage Canada-wide networks to address cardiovascular disease, which is the leading cause of death and hospitalization among women in Canada.

For the next phase of the initiative, CIHR will invest in a hubs coordinating centre; biomedical discovery research; translational research in health care diagnostics, therapeutics and devices; as well as implementation research to remove barriers to accessing health care. This initiative aligns with additional investigator-driven CIHR investments in women's health research, which totalled over $60 million in 2021-22 alone.

As a short example, I'd like to highlight the work of Dr. Gina Ogilvie and her team at the Women's Health Research Institute in British Columbia, who are advancing research on HPV vaccination and cervical cancer screening methods. Dr. Ogilvie's world-class research program is accelerating Canada's efforts to become the first country globally to eliminate cervical cancer.

As you can see, CIHR is committed to advancing research that stands to improve women's health and health care. I deeply look forward to the outcomes of your study and would be pleased to assist your efforts in any way.

Thank you.

● (1115)

The Chair: Thank you, Dr. Kaida.

We're going to begin rounds of questions now, starting with the Conservatives for six minutes.

We have Ms. Vecchio, please.

Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC): Thank you very much. I really appreciate it.

Thank you to all of the people who have come here to provide us testimony today.

I want to start with Cindy.

Cindy, I have your first name here, but I didn't get your last name down.

You noted the priorities. I wanted to find out from you, in terms of this list of priorities, whether the priorities are chosen by the health officials. Is there some sort of consultation done with the people on the ground, such as the physicians, nurse practitioners and the people who are working hand in hand with the patients themselves?

Ms. Cindy Moriarty: Thank you for the question.

If I'm understanding your question properly, it's really about priority setting generally. It's very much an iterative process. Very often, priorities are determined through long-standing work, trends that are emerging or issues that are being presented to government or to the department. They could come through a crisis or something that happens in the media that draws attention to something. It's not a one-size-fits-all. If there's a particular issue you're interested in, I could maybe drill down a little bit more.

Mrs. Karen Vecchio: No. That's perfect. I just wanted some information on that specifically.

I have a specific question, though. You can answer this one, or perhaps somebody from one of the departments may be able to answer. When we were looking at the gender-based analysis and at things that had come out from the Auditor General, she was indicating that only 40% of budgets and policies had actually gone through the GBA. I was wondering if you could advise me of whether or not your department went through a thorough GBA for all of your programs, policies and budget advancements.

Ms. Cindy Moriarty: I can speak for Health Canada. I'll let my colleagues from the Public Health Agency and CIHR speak for themselves.

Generally speaking, the health portfolio is seen as a lead in sex- and gender-based analysis. I just want to clarify that, in the rest of the department, it's GBA. In health, we talk about sex and gender, because sex is about the biology and the science as well as the gender.

We have consistently been ahead of the pack. I can assure you that all of our budget proposals, MCs and Treasury Board submissions are 100% vetted and go through a process with sex- and gender-based analysis.

Mrs. Karen Vecchio: Thank you very much. I really appreciate that.

Shannon, I want to turn over to you. I'm not sure specifically what department you are with. You are with the centre for mental health and well-being. Is that correct?

Ms. Shannon Hurley (Associate Director General, Centre for Mental Health and Wellbeing, Public Health Agency of Canada): Yes. That's right.

Mrs. Karen Vecchio: Excellent.

With regard to women, we're hearing from the numbers that violence against women has just boomed. We know that. Working on the status of women committee, we also know that the money has also increased, but it is not keeping up with the numbers with regard to violence. I think 79% is what I heard most recently.

What's something that you see we'd able to do through Health Canada that would help start alleviating these issues when we have violence against women?

Ms. Shannon Hurley: Thank you.

Just to clarify, I work with the Public Health Agency of Canada at the centre for mental health and well-being. I can say that, at the Public Health Agency of Canada, we really try to contribute to addressing the problem of violence against women and gender-based violence in all its forms through programs that deliver interventions and that also test and learn about effective approaches, so that they're building the evidence base of what works.

● (1120)

Mrs. Karen Vecchio: I really appreciate that. I think one of the greatest challenges in Canada, though, is the geography. If you live where I live, you're 20 minutes away from the London Health Sciences Centre, but for the people that I'm speaking to, especially women who are trying to flee violence, sometimes it's an airplane away. Sometimes there's not a registered nurse on a reserve.

How do we make sure that GBA+ and accessibility are there for those people who are living remotely?

Ms. Shannon Hurley: That's a really great consideration. I'll say that the kinds of programs we support are about promoting the health of people who have experienced violence and also about preventing violence through health promotion, healthy relationships, building skills and building ability.

We're not the order of government that's delivering the services, but we certainly work with partners. It really requires a multisectoral approach to address this issue.

Mrs. Karen Vecchio: Finally, do you have any programs specifically directed at men? When we talk about violence against women, we know that it's not just about women. It's about men and women working together to change that type of relationship so that it is much more respectful.

What programs do you have that are directed at men and abuse?

Ms. Shannon Hurley: Absolutely—it's not up to women to end violence against women. We have streams of funding addressing family violence and gender-based violence. Of course, these are intersecting issues. Some of the projects funded through those programs are indeed reaching men and boys. For example, there's one working with police services to look at gender norms. There's one that's working with adolescent boys to teach them more healthy ways of being a guy, expressing their emotions and being able to use language about their emotions.

Indeed, we absolutely recognize the need to work with men and boys too.

Mrs. Karen Vecchio: Awesome.

Since I still have the floor, I'm going to pass it to you, Mark, because I see that you deal with the correctional system.

When we're looking at women in the correctional system, what's the percentage of indigenous women who are in the federal correctional system? Can you give me a percentage there?

Mr. Mark Nafekh (Director General, Centre for Health Promotion, Public Health Agency of Canada): I do work for the Public Health Agency. I have worked for Correctional Service Canada in the past.

I don't have a response to that in my current role. You have my apologies. I can look at that and bring it back.

Mrs. Karen Vecchio: That would be wonderful. I think knowing that correlation is really important there as well.

You do bring lots of experience from that, of course. Would you be able to put on that hat from before and tell me whether, when we're looking into these penitentiaries, they're actually talking about violence against women and how to change their beings or anything like that? Do you see any of that, where we're doing things to contribute to the person's outcomes?

Mr. Mark Nafekh: I'll preface my response by saying that it's been three and a half years since I've worked for Correctional Service Canada. I can tell you that you're absolutely right that indigenous women are very much overrepresented in the federal correctional system. They do offer violence prevention programs there. I just can't give you the details at this point in time.

Mrs. Karen Vecchio: Perfect. Thank you so much.

The Chair: Thank you, Ms. Vecchio.

Next we have Mrs. Atwin online for six minutes.

Mrs. Jenica Atwin (Fredericton, Lib.): Thank you very much, Mr. Chair.

Thank you to our witnesses for being with us today for this really important study. I'm really excited about this. I think it's a long time coming.

I'm speaking to all of you from Fredericton, New Brunswick, the unceded Wolastoqiyik territory here.

I'll start with Ms. Moriarty.

Specifically, you mentioned sexual and reproductive health. I have a particular preoccupation with that. I'm from New Brunswick, and we are perhaps infamously known for not upholding the Canada Health Act as far as having access, regardless of where you live in the province, to reproductive access and care is concerned.

We actually have a research study that's being undertaken here. It should be close to completion, quantifying what that experience looks like here in New Brunswick and some of the impacts from not having that ease of access. The province was concerned we weren't moving beyond anecdotal evidence. It's really important to have this research project capture that.

As a result of some of this, we've actually had health transfer dollars held back throughout the province of New Brunswick. It seems to be the only kind of stick we have. It's not necessarily working, especially in a province that has surplus budgets.

Can you provide us with any direction as far as the Government of Canada is concerned? What other mechanisms do we have, or should we have, to enforce the Canada Health Act when it comes to reproductive care and access?

Ms. Cindy Moriarty: I am not an expert in the Canada Health Act, but I hear you. There have been deductions to New Brunswick. I guess it depends on your point of view whether they are significant or not. In 2020, there was $334,000. That may not be having the impact you desire.

There are limits to the Canada Health Act. I would point to other efforts that the government is making through the sexual and reproductive health services program. We are funding community-based organizations. We have some funding that's specifically targeted to improving and increasing access to abortion.

We can't pay for the abortion service itself. That's within the provincial jurisdiction. Certainly, everything that helps the women get there and get back is covered—for example, travel, child care and hotels. This is a particular issue with geographic boundaries, women of low income and all sorts of other circumstances. We're putting our efforts into improving and increasing the access overall.

● (1125)

Mrs. Jenica Atwin: Thank you.

Clinic 554 is here in Fredericton. It's often at the centre of that conversation. What it also really served as was this centre of excellence for trans care and gender-affirming care. The latest census data has us as the fourth most gender-diverse city per capita, of which we are very proud. Again, we know there are issues with access.

Again, I am just seeking your advice on how we can ensure better health outcomes for the 2SLGBTQ+ community, regardless of jurisdiction, even in small provinces like New Brunswick.

Ms. Cindy Moriarty: That's a big question.

You know, we're very well aware of the misinformation and disinformation campaigns and the public discourse that's anti-trans and anti-2SLGBTQ2. A lot of the context is really around the social context and where people are at. It's a challenge that I think every jurisdiction and every community is going to have to meet with different things.

We are providing funding through the sexual and reproductive health services program to support access, training for health care providers and support that's going to patient-centred organizations in terms of knowing their rights and knowing where to go. I'm very concerned about ensuring that people know where to get good and reliable information, and that they are taken care of safely.

There are large challenges ahead of us. I don't want to deny that on this front. It's something that we're looking at with great concern.

Mrs. Jenica Atwin: Thank you. I hope you feel better soon.

I've have another big question for Dr. Kaida. I know my time will be wrapping up.

This will be a recurring theme for me. I ask it just about every time we have witnesses on this panel.

It's in regard to Joyce's principle. I'm thinking about the horrific story and experience of Joyce Echaquan in Quebec around systemic discrimination and racism in our health system. I'm really looking for ways that we can formulate measurables.

What can we do in a health care setting to ensure that everyone has access, regardless of where they come from, and to ensure that they are being culturally respected at the same time?

Dr. Angela Kaida: Thank you so much for that excellent question.

I will share with you that I hope to be asked that question over and over, as it's similarly a priority for me.

From a research perspective, certainly CIHR recognizes racism and discrimination as structural forms of discrimination that negatively influence our health. We also recognize that racism and other forms of discrimination disproportionately affect key members of our Canadian communities, including indigenous women, Black women and other racialized communities.

In terms of our priorities, we have been funding research teams that are looking specifically at the impacts of racism on health outcomes. They are trying to identify community-led solutions to address racism in the health care system, as well as generally in our society, as Canadians. That focus on the specific question of racism—not just generally about structural violence—is such an important part of what we are committed to in terms of the research we fund on health outcomes.

The Chair: Thank you, Ms. Atwin. That's your time.

[*Translation*]

Ms. Larouche, you have six minutes.

Ms. Andréanne Larouche (Shefford, BQ): Thank you, Chair.

Thank you to all the witnesses for being with us today for this study, which is important for understanding why there is so much work to do for women. As you said in your opening remarks, we haven't yet given enough thought to the right way to treat certain types of cancer that are specific to women.

Dr. Kaida, on this subject and before I go any further with my questions, you touched on the issue of cervical cancer in your opening comments or in one of your answers. What's worrying in the data that's recently emerged is that the number of cases of this type of cancer is on the rise. To what do you attribute this and what are your potential solutions?

● (1130)

Dr. Angela Kaida: Thank you for the question.

[*English*]

Absolutely. Cervical cancer is a priority for us as Canadians, and it's a priority for us at CIHR, in terms of innovative research to address rising incidents of cervical cancer. As I mentioned earlier, we are very proud and fortunate to be able to fund Dr. Gina Ogilvie at the Women's Health Research Institute here in British Columbia. Her work has focused for decades on looking at HPV vaccination, uptake of HPV vaccine and moving us from cervical cancer screening towards HPV screening as a strategy for eliminating cervical cancer in Canada.

The Canadian Partnership Against Cancer, or CPAC, which is funded by the Government of Canada and its partners, has developed an action plan to eliminate cervical cancer in Canada. Importantly, this action plan engages with partners across the country. These partners include women and gender-diverse people with lived and living experience of cervical cancer within the action plan's priorities. To reinforce this, these priorities include improving HPV vaccination rates among young girls and young boys, as well as young women; implementing HPV primary screening; and enhancing efforts to follow up abnormal results of testing procedures.

CPAC also hosts the pan-Canadian cervical cancer screening network, which undertakes system performance for reporting on cervical cancer and support for the development of sharing best practices for screening and treatment.

I'll reinforce that this is a priority area for research, programming and practice to transform cervical cancer incidents among, and their impact on, women and gender-diverse people in Canada. Thank you.

[*Translation*]

Ms. Andréanne Larouche: Very well. I understand that one possible measure to tackle cervical cancer is to combine vaccination and screening. Let's keep in mind that this is one of the few cancers for which we have a vaccine and on which we can really take action. In a few years, it will be interesting to see the impact of this vaccination on that type of cancer.

Ms. Moriarty, you mentioned in your opening remarks that, according to some health research institutes in Canada, sex and gender influence the risk of developing certain diseases, reactions to medical treatment, and the frequency with which a person seeks health care. In addition, gender is one of 12 health determinants identified by the Public Health Agency of Canada.

As you said, there's a bit of a narrower approach, certain things that are exclusively for men, and others that are specific to women. Please give us a few more examples of how sex and gender factors can have different effects on women's health compared to men's.

Ms. Cindy Moriarty: Thank you for the question.

I'd like to be sure I understood you. Are you asking for examples of general differences, rather than on a particular health topic?

Ms. Andréanne Larouche: You mentioned different diagnoses. Among the differences, there are not only diagnoses, but also treatments and symptoms that would not be the same. Please expand on that issue.

Ms. Cindy Moriarty: That's a broad statement that covers a number of situations and conditions. For example, in cases of heart attack, women's symptoms are different from men's. Sometimes they go unrecognized. Women themselves may not recognize the symptoms. A misdiagnosis can therefore ensue.

I'll let my colleague Ed Morgan talk about medical devices. I can tell you, however, that historically, many of these devices were designed for a man's body from a size perspective and did not necessarily meet women's needs.

When it comes to differences in diagnoses, treatment and symptom identification, it's hard to find a disease or condition that wouldn't be affected by these circumstances. That's why we conduct sex and gender analyses in all our work, because we don't know what we don't know. It's really about making sure that we take the different circumstances and needs of all populations into consideration.

● (1135)

[*English*]

Ed, I don't know if you want to add anything in terms of diagnostics and medical devices for men and women, just in terms of differences.

Mr. Ed Morgan (Director General, Policy, Planning and International Affairs Directorate, Department of Health): I think you did it wonderfully. I'd only add that we do have an expert scientific committee helping to provide the department with advice on these issues as well. However, other than that, I think you covered it well.

The Chair: Thank you, Mr. Morgan.

Thank you, Madame Larouche.

Next we have Mr. Garrison, please, for six minutes.

Mr. Randall Garrison (Esquimalt—Saanich—Sooke, NDP): Thank you very much, Mr. Chair.

I know you all note my late arrival here this morning. The vagaries of House scheduling meant that Ms. Idlout had to step into the House to give a speech on the very important Truth and Reconciliation Commission call to action number six on the physical punishment of children. Therefore, I get the privilege of being here for a few moments on this very important topic.

I know that other members of the committee have already noted that this is a long overdue study in this committee. One of the things I hope the committee will consider as it works its way through is including in its mandate for its study here of women's health the study of gender-affirming health care for transgender and gender-diverse women in this country who do not have equal access to services.

However, I want to focus my questions this morning on something that most frequently comes up in my riding when it comes to women's health, and that's access to mental health services—especially for young women and girls in Canada and also, because my riding stretches from urban to rural, in rural areas—and this lack of availability.

Earlier this year, in March, the House of Commons' status of women committee completed a study on the mental health of young women and girls. I guess my question for you, Ms. Wong, is this: How is the government making progress in responding to those recommendations, making sure that equitable services are available in mental health for women and girls?

Mrs. Suki Wong (Director General, Mental Health Directorate, Department of Health): I think that, as members of this committee know, the delivery of health services access is the responsibility of provinces and territories. With that view, we work very closely with our colleagues in the provinces and territories to ensure that access to vital mental health services is provided in a timely way.

As you know, and it's represented by the sheer number of colleagues around this table, the delivery of mental health services is shared across the federal jurisdictions, whether it's the Public Health Agency from a prevention and promotion perspective, my colleagues at the CIHR from a research perspective, or our colleagues at WAGE, the Department for Women and Gender Equality, as well. We're working very closely with our partners in other federal government departments.

As you also know, in the recent budget, the amount of $25 billion over five years was transferred to provinces and territories to ensure that they do address mental health as part of the shared priorities. We're working very closely with colleagues to ensure that the really important recommendations from the committee continue to be addressed.

Mr. Randall Garrison: Thank you very much.

I appreciate, of course, that health and mental health are a shared jurisdiction, but there are some areas for which the federal government has primary jurisdiction, particularly in dealing with mental health for indigenous people. I have a large indigenous population in my riding. There are both on-reserve and urban aboriginal populations.

Can you speak a bit about what's happening with the provision of mental health services for indigenous communities and making sure that culturally appropriate services are available?

Mrs. Suki Wong: Absolutely. I just want to say that the best people to answer this question would be our colleagues at Indigenous Services Canada.

However, with respect to how we are working to increase access to mental health services in indigenous communities, we are working very closely with our colleagues. There are specific hubs especially for access for youth and children as part of our integrated youth services program at the federal level. We're working very closely to advance and roll out those services in the communities as well.

● (1140)

Mr. Randall Garrison: I know delivery is primarily a provincial responsibility, but we see very large gaps in the availability of mental health services in rural areas throughout British Columbia, where I'm from. Quite often, people in crisis are told to come back later because of a long wait-list for services.

Are there any ways in which the federal government can provide pilot projects in rural areas or leadership in rural areas to improve the access to services, perhaps through technology?

Mrs. Suki Wong: One of the programs I think are important to address in terms of access and special rural access is the Wellness Together Canada program. It was first implemented during the pandemic to assist Canadians from all jurisdictions to have access to 24-7 counselling, as well as to access their own mental health services.

Right now, for the delivery of mental health services virtually, we would like to point to the Wellness Together Canada portal, where all Canadians can have access not only to 24-7 self-assessment peer counselling, but also to 24-7 mild to moderate mental health services.

Mr. Randall Garrison: Thank you.

The Chair: You have 30 seconds, Mr. Garrison.

Mr. Randall Garrison: I'll ask a quick question about access to reproductive health. I'm not sure who this actually goes to around the table.

British Columbia recently made reproductive health and birth control free. Are there any initiatives by the federal government to encourage other provinces to make contraception widely available, especially to young women who don't have financial resources?

Ms. Cindy Moriarty: Thank you for that question. That would be for me.

I'm not specifically aware of discussions between the federal government and provincial jurisdictions on that matter. I would expect that other jurisdictions are looking at it closely. I was certainly very happy to see that initiative from B.C.

The Chair: Thank you, Mr. Garrison.

Thank you, Ms. Moriarty.

Next is Mrs. Roberts for five minutes.

Mrs. Anna Roberts (King—Vaughan, CPC): Thank you, Mr. Chair.

My question is general. I'm not sure who wants to answer it.

In our province of Ontario, I've met with numerous international doctors who have passed their boards and, unfortunately, can't practise. I know from speaking to residents that there is a lack of services. I'm not sure who wants to take this question.

What solutions or issues, if any, do you hear about, and how can we improve them? I don't think it's just an Ontario issue. I think it's across Canada. Can someone respond to that?

Ms. Cindy Moriarty: Thank you for the question.

I don't believe there's anyone on the panel who has the specific knowledge for that question. We can take it back.

I can tell you that, in some of the other issues we're representing, our focus is really working with providers to improve their capacity and knowledge to deliver services properly, and not on recruiting other health care workers or looking at workers with foreign credentials. I believe the committee recently did a study on health human resources, and there should be a separate response to that.

However, we can take that back, if it would be helpful.

Mrs. Anna Roberts: One of the reasons I'm asking that question is that I recently met with a constituent who was very upset about the fact that she had to wait so long to get a mammogram, because of the wait and the timelines, and to get an appointment with a doctor who specializes in her particular cancer. By the time she got in to see the doctor, the cancer had progressed to stage three.

How, then, can we protect women if we don't have the capacity to serve them? That's my concern.

I don't know who wants to take that.

Ms. Cindy Moriarty: Thank you for that.

It's hard. I can't see my colleagues in the room. If anyone's putting their hand up to answer, I'll step back, but I think that's something we'll have to take back.

I just want to recognize that these are challenges not just for women but for everyone in the health care system. I think we're all aware of some of those anecdotes in our own lives and among our friends. It's a bigger challenge in terms of health human resources.

There are efforts under way. The federal government is working with provinces and territories looking at initiatives and different efforts. I just don't have the depth of knowledge to speak about those with any authority.

● (1145)

Mrs. Anna Roberts: If we look at Canada as a whole, is there one province that would be an example to the entire country, which does provide services in a much more efficient manner and could be adapted to other provinces?

Ms. Cindy Moriarty: I could take that question back.

There may be some good examples in one area or another area. Sometimes these examples are more localized. They're not even province-wide. One challenge is the diversity of how health care systems are delivered across the country and the various focuses or priorities.

There isn't one province in particular that, as a whole, has this figured out and sets the example for the others.

Mrs. Anna Roberts: I'd like to ask this of Dr. Clifford.

What is the percentage of women with health issues like cancer or mental health issues, as opposed to gender...? If we look at transgender, what is the percentage?

I'm just trying to understand where we need to focus. Could you help me understand that?

Dr. Tammy Clifford: Thank you so much for that question.

I wish I had the number right on the tip of my tongue or at the front of my head. I'm happy to bring that number back to you. It's a critically important question, and I'm so glad that you brought it forward here today. We'll get that information for you.

Mrs. Anna Roberts: Thank you.

For my next question, I heard from Cindy that a lot of funds have been provided through Health Canada on different research projects.

Which one was the most successful as far as the research goes? Have we come up with anything? For example, I know we keep praying for cures for cancer and heart disease. Is there any area of research where we've really excelled?

Ms. Cindy Moriarty: I would turn to my colleagues at CIHR.

I also wonder, Annie, if you want to speak to the breast cancer screening guideline work.

Dr. Tammy Clifford: Not to throw the ball over to my colleague, Dr. Kaida, but I know this is right in her area of research.

I'll pass it over to you, Angela.

Dr. Angela Kaida: Thank you so much for that question and for an opportunity to share success stories as well.

I do think that we have a really robust women's health research community here in Canada. I would say that we have a few really shining examples of research informing practice that leads to health outcomes. There are examples around HPV vaccination and HPV screening. There are examples around sexual dysfunction and sexual pain, and how that research is implemented to transform health outcomes for women.

We also have really successful examples of women-centred HIV care and the provision of care services for women and gender-diverse people living with HIV. I would estimate that as recently as 10 years ago, we really did not have a robust evidence base that could inform clinical practice.

There are many other examples, but I want to assure you that we have some really shining success stories of women's health research in Canada that are being implemented to lead to tangible changes in women's health and women's health care.

The Chair: Thank you, Dr. Kaida.

Next we're going to Ms. Sidhu, please, for five minutes.

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

Thank you to all the witnesses for being with us. Thank you for the hard work you are doing.

My first question is for Cindy Moriarty.

According to Dr. Bruce Aylward, who is a Canadian physician, epidemiologist and assistant director-general of the WHO, pregnant women, babies and children face some of the gravest consequences from all forms and impacts of climate change, such as heat and air pollution. Do you all agree with this statement?

What research and work has been done through the health portfolios on the impact of climate change on women's health?

● (1150)

Ms. Cindy Moriarty: Thank you for the question.

I'm not familiar with that work by the WHO. It doesn't surprise me. Pregnant women, kids and babies are more vulnerable, generally, to a number of conditions.

This is fairly new work, in terms of looking at the impact of climate change. It's something the department is looking at, as we looked at sex- and gender-based analysis. It's considering the impact of climate change while developing programs and policies. It's relatively recent, so I don't have an example. We've been doing sex- and gender-based analysis for years, so we can point to past work that has reached some result. I don't have a specific example for you with respect to climate change.

I don't know whether any of my colleagues around the table are better positioned to answer that.

Ms. Sonia Sidhu: Dr. Kaida, do you want to add to that?

Please, go ahead.

Dr. Angela Kaida: Thank you so much for that question. It's such an important question. I am aware of that report.

I will share that, from a CIHR perspective, absolutely, the gender dimension of the impacts of climate change is a priority for us. I can speak about a few recent funding opportunities CIHR has held to support research by our research community in this area.

One funding opportunity was a response to the chief public health officer of Canada's report, “Mobilizing Public Health Action on Climate Change in Canada”. There was a funding opportunity put forward by several of our institutes that asked our research community to address the priorities raised in the chief public health officer's report around climate change and to integrate sex- and gender-based considerations, of course, within that research.

That's a fairly new funding opportunity. It was launched in 2022. We are carefully and eagerly following the work of these researchers to inform our evidence base around how climate change is impacting women, girls and gender-diverse people here in Canada, as well as globally.

Ms. Sonia Sidhu: Dr. Kaida, I also want to add that we know that evacuation in B.C. and across the Canadian north interrupted crucial care. It led to stress for pregnant women. It caused serious high blood pressure. It can also impact their whole health.

What perinatal health measures are we taking? Are we making any programs for that? What measures is the government taking on that?

Dr. Angela Kaida: Thank you again for that great question.

I'm going to comment briefly and then invite my colleague Dr. Clifford, or Health Canada, to comment further.

I know we funded research around the Fort McMurray fires that documented what happened in terms of health outcomes and health consequences, as well as the recovery period. I am not familiar at this time with the specific findings related to perinatal health, but I can certainly look into that and get back to you with some specific responses.

I'll open that up to my colleagues, as well, in case they have additional information.

Dr. Tammy Clifford: I would like to address that.

I'm sorry. Go ahead.

Mrs. Suki Wong: I'm sorry. I didn't mean to take your turn, but I want to speak about what Health Canada is doing in the area of perinatal mental health.

We recently funded a study with Women's College and Dr. Simone Vigod to look at conducting a study on perinatal mental health, in order to identify treatments and clinical guidelines for practitioners, not just for pregnancy and the perinatal aspect but also for postpartum as well.

Dr. Vigod has just started this work. She's talking to stakeholders and people with lived experience, in order to look at how she can develop culturally safe, evidence-based clinical guidelines.

The Chair: Thank you, Ms. Wong.

Thank you, Ms. Sidhu.

[*Translation*]

Ms. Larouche now has the floor for two and half minutes.

Ms. Andréanne Larouche: Thank you, Chair.

Mr. Morgan, you spoke at the end of my first round of questions and now I’d like to follow up with you.

Following in the footsteps of countries that implemented women’s health strategies in recent years, including Australia, New Zealand, Scotland and England, is the Canadian government considering renewing its women’s health strategy? If so, is there a timetable for doing so? Fairly briefly, what can you tell us about what’s happening in countries that now have such strategies?

● (1155)

Ms. Cindy Moriarty: Thank you for the question.

At the moment, there is no plan to renew the Women’s Health Strategy. What makes Canada very different from other countries, as I imagine you know, are jurisdictional challenges. The provinces and territories are responsible for the delivery of health services. So there’s a limit to the federal government’s power and influence.

I’d also like to mention that I worked on the Women’s Health Strategy, back in the day, at Health Canada, and the issue of women’s health was primarily a concern for those who were responsible for it. It was considered a separate issue. It wasn’t something that was integrated into all the programs, services and policies for which we’re responsible today.

With the evolution of gender-based analysis, our approach changed. Instead of a specific strategy, we expect every activity, policy and law, whatever it may be, to take into account the needs of women, non-binary or trans people, among others, as well as the differences between all groups.

Ms. Andréanne Larouche: Thank you very much, Ms. Moriarty. During my next turn, I’ll return to the issue of jurisdiction, as a matter of fact. I’ll also have questions for Mr. Morgan.

The Chair: Thank you, Ms. Larouche.

[*English*]

We have Mr. Garrison, please, for two and a half minutes.

Mr. Randall Garrison: Thank you very much, Mr. Chair.

I want to turn to something that Dr. Kaida raised, and that's the addressing of HIV/AIDS and the possible eradication of HIV/AIDS.

The federal government adopted targets a number of years ago, yet in the last budget there was no new funding and in fact not even a mention of HIV/AIDS in the federal budget. I'm wondering, I guess, how we're doing on achieving the goals that Canada set for itself in terms of eradicating HIV and whether we really recognize that those who are suffering from HIV/AIDS now have shifted.

As a gay man of a certain age, I know that HIV/AIDS has always been associated with older gay men, but we now see an incidence much more prevalent among women and, in particular, indigenous women. I wonder how we're doing on those goals we set for ourselves in eradicating HIV/AIDS.

Dr. Angela Kaida: Thank you again for such a great question. I'm going to speak from a research lens, and I'll invite my colleagues to speak from a policy and service delivery lens.

From a research perspective, I think we obviously have seen a complete transformation over the last 30 to 40 years in what HIV/AIDS looks like for people living in Canada. The research base, the scientific contribution to that change, has been, I would say, nothing short of remarkable.

I absolutely agree with you. I think that in HIV we do see desperate disparities in terms of what it means to be a person living with HIV today or a person at risk of acquiring HIV today. Certainly, we've seen some remarkable progress for gay men, particularly those in urban settings, whereas we have seen much less progress and some really concerning trends for women and transgender individuals, especially those in the prairie provinces of Saskatchewan and Manitoba.

In terms of meeting our targets, we certainly have not met those targets uniformly. We have some communities and populations across Canada who have exceeded the targets set by the federal government and by the community organizations themselves. Certainly, we do continue to see gender-related gaps in terms of achieving those targets.

I'm very happy to say that one of the national women's health research initiative hubs that were funded earlier this year is focused specifically on improving access to care and treatment prevention services for women and gender-diverse people living with and affected by HIV. In mobilizing that research evidence base, we are very hopeful, again, to see that help minimize the gaps we are currently seeing today.

● (1200)

The Chair: That you, Dr. Kaida.

Next we have Dr. Ellis, please, for five minutes.

Mr. Stephen Ellis (Cumberland—Colchester, CPC): Thanks very much, Chair.

Thanks, everyone, for coming.

Ms. Moriarty, in your opening statement you talked about the high priorities of women's health. Could you enlighten the committee as to what those are?

Ms. Cindy Moriarty: I mentioned a number of issues in my opening statement, but I think the current priorities for.... First of all, everything is a priority for women's health. All of the issues we're looking at, we're also looking at with a lens in terms of impacts on women. Speaking for the health portfolio and not just for the department, sexual reproductive health is a key priority as are cancer research and breast cancer screening.

We have a scientific advisory committee, as my colleague mentioned, that's looking at medical devices and their impact on women, and we have the drug regulatory. There's not a health issue that doesn't have an impact on women and doesn't require that attention.

Mr. Stephen Ellis: Of course there isn't; that makes perfect sense. As I heard you pose your answer, though, there were high priority areas specifically for women's health, and I was wondering if there were things.... You did mention ovarian cancer. There was $10 million in funding allotted in 2019. Can you tell us a bit about that?

I mean, ovarian cancer, as I'm sure you well know, is always detected too late, because there aren't any great screening programs for it. How are we helping women in Canada deal with ovarian cancer specifically, and how has that $10 million been spent?

Ms. Cindy Moriarty: I don't have a lot of depth of knowledge in terms of ovarian cancer. I'm not sure if I have anyone at the table today who can help you. If not, we can take that back and come back to you.

The Chair: Dr. Clifford wants in here.

Dr. Tammy Clifford: I'm not an expert in this space at all, but I did want to let you know about some research we have funded through CIHR, about $35 million in funding towards ovarian cancer research in the past five years. This research focuses on projects that look at point-of-care testing devices, so there's recognition there around point of care, meaning perhaps increased accessibility for those who are living outside of urban areas, improving detection and diagnosis, and, of course, treatment.

In particular, there is a large project that is going on at UBC with Dr. Samuel Aparicio working on detection in that space. Again, it's research that's under way. As Dr. Kaida mentioned in her response to an earlier question, we will be paying attention to that research as the results come out in order to implement them into care.

Thank you.

Mr. Stephen Ellis: Thank you very much.

Through you, Chair, I'll ask both of our guests to table that information with the committee. That would be ever so helpful, since ovarian cancer will be one of our areas of focus.

Dr. Kaida, you mentioned specifically that there were $8.3 million for women's health hubs. Again, I'm looking for more specificity around that, where the health hubs are located and maybe a line or two about what they're doing.

Dr. Angela Kaida: We've funded 10 national women's health research hubs across the country. We have them distributed. We have three that were funded in British Columbia and three that were funded in Alberta. We have, I think, two in Quebec and two that are based in Ontario. Across all of the hubs, one key criteria was that they had a national scope, and that involved including researchers, clinicians, people with lived and living experience, indigenous leaders, trainees, etc., from across the country. Even if a hub was specifically funded in Alberta, for instance, there was a national network of folks committed to that research area.

If I can share a couple of examples of the hubs we were able to fund—

Mr. Stephen Ellis: Dr. Kaida, we're short on time. If you wouldn't mind tabling that with the committee, that would be excellent. I'd really appreciate that.

Dr. Angela Kaida: I would be delighted to do so.

Mr. Stephen Ellis: Thank you. I'm sorry for interrupting.

Chair, I think I have about 30 seconds or so left. To whomever may have an answer, we often talk about how there are multiple screening programs specifically for cervical cancer that are great across this country. How do we focus on allowing one of them to come to the forefront, realizing there is provincial and territorial supervision of those projects but, sometimes, somebody's better at it than the others? How do we help that happen?

Does anybody have an answer on cervical cancer?

● (1205)

Ms. Cindy Moriarty: I'm sorry. We'll come back to you on that.

The Chair: Dr. Powlowski, you have the floor for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I'm surprised that Stephen didn't go where I'm going here.

On breast cancer screening guidelines, I thought I would first, as Ms. Moriarty and I think Ms. Comtois wanted to talk about this, point out that the current recommendations came from the task force on breast screening and came out in 2018, according to the government website. These are currently being reviewed, and that was as of June 2023. I wonder where that's at.

I have certainly heard a lot of concern about those recommendations, particularly from the group Dense Breasts, which is made up of breast screening experts who feel that the current recommendations are inadequate. Currently, we're not recommending any mammograms for women under 50. Certainly, some of the concerns are that Black and Asian women tend to have their peak incidence of breast cancer 10 years younger than Caucasian women. Also, women who get breast cancer early tend to have more aggressive cancers.

The U.S. Preventative Task Force draft recommendations are now that women start getting mammograms at age 40 and every two years up until age 76. Again, we're at 50.

This is potentially a big problem, if you listen to Dense Breasts. This results in quite a few women not being diagnosed with cancer as early as they should be. It is being reviewed. When will those reviews be finished? When will we have new recommendations?

I ask that to either of the two of you, Ms. Moriarty or Ms. Comtois, and hopefully someone has an answer.

Ms. Cindy Moriarty: I think, Annie, that one's for you.

Ms. Annie Comtois (Executive Director, Centre for Chronic Disease Prevention and Health Equity, Public Health Agency of Canada): Yes, I'm happy to take it.

On November 15, the Canadian Task Force on Preventive Health Care, which is an arm's-length independent organization, announced to their members and the public that their guidelines had to be delayed until the spring of 2024. They had initially anticipated to release them in the fall, but because of the volume and complexity of the evidence that they're currently looking at, which includes looking at evidence for women with dense breasts and looking at health equity considerations, they determined that they needed a little bit more time, and the organization they're working with requested more time. Now they're looking at spring 2024 to release the new guidelines.

Mr. Marcus Powlowski: I believe the task force on breast screening is an arm's-length body made up of 15, I think, primary care practitioners. Certainly, according to Dense Breasts, they had some complaints about the decisions of the committee and the fact that the committee did not include people with expertise on breast cancer or breast cancer imaging. I admit to a somewhat biased perception, because I talked to Dense Breasts, but I haven't talked to the people on the committee.

Certainly there was concern that there ought to be specialists in that group. I certainly have some sympathy, since I spent my whole life as an emergency room doctor or doing other forms of general practice. I always was happy to bring in a specialist who knew more about this than I did.

Why do we not put specialists in that group that makes these recommendations? Is there any consideration of perhaps changing the makeup of that group of people?

Ms. Annie Comtois: I would just start with a clarification.

It's the Canadian Task Force on Preventive Health Care. They develop a wide range of guidelines, including breast cancer screening guidelines. It's a subcommittee, a working group of the whole task force, that is developing the guidelines.

As part of that working group, they have four experts supporting them, a clinical oncologist, a surgical oncologist, a radiologist and a radiation oncologist.

Mr. Marcus Powlowski: Is that the group that's currently looking at making up new recommendations?

Ms. Annie Comtois: Exactly, yes.

Mr. Marcus Powlowski: Then that's new. You have, in fact, changed the approach.

Ms. Annie Comtois: My understanding is that there were always experts brought into the development of guidelines, but, in this one instance, I know that there are specifically four experts who are engaged in the working group, including three patients with life experience.

● (1210)

Mr. Marcus Powlowski: It wasn't my understanding that there were experts brought in, because that was part of the complaint.

Okay. Who selects the members of the task force? I assume it's someone in government. Who is that?

Ms. Annie Comtois: The selection of task force members is done through a selection committee. The chairs of the task force are part of that selection committee. There's also a representative from the Public Health Agency of Canada and one from the College of Family Physicians of Canada.

The Chair: Thank you, Dr. Powlowski and Ms. Comtois.

Next is Dr. Kitchen, please, for five minutes.

Mr. Robert Kitchen (Souris—Moose Mountain, CPC): Thank you, Mr. Chair.

Thank you, all, for being here. It's greatly appreciated. I know we have the Department of Health and PHAC and researchers here as well, who are great to have.

We're looking at women's health and ultimately how we address this issue. There's a lot of concern, and I'm going to go right to what I hear from patients. Ultimately, one of the concerns you hear from patients is that female patients, first, can't find female practitioners. When I went to school 39 years ago, there were more men than women in the practice. Now, when you look at it today, you're looking at over 50%.

In my latest research I saw that, overall in Canada in 2022, 49.7% of physicians were female. When we look at gynecologists, we see that just under 60% are female gynecologists, which is great to see, and because that knowledge is there there's that ability to interrelate.

However, the concern a lot of female patients have is that they can't get access to a practitioner who will talk to them or a female practitioner they can relate to. This question is for all of you, and maybe I'll start with Dr. Clifford. What do we need to be able to do here in Canada to, first, have more female practitioners and, second, make certain we have them out there such that patients have a chance to see them?

Dr. Tammy Clifford: Thank you so much for the question.

I really wish I had an answer to it as well. I'm hoping that the other study that occurred on health human resources might shed some light on that. In fact, if it was taking a GBA+ approach, that should be picked up in that conversation as well.

From CIHR's perspective, I can tell you what we do in terms of researchers who identify as female, because we've certainly recognized the importance of this in terms of not only the research community but the types of questions that researchers study. There is a link there in terms of what actually gets taught to physicians and, of course, what gets practised.

For a few years now at CIHR, what we have decided to do is to equalize success rates, if you will, in our largest grant program, which is called the project grant program, because we recognized that, despite the fact that there are increasing numbers of female principal investigators who are applying, they were not, for a variety of reasons, achieving the same success rates. Therefore, for a few years now, we have said, for example, that if 40% of the grants come in from female researchers, 40% of the grants we award will also go to female researchers.

That is one step. I know it's not specifically answering your question, but in terms of research contributing to clinical care, we felt that this was important to do based on the levers we have.

Mr. Robert Kitchen: Thank you. I appreciate that. You've opened a whole new kettle of thought in my mind.

As we indicated, CIHR gets a lot.... There's money that's given by the federal government for a lot of research. It's great to see that you're looking at delegating that for female researchers.

Ultimately, though, the patient wants to know the outcome, and they want to know the research is actually going to provide an outcome to something that's going to improve female health. I'm just wondering how many studies are being done where you actually have an outcome that can be put forward to improve female health care.

Dr. Tammy Clifford: That's a wonderful question. I might also tee up my colleague to be ready to get in here with specifics.

Again, it's relatively recently, but what I can tell you is that CIHR now requires that those who are funded through federal tax dollars ensure that the results of their research end up in the public domain. This is a fairly new phenomenon. This is particularly true for clinical trials. Those data need to appear in the public domain within one year of the completion of the study.

● (1215)

Mr. Robert Kitchen: Thank you.

I know my time is basically up. I suspect we will probably address it when we get to the endometriosis study, but the reality where we have so many issues dealing with.... I know when I went, I took an interest and followed my stream into what I wanted to go to. I see that so much out there. The concern we have for so many patients who are dealing with endometriosis is that they're not able to find a practitioner who even has it as an interest or can even answer their questions.

Perhaps you might be able to provide suggestions on how we get that interest into practitioners such that they're aware of this topic and are continually on top of it such that, when women come to them, they're able to deal with that aspect. I realize there's no time to answer that, but I appreciate that. Thank you.

The Chair: Can you respond very briefly to that?

I would be interested to hear the response, although we are out of time.

Dr. Tammy Clifford: Go ahead, Cindy.

Ms. Cindy Moriarty: Thanks.

We are funding a couple of projects through the sexual reproductive health fund that are focused on endometriosis. One is going to the Endometriosis Network Canada. They are doing patient-centred public education. We're also providing funding to the Society of Obstetricians and Gynaecologists to look at capacity building and training for health care providers to have a better understanding of endometriosis.

I'm happy to provide more information on either of those, if that would be helpful.

The Chair: Thank you very much, Ms. Moriarty.

We'll go to Dr. Hanley for five minutes.

Mr. Brendan Hanley (Yukon, Lib.): Hello to everyone. Thank you so much for coming out. I also want to thank you for all the work you do.

First of all, I wanted to clarify something. I believe there was a comment earlier from my colleague, Madame Larouche, about an increase in the incidence of cervical cancer. To my knowledge there is no increase. There may be a recent attenuation of the decrease.

I wonder if Dr. Kaida or someone else could please clarify that quickly for us.

Dr. Angela Kaida: Thank you so much for the question and opportunity to clarify.

I don't have the specific numbers for the incidence of cervical cancer in Canada right now. I do know that, because of improving detection and earlier screening, we may see an increase in the number of cases that are detected, but that's possibly a good sign. It just means that we are identifying those cases earlier.

Unfortunately, I don't have the numbers right in front of me about whether we have seen an increase in cervical cancer in Canada or whether it is, as you say, an attenuation.

I'm happy to provide that.

Mr. Brendan Hanley: I think that would be very useful to get some clear data and clarification on that because, despite what you're saying about increased detection, I don't believe that's a factor. I could be wrong if there's a recent change. That would be very important for us to know.

I wanted to switch to a point that was referred to earlier. I just want to get a bit more information. This is about perinatal mental illness.

Recently I had a conversation with someone in my riding who described her own experience and was also advocating and researching how we can improve access to perinatal mental health services for those mothers who are struggling, whether that's expectant mothers, after birth or through the process. We know that getting help has not always been easy.

Ms. Wong did mention the project, which I appreciate, that is currently under way through Women's College. I wonder if Dr. Kaida could briefly comment on what efforts and initiatives there are for improving access to perinatal mental health services from a research point of view. Then I would ask Ms. Hurley to comment on other projects within the scope of the Public Health Agency.

● (1220)

Dr. Angela Kaida: Thank you so much for the opportunity to follow up on that question.

From a research point of view, this is definitely a priority for us. One of the knowledge mobilization hubs that we funded in August 2023 is from a group at the University of Calgary that is focused on the Inuit perinatal health hub. It is really about developing and building Inuit-specific resources and support for Inuit women in Nunavut. I think that's an example of a very particular community and of mobilizing research evidence that is focused on perinatal health.

I'll add that on March 9, 2022, a ministerial round table was held with some key stakeholder groups in perinatal mental health, which included experts, practitioners and people with lived and living experience. It focused on examining access to perinatal mental health. We're looking forward to seeing the results of that study.

I think my colleague Cindy also mentioned the work that's focused on creating a national clinical practice guideline for perinatal mental health. I'll be happy to follow up with you with additional details from that research and what we're learning.

Thank you.

Mr. Brendan Hanley: Thank you.

Ms. Wong or Ms. Hurley, would you have anything else to add in terms of more on-the-ground support for access to care?

Ms. Shannon Hurley: I'll close the loop.

In terms of mental health promotion, our programs at the Public Health Agency of Canada are not specifically aimed at perinatal mental health but more at addressing risk factors and boosting protective factors. We do have one project that's funded right now that's looking at maternal mental health through a wraparound model, and that's just an example among more general programming.

I'll turn to my colleague Mark, who works more with the children and youth division.

Mr. Mark Nafekh: We do offer the Canada prenatal nutrition program, which is a $26-million annual program to community-based groups. Through those community-based groups, we look to develop and deliver comprehensive culturally appropriate programs that promote health, including mental health.

An example would be a program called “Nobody's Perfect,” where trained facilitators work with participants to increase their understanding of health behaviours and also to bring them in contact with community resources and services, including for mental health.

The Chair: Thank you.

[*Translation*]

Ms. Larouche, you have two and half minutes.

Ms. Andréanne Larouche: Thank you, Chair.

Mr. Morgan, you may have had the opportunity to look at national women's health strategies in other countries. During my last turn, I listed examples of countries that recently published such national strategies, including Australia. Do you have anything to add in relation to the question I asked earlier?

Mr. Ed Morgan: Internationally, we work very closely with our counterparts on these issues. For example, we work with ICH, the International Council for Harmonisation of Technical Requirements for Pharmaceuticals for Human Use, which is responsible for harmonizing and updating our rules and guidelines for clinical trials.

[*English*]

That's one example.

[*Translation*]

We're also part of other international working groups. We're working with ICMRA, which is the International Coalition of Medicines Regulatory Authorities, an international coalition made up of regulatory bodies, on the issue of data and how we can improve the way we ask big companies to provide us with their data. So we're working very closely with our partners on the international stage.

● (1225)

Ms. Andréanne Larouche: As previously stated, in Canada, health care is the responsibility of Quebec and the provinces. They have the expertise and manage the health care system. This is a uniquely Canadian feature. However, when it comes to health care, it's true that statistics, data collection and research are the responsibility of the federal government. How do you take this division of powers into account when you compare Canada's strategy with those of other countries?

Mr. Ed Morgan: I can tell you that clinical trial data, for example, is not protected and therefore does not raise any major concerns. When it comes to data in general, however, my colleague Cindy Moriarty can provide you with a better answer.

The Chair: Please keep your answer brief if possible, Ms. Moriarty.

Ms. Cindy Moriarty: When it comes to data in general, we share what's available wherever possible. We're not out to reinvent the wheel. When it comes to developing strategies on data and its collection, we work closely with other countries and international organizations.

The Chair: Thank you, Ms. Larouche.

[*English*]

Next, we have Ms. Idlout.

Welcome to the committee. You have the floor for the next two and a half minutes.

Ms. Lori Idlout (Nunavut, NDP): *Qujannamiik, Iksivautaq*. Thank you, Chair.

I'd like to thank the witnesses for their important testimony.

I'd like to ask one question for all three witnesses to answer. My question will be related to the calls for justice.

As you'll remember, the missing and murdered indigenous women and girls commission was started in 2016. Three years later, the final report was published. There were 2,038 participants who engaged in the important work of the commission. Unfortunately, out of the 231 calls for justice, only six of the seven are being implemented.

Could each of you explain why the federal government has failed to meaningfully address these calls for justice to date?

Qujannamiik.

Ms. Cindy Moriarty: Thank you for the question.

I can't speak on behalf of all departments. I can share a little bit about what is happening at Health Canada.

We have a program that provides funding directed at addressing anti-indigenous racism and making changes in the health system. We're providing funding for various projects through that to make systemic change. We're certainly looking within the department at everything we're doing with that context in mind.

We also contributed recently to a study that was done on forced and coerced sterilization, which has targeted largely—but not exclusively—indigenous women. It's something we're looking at with great attention.

I'll refer to my other colleagues from the Public Health Agency and CIHR to see if there's anything else they want to add.

The Chair: Ms. Hurley, go ahead, please.

Ms. Shannon Hurley: I'd be pleased to add.

From the point of view of the Public Health Agency of Canada, addressing the calls for justice is a multi-sector, all-of-government responsibility, and we are contributing from a health perspective.

I have mentioned some of the programming we do to address family violence and gender-based violence. That includes projects that are specifically supporting the needs of indigenous women and girls and indigenous communities. Our department also works with indigenous partners on data collection, so we can better understand what family violence, including child maltreatment, looks like for all populations, including indigenous populations.

That's part of our contribution and—

The Chair: Thank you, Ms. Hurley and Ms. Idlout.

Next we have Mrs. Vecchio, please, for five minutes.

Mrs. Karen Vecchio: Thanks for having me back on this.

I would like to talk about eating disorders.

When we're looking at mental health and wellness, eating disorders are very prominent among our young women. What are we doing through education and awareness programs to encourage young women to understand healthy eating?

● (1230)

Ms. Cindy Moriarty: Shannon, is that something you can take?

Ms. Shannon Hurley: Thank you.

From the point of view of the Public Health Agency of Canada, as I've mentioned, we work in programming to promote mental health and prevent mental illness. That's addressing risk and protective factors across a range of areas.

We are currently supporting two projects that I can think of in particular. One is working to create a peer support network for people with eating disorders. One is working on addressing weight-related bullying and unhealthy body images. Those are some examples of how that programming can address that issue.

Others may have other comments.

Mrs. Karen Vecchio: I know, but I have questions on a variety of different things. I'm sorry.

I believe Mr. Garrison also talked about dosages when it comes to medication. Something I've found really strange is that my son, who is a 20-year-old, six-foot-two man, and his 52-year-old mom are taking the exact same dose of a medication.

Can you give me some ideas on what we're doing to ensure...? What studies have been done or when are we expecting studies to come out indicating what the dosage properly should be based on gender?

Mr. Ed Morgan: Maybe I can jump in quickly, if it works.

One thing we're doing right now is actually moving regulations. We've just gone to Canada Gazette, part I, to ask companies or people to basically bring forward submissions of disaggregated data. Whatever data they have that they may have provided to other jurisdictions, we want them to provide to us.

That's one step. Again, it's gone to CG, part I. I think stakeholders were quite happy with it. We're hoping to move that forward within the next year or so to finalize it .

A second step we're taking is part of our clinical trials reform. We're looking at the whole regulatory structure of clinical trials. One thing we want to ask companies to do is to provide us with a diversity plan. We've gone out and my colleagues have consulted on it. Right now, it seems to have been received favourably, so that would again require providers to try to provide us with disaggregated data.

Those would be—

Mrs. Karen Vecchio: Thanks so much.

That, to me, is just so important. I look at it and think, “We're so different. How are we taking the same medication?” It just doesn't make any sense to me. I really appreciate that.

I'll go back to a different area of public awareness and fetal alcohol syndrome. We know that just a drop of alcohol can cause problems, especially in the first few weeks of pregnancy. What are we doing to ensure that Canadian women are aware that they could be at risk of fetal alcohol syndrome for their child? What are we doing for prevention there?

Mr. Mark Nafekh: Thank you for the question.

The FASD national strategic projects fund funds $1.5 million annually to collaborate with key stakeholders and partners across Canada to develop nationally applicable tools, resources and knowledge that can be used to prevent FASD and improve outcomes for those who are already affected, including families and communities. Also, through the programs I mentioned earlier—the Canada prenatal nutrition program and the community action program for children—we provide information, guides and facilitators to share information with pregnant people about the risks of alcohol and substance use in general during pregnancy.

Mrs. Karen Vecchio: Thanks very much.

I'm getting into a bit more of a dicey area, but when we talk about safe supply, I look at safe supply and I look at women using safe supply, and the environment where the safe supply is being used becomes extremely unsafe for women.

Are there any comments on that when it comes to safe supply, the safety of women and how it could lead to violence?

Ms. Cindy Moriarty: Thank you for the question.

I'm sorry. We don't have anyone here who has expertise in substance use and addiction. My understanding is that there is a separate study under way or that's going to be under way on it.

In terms of your link to violence, I don't know if my Public Health Agency colleagues have something to say.

Ms. Shannon Hurley: I will only add that I don't know the details about safe supply, but certainly substance use and its links to violence, and as an outcome of having experienced violence, are really interconnected issues. A lot of the work we fund and support addresses both of those issues together. For example, we're supporting mothers who have experienced abuse and substance use. That's just as an example.

Mrs. Karen Vecchio: Thank you.

The Chair: Thank you.

We'll go to Ms. Atwin, please, for five minutes.

● (1235)

Mrs. Jenica Atwin: Thanks, Mr. Chair.

We've really covered the gamut here of a lot of different topics. I'm so appreciative of our witnesses for their wealth of knowledge.

Ms. Clifford, in your opening, you mentioned that there's been a marked shift over the last decade or so as far as a renewed focus on women's health and women's health research, in particular, is concerned. Can you expand on that?

What do you account for in this shift? Certainly, government support is one piece, but I'd really love to highlight the different women's voices and advocacy that have created this very important shift.

Dr. Tammy Clifford: Great. Thank you for the question. How long do you have?

First of all, I have to credit so many people, including Dr. Kaida, who is here today as our current scientific director of the CIHR institute of gender and health. Dr. Kaida joined us within the past year or so. Before her, it was Dr. Cara Tannenbaum, who held the tenure of that institute for eight years.

Again, I would say it's through a combination of efforts that CIHR recognized early on the importance of encouraging the research community to pay attention to the importance of studying sex and gender in their research projects. It probably won't come as a surprise to you that, initially, what we did was simply put a tick box on an application asking, “Did you consider this—yes or no?” It didn't take us long to figure out that it was inadequate, because you can tick a box, but that doesn't mean you did it or you did it well.

Over the years, what we have done is, little by little, ensure that those who apply for our funding and those who are peer reviewing funding must take training modules to make sure that they're aware of this. When the actual research protocols are then reviewed, there is a discussion about this.

The entire academic research community is much more aware of these issues. I have to say it's thanks to champions like Dr. Tannenbaum, Dr. Kaida and others who ensure that this topic remains front of mind for all of us who are doing this work.

Thank you for the question.

Mrs. Jenica Atwin: Thank you very much.

Ms. Moriarty, I can't help but think about how there are so many women, in particular, who are nurses or nurse practitioners—of course, they are physicians as well. It's very female-dominated in certain sectors. I also think about how we're seeing a lot of burnout.

I'm wondering if you can provide us with some direction for or advice on how we can better care for those who take care of us.

Ms. Cindy Moriarty: Thank you for that question.

I wish I had an easy answer for you. I think the COVID pandemic really did a number on everyone. I'm not saying anything you don't know. The system was so stretched, and then the pandemic just put everything at the individual level and the system level over the edge.

I don't have easy answers for you. The mental health supports that my colleague Suki Wong talked about are available to practitioners just as much as they are to patients. I think there's other work that's going on among the department and provincial and territorial governments to look at this crisis in terms of health human resources, but I don't have a specific solution for you. I'm sorry.

Mrs. Jenica Atwin: Would anyone else like to add to that?

Ms. Shannon Hurley: I could add more.

From the point of view of, again, the mental health promotion work at the Public Health Agency of Canada, we are administering some funding that was provided in budget 2021 to address the mental health impacts of the pandemic. That included funding to address PTSD and trauma in service providers, including health care workers as well as public safety personnel and other people on the front lines during the pandemic.

Those projects are doing things like peer support, training for resiliency, trauma-informed practice and reducing stigma. We do hope they'll have a lasting impact and leave a legacy of some knowledge and resources that will help address some of those issues.

Mrs. Jenica Atwin: Thank you very much.

With my remaining time, Dr. Kaida, you mentioned health hubs. I think you mentioned there would be five across the country. As a proud Atlantic Canadian, I'm wondering if there's one in the Atlantic region. What can we expect as far as projects or initiatives that will be undertaken?

Dr. Angela Kaida: Thank you so much for this question.

There are 10 health hubs across the country. There isn't one specifically located in your province. However, what was very critical for us as the funder was to ensure that whomever was funded had national networks across the country. These are virtual hubs. They're not bricks and mortar. Perhaps the principal investigator is not located in your province, but there will be researchers, people with lived and living experience, community advocates, leaders, etc., who are based in your province.

I'm happy to provide the specific details of the folks who are involved, but that has certainly been a priority for us as an initiative, making the most of the fact that we obviously have diverse priorities over the provinces, but we have expertise from coast to coast to coast.

● (1240)

The Chair: Thank you, Dr. Kaida.

Next we have Mrs. Roberts, please, for five minutes.

Mrs. Anna Roberts: Thank you, Mr. Chair.

I'm going to address my question to Mark. In Toronto, 75% of women have experienced violence on our transit system. When they get arrested, I know we provide education when they go to jail. What is the percentage of women receiving that same type of attention as opposed to the men?

Mr. Mark Nafekh: I don't have those numbers available to me at this point. That's something I would have to bring back.

Mrs. Anna Roberts: Okay. That would be great.

Women are being attacked more than men—let's be honest. It's important, as a mental health issue, that we provide them with the proper mental health care they require.

I, personally, in my previous life—I was a branch manager—was robbed five times and shot at once. I appreciated the counselling. I'm blessed that I have a thick skin. I don't know, but maybe that's the Italian in me. It's important that we address that. I always find when I talk to constituents that.... I've spoken to a few women who said, “When you report it and when it comes out, you're asked what you did to provoke it. What were you wearing? What were you doing?” That's an issue that I think we have to get our heads around.

Women are women. Men are men. We provide them the tools they need while they're incarcerated to make sure they don't go out and reoffend. What guarantees do we have for the women who have been subject to these offenses, and how can we protect them better?

Mr. Mark Nafekh: My corrections background seems to be calling me back a little bit here, but I would like to give the opportunity to any of my colleagues on this panel who have more of an expertise in violence and mental health.

Ms. Shannon Hurley: I can just really confirm how important it is, as you say, that the people providing services and supports to people who have experienced violence understand how violence can affect people. That's being trauma-informed. It's not asking, “What did you do? What were you wearing? Why did you let him to do that to you?”

Mrs. Anna Roberts: That's right.

Ms. Shannon Hurley: Some of the work that we're doing is in fact aiming to educate and equip service providers. That's health care workers and social service providers, but others too—teachers, coaches. In fact, all of us should be trauma-informed, and we shouldn't need to know whether you were shot at. I'm so sorry to hear that happened, but we shouldn't need to know. We should use safe approaches with everyone, and that's part of the work that we're doing to educate, not just to stop the violence but also to make sure that people are getting appropriate care from service providers.

You raise a really good point.

Mrs. Anna Roberts: We continuously talk about the fact that women are more susceptible to violence than men. It is our responsibility to make sure that we educate our children, especially our male children, on respect for women. I know, being part of the status of women committee, that it is something that we definitely spoke about.

We recently had the gymnastics review, where the CEO—I questioned him personally—said that there were over 600 women who reported violence and nothing was done. When I asked him if his children had been in the same situation, where they came home and said, “This is what happened to me”, he would have launched an investigation, his response was yes.

We have to make sure that men understand that women are just as important, and we need to provide that service to them so that they can move on with their lives, because sometimes, if you don't, it sets them back and some don't recover.

As parliamentarians, we have to make sure that people understand the importance of mental health in violence against women. Would you agree?

● (1245)

Ms. Shannon Hurley: Absolutely. It's so fundamental. Experiencing violence, particularly in a relationship with your spouse, your dating partner or your parent, where it can be repeated or ongoing, can have.... The more it goes on, the longer lasting the impact can be on physical health and certainly on mental health.

Absolutely, to be able to go on and have healthy relationships later in life, we need to be able to prevent the violence and also to support those who have been affected by it.

Mrs. Anna Roberts: I'm not sure if you know Bill S-205 that we're working on right now, sponsored by one of the senators who lost a daughter to the same situation. Hopefully we can make a difference in this Parliament to ensure that this never happens again with the electronic monitoring system, because it's a tragedy that we have no opportunity to protect the women we should be protecting.

The Chair: Thank you, Mrs. Roberts.

Next we have Ms. Sidhu, please, for five minutes.

Ms. Sonia Sidhu: Thank you, Mr. Chair.

My question is about ovarian cancer. We know that early detection is the key and, if we detect it early, the survival rate is high. I know my colleagues have already talked about ovarian cancer. Ovarian cancer is the fifth-leading cause of cancer-related deaths in the western world. One in four women on first-line treatment chemotherapy don't respond.

What measure is being taken on the research side so that we can find some kind of treatment that ovarian cancer will respond to? What research can be done?

The other question is related to that. In the 10 women health hubs, are we giving education and awareness in those hubs?

These are the two questions I have. The first, I think, Dr. Clifford, you can respond to.

Dr. Tammy Clifford: Maybe I'll start off and then I'll turn it over to Dr. Kaida.

I agree with you that those statistics around one in four women not responding to the first-line treatment certainly underscores the importance of our finding other treatments.

I don't have it handy right now, but I will go back and take a look at what we have funded in this domain to see whether there may be some early studies that are showing some promising treatments and maybe what will go on after that. That's on me to follow up and ensure that I provide you and the committee with that information.

Maybe, Dr. Kaida, the question specifically around the hubs is for you.

Dr. Angela Kaida: Thank you, Dr. Clifford.

Thank you for that question.

I think your question was, are education and knowledge exchange important components of the hubs in terms of an objective? It is an explicit objective of the funded hubs. The idea and the need for the hubs really speaks to the fact that sometimes we have research evidence and we have scientific findings, but those findings are not being mobilized or translated to the communities, patients, families and individuals who need that information and can use that information to improve their own health.

One of the first objectives of these hubs specifically is to—and I'll read it to be accurate—"mobilize and scale-up newly generated and existing knowledge and models of care". The audiences for that knowledge include patients, providers, policy-makers and the general public, who deserve to know what we're finding in our scientific research in women's health.

Ms. Sonia Sidhu: Thank you, Dr. Kaida. My next question is for PHAC.

Women with diabetes in pregnancy continue to have poor pregnancy outcomes compared with women who don't have diabetes. What efforts are being taken to respond to this through the national framework for diabetes?

What are the efforts to collect data on gestational diabetes, which is impacting women?

Ms. Annie Comtois: Thank you for your question.

I also want to thank you for your bill that led us to the development of the diabetes framework in Canada.

Specifically for data, we have some systems with which we collect information. I don't have the information about gestational diabetes, so I will have to get back to you and the committee on that.

With regard to pregnant women, you may be aware that last year the Public Health Agency launched a type 2 diabetes challenge in collaboration with the Privy Council Office. One project, which was a semi-finalist, is specifically an indigenous project that addresses young mothers. It's called 39 moons. It's an indigenous project that will focus specifically on young mothers and educating them about healthy eating and healthy behaviour to help prevent diabetes for them and also their children.

● (1250)

Ms. Sonia Sidhu: Thank you.

For my last question, we know that virtual and remote care is one of the many important tools that assist patients. What perspective can you give us on using virtual and remote health care when it comes to women's health?

Anyone can answer that.

Mrs. Suki Wong: I'll take the question.

The issue of women facing a need for access is especially acute in remote areas, so thank you for that question.

One tool we have to help women in remote areas would be the Wellness Together Canada tool, where we do have 24-7 access to not just counselling but also stepped care, self-assessment and peer discussions.

The Chair: Thank you very much, Ms. Sidhu.

[*Translation*]

Ms. Larouche, you have two and half minutes.

Ms. Andréanne Larouche: Thank you, Chair.

My next question is for Ms. Moriarty or Ms. Hurley.

I'm vice-chair of the Standing Committee on the Status of Women. As others have mentioned, in March 2023 that committee held a study on the mental health of young women and girls. The recommendations included funding for community organizations and health services. We met with Véronique Couture, who works at a transitional mental health shelter in Granby. She told us that in Quebec, the Ministère de la Santé et des Services sociaux, which funds social services in the province, was willing to fund community organizations like this shelter, which has a different approach, but that it lacked financial resources for certain projects.

We hear that often. How important is it to increase health transfers to give a financial boost to systems in Quebec and the provinces, which would enable us to work more effectively on the issue of mental health and many other things?

Ms. Cindy Moriarty: Thank you for the question. As Ms. Wong is our mental health expert, I will turn to her for an answer.

[*English*]

Suki, can you take this?

Mrs. Suki Wong: Thank you for the question.

You know well that the delivery of mental health services is a shared jurisdiction. I note the action plan that the Province of Quebec put together with respect to the pillars to address mental health. We are working very closely with our colleagues in the Province of Quebec to look at how the services can be delivered in a way that's targeted to the needs of the jurisdiction.

[*Translation*]

The Chair: Thank you very much.

[*English*]

The last round of questions for this panel will come from Ms. Idlout for the next five minutes, please.

I'm sorry. It's two and a half minutes.

Ms. Lori Idlout: Thank you. I was going to ask many more questions if I had that five minutes.

My questions will go to the Department of Health.

We all know that my riding is huge. My riding has three time zones and 25 communities. I know that for medical appointments, because of a lack of available doctors and nurses, the reliance on medical travel is huge. For example, the Government of Nunavut, in 2019, reported that they expected to spend $92 million just for medical travel. All these expenses probably ended up in the pockets of airlines and hotels in the south, with meals being covered in the south.

I wonder if the department can share with me what investments they have for medical care to be provided in Nunavut—how many doctors and how many nurses will increase—rather than our having to spend to send medical patients outside of our riding.

● (1255)

Ms. Cindy Moriarty: I think, unfortunately, that question would be better directed to Indigenous Services Canada, which manages much of this. We can take that back if that would be helpful. Other than that, all I can offer is that, through the bilateral agreements, including with Nunavut, investments will be made. My understanding is that those are still being negotiated and haven't been finalized yet.

Ms. Lori Idlout: *Qujannamiik.*

Does the department have data on how many doctors and nurses are in Nunavut who are full-time and who remain in Nunavut?

Ms. Cindy Moriarty: I don't have that information offhand, no. I understand it's a challenge—I truly do—but I just don't have the data handy.

Ms. Lori Idlout: Could you make that available to this committee once you get it?

Ms. Cindy Moriarty: Yes, we can do that. We'll have to follow up with Indigenous Services Canada as well.

Ms. Lori Idlout: Thank you so much.

I also understand that in January 2021 the federal government announced ongoing consultations with indigenous partners, the provinces and territories, to codevelop distinctions-based indigenous health legislation. However, the government has yet to table this legislation.

Can you confirm when the federal government plans to table this distinctions-based indigenous health legislation?

Ms. Cindy Moriarty: I'm not in a position to give you a specific time frame on that at this time. I'm sorry.

The Chair: Thank you, Ms. Idlout. That's your time, and that's all the time we have for questions.

Just as a reminder to committee members, today is the deadline for any supplementary or dissenting reports on medical devices, so I presume that if there are going to be any dissenting or supplementary reports, they're well under way and mostly translated by now.

To all of our panellists, thank you so much for being here with us today. This was an excellent briefing. It's not often that we have a large collection of officials, and every one of them has their expertise to contribute and gets a chance to contribute. It was very comprehensive, and we certainly appreciate your professionalism and patience in the way you've handled all the questions.

Ms. Moriarty, I hope you're feeling better. Good on you for plowing through the COVID fog in this panel. We greatly appreciate it.

Ms. Cindy Moriarty: You're very welcome. The transcripts will speak for themselves, but I thank you all for your patience as well.

The Chair: Is it the will of the committee to adjourn the meeting?

Some hon. members: Agreed.

The Chair: We're adjourned. Thank you.