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Chair

Mr. Bill Casey

Standing Committee on Health

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● (1540)

[*English*]

The Chair (Mr. Bill Casey (Cumberland—Colchester, Lib.)): Welcome to meeting 140 of the Standing Committee on Health. We will continue our study on LGBTQ2 health in Canada.

We have four presenters today. Each presenter will have 10 minutes for an opening statement.

Welcome back.

Mr. Jody Jollimore (Executive Director, Community-Based Research Centre): Thank you.

The Chair: I'd like to introduce Mr. Gabriel Girard, researcher and sociologist; from the Community-Based Research Centre, Mr. Jody Jollimore, executive director; and from Conseil Québécois LGBT, Mr. Joël Xavier, administrator.

[*Translation*]

Mr. Joël Xavier (Administrator, Conseil québécois LGBT): Good afternoon.

[*English*]

The Chair: From OUTSaskatoon we have Ms. Ms. Rachel Loewen Walker, executive director, and Ms. Martha Smith, board chair.

We will start with you, Mr. Girard. You have 10 minutes.

[*Translation*]

Mr. Gabriel Girard (Researcher, Sociologist, Centre de recherche de Montréal sur les inégalités sociales et les discriminations): Thank you.

Mr. Chair, ladies and gentlemen, members of the committee, dear colleagues, I am very happy to be participating in this committee's work on LGBTQ+ health. I want to congratulate you on this work of collaboration and consultation.

Before I begin my remarks, allow me to introduce myself quickly.

First, on a personal level, I am a gay and cisgender man. On a professional level, as it is in that capacity I am participating in the committee's work, I am a sociologist, a member of the Centre de recherche de Montréal sur les inégalités sociales et les discriminations—CREMIS—where I coordinate the activities of a working group on gender and sexual diversity. I am also a planning and research officer at the Montreal regional public health directorate.

My professional and scientific expertise mainly focuses on gay and bisexual men, and other men who have sexual relations with men, be they cisgender or transgender. To shorten this, I will use the acronym gbMSM. I am interested in those men's conditions and situations mainly in the urban context. So I will speak today based on that expertise.

As an introduction to my presentation, I would like to specify the theoretical framework of my remarks—analysis relative to social inequalities in health. That analysis makes it possible to simultaneously look at systemic dimensions and community and individual realities of social health determinants. When we consider LGBTQ+ health, the analysis relative to social inequalities highlights the importance of a holistic health approach, in order to understand why sexually and gender diverse individuals are structurally in poorer health than the general population in terms of physical health, mental health, or in terms of the prevalence of blood borne and sexually transmitted infections, or STBBIs.

In the remainder of my presentation, I will identify the various health barriers faced by LGBTQ+ individuals as they appear both in scientific literature and in my professional practice.

In Quebec, LGBTQ+ health difficulties are documented inconsistently. For MSM, there are numerous studies, both quantitative and qualitative, mainly related to the HIV/AIDS epidemic. However, for lesbians, bisexuals, trans individuals and other sexually diverse people, the data is unfortunately more limited, often less specific, and mostly comes from what community organizations have been noting on the ground. However, there is sufficient retrospective to identify a few useful pieces of information on the various barriers LGBTQ+ individuals face in the recognition of their health problems.

My first point focuses on systemic or structural barriers.

In Canada, as in a number of developed countries, LGBTQ+ individuals have practically obtained equal consideration before the law. I say “practically”, as some rights are yet to be obtained, especially for trans individuals in Quebec. However, legal equality is not true equality. In other words, recognition of same sex couples and implementation of anti-homophobia policies are indisputable achievements, but they are often offside with the experience of many LGBTQ+ individuals.

In a society where heterosexuality remains the prevailing social norm, the experience and development of young LGBTQ+ people in particular remain strongly steeped in feelings of shame and, unfortunately, in name calling, bullying and violence. Those dimensions, which profoundly affect self-esteem, in large part explain the high rate of suicide attempts among LGBTQ+ individuals, but also more broadly the high prevalence of mental health issues, including anxiety, ill-being and poor body image. Saying this is not an acknowledgment of powerlessness. Our societies are evolving and can still evolve thanks to increased visibility of sexual diversity and gender and the proliferation of positive models, but also thanks to the work of allies and innovation in education.

My second point concerns barriers to LGBTQ+ health in the health system.

Over the past few years, a great deal of progress and innovation has been achieved, most often in response to the urgency of the AIDS epidemic. These advances are a very important source of education. However, they have two main limitations.

First, the existing services generally confine the health of sexual minorities to sexual health or the fight against STBBIs. Second, those services are first and foremost all adapted, with a few exceptions, to gay and bisexual individuals and other cisgender MSM.

● (1545)

However, the health problems of LGBTQ+ individuals largely stem from their difficulties to be recognized and welcomed in the health system as people with specific challenges and needs. That is a more obvious reality for LBTQ individuals than for gbMSM. The health care system, specifically in Quebec, is still all too often struggling to adapt to that reality for the following reasons.

First, the population in question is often perceived as a very small minority by the decision makers. That may be true in certain contexts, but it does not preclude the implementation of inclusive approaches and policies. Second, the health care needs expressed by LGBTQ+ communities unfortunately do not appear to always be a priority in the context of fiscal restraints. Finally, health authorities do not always have an adequate perception of health needs. In the absence of studies and available data, as I was saying in my introduction, certain segments of the population are unfortunately still being ignored. However, experience shows, specifically in Montreal, that service adaptation can be the focus of close cooperation between the affected communities, the organizations that represent them and health services.

The third level of barriers to LGBT health I wanted to talk about today stems directly from the precedent, as it concerns professional practices.

All too often, LGBTQ+ people ask for health services, but they are struggling with difficulties or going through negative or arbitrary experiences. Those difficulties can manifest in a number of ways.

First, there are discriminatory or stigmatizing practices, which unfortunately still exist. Second, health stakeholders or professionals, feeling insufficiently trained, refer patients to other colleagues, and that sometimes leads to unjustified wait times. Finally, more generally, it is difficult to reach a health care professional who is open and welcoming, either for reasons of geographic remoteness or financial barriers, or because those professionals are already overbooked.

The last barrier level I want to talk about has to do with the individuals themselves. Taking care of ourselves and our health is an eminently social and cultural practice. Gender and sexual orientation, but also skin colour, education level, income level and community integration play key roles in all those processes. Why? Because becoming aware that we have particular and legitimate health needs as LGBTQ+ individuals requires a certain level of personal comfort, a knowledge of our body, an ability to reason and a desire to take care of ourselves that also develop through interactions with other members of our community and with the health care system. The transition from a perceived health care need to the effective use of health care is part of the relationship map in the same way as care maintenance, pursuit of our treatment or medical follow-up.

Having provided a brief overview of these different barriers, I would like to conclude my presentation by identifying a number of potential solutions that stem mainly from my professional experience. From the outset, I want to specify that the success of these solutions is based on three winning conditions: intersectoral collaboration, recognition of the expertise of the affected communities, and the taking into account of diversity of health care needs of LGBTQ+ individuals.

The first potential improvement has to do with the health journey.

The first challenge related to the health journey is related to navigation. In Montreal, research with gbMSM has shown that, beyond specialized or adapted services, the key is also in the affected men's ability to navigate the health care system. Access to regular STBBI screening is a good thing, but that gateway should also make it possible to be referred, if necessary, to mental health services and addiction services, or community resources to break down isolation. The silo approach still conditions the use of care too often. Putting in place navigation tools, such as online service mapping, would make life easier for affected individuals and facilitate the work of health care professionals.

The second challenge related to the health journey is that health care needs of LGBTQ+ community members vary depending on identities and life stages. For example, LGBTQ+ seniors need services as seniors, but also as LGBTQ+ individuals. An integrated approach would help take that into account accordingly.

Finally, a third very simple idea to facilitate the health journey would be to implement visual tools such as posters or pamphlets in services or organizations indicating that LGBTQ+ individuals are welcome. Those signs of consideration, often discrete, are a favourable signal for the affected people to feel comfortable opening up to their health care professional.

The second potential improvement has to do more directly with health care professionals. It clearly concerns knowledge—so initial and ongoing training—as numerous tools now exist to develop the skills of professionals who deal with LGBTQ+ patients. It also has to do with know-how, as, contrary to a preconceived notion, it is not necessary to be an LGBTQ+ health care specialist to take on patients from those communities.

● (1550)

In most situations, availability and attention to the individuals can be enough to identify difficulties and consider health options or a direction to take. A patient disclosing their sexual orientation or their gender identity must be seen as a very significant step by health care professionals.

[*English*]

The Chair: All right.Thank you very much.

Now we go to Mr. Jollimore.

Mr. Jody Jollimore: Good afternoon, Mr. Chair and members of the Standing Committee on Health. I am grateful for the opportunity to speak to you here on the traditional territory of the Algonquin first nations.

My name is Jody Jollimore and I'm the executive director of the Community-Based Research Centre or CBRC. My expertise comes from 15 years of HIV prevention, a master's in public policy, but most importantly as a gay man who has lived, worked and loved in Nova Scotia, Quebec and British Columbia.

I'm lucky to have been born in a time when it's good to be gay. I grew up with *Will & Grace*, Svend Robinson, and for the most part, gay marriage. By the time I had my sexual debut, life-saving medications meant that men like me were no longer being cut down in their prime by AIDS.

But despite the immense political and human rights gains, our health outcomes, the health outcomes of all queer people, continue to be some of the worst in the country.

My organization, CBRC, was started in 1999 as a response to HIV among gay men in B.C. While we were founded for and by gay men, we made strides to include other sexual minority men, including bisexual, queer—cis and trans—and 2-spirit people. Our nationwide Sex Now survey comprises the largest dataset of this population, which continues to be an important source of information for policy-makers and program planners.

You see, while governments were trying to either ignore or, worse yet, erase our population, we were in the background quietly collecting data, developing reports and talking about gay men's health to anyone who would listen. These days, we've increased our focus on public policy, recognizing that the kind of change needed is transformational and structural. For instance, we've partnered recently with Canadian Blood Services to inform their policy change on blood donations for men who have sex with men.

But before we talk policy, I want to tell you a story that I think contextualizes some of the struggles we face as a community.

One of my best friends in high school was gay. He was a great friend and mentor to me. We both left rural Nova Scotia to pursue our dreams. But my friend had always struggled with undiagnosed depression and this worsened when we moved to the city. Despite being surrounded by more of his peers than ever, he continued to feel lonely, depressed, anxious, all very common issues impacting queer people, even in big cities. He self-medicated with substances and eventual started using crystal meth. Meth made him feel good. It made him feel wanted and accepted and part of something. It's hard to tell whether he was using meth or not when he contracted HIV, but I was with him the day he got his results. And we cried together. But we knew it would be okay because there were treatment options to keep him alive, especially in British Columbia. Only my friend didn't opt for treatment. Instead, he further isolated himself. He lost jobs, apartments, lovers and friends because of his meth use.

Left untreated, HIV becomes AIDS. And though it's rare in Canada, it does still happen, and usually only to those who are most marginalized and disconnected from care. My friend died of AIDS in the late 2000s despite there being free medications that would have saved his life. And my friend was not one of the most marginalized. Instead. like me, he was quite privileged. I'm white, I'm able-bodied, I'm cisgender, and I'm HIV-negative. These all make me privileged, and yet, according to the Public Health Agency of Canada, the fact that I'm a gay man means that I'm 131 times more likely to get HIV, 20 times more likely to develop an HPV-related anal cancer, and 4 times more likely to commit suicide.

This is startling. Yet, this is what we consider a healthy, privileged gay man. So the bar is set pretty low.

I listened to my colleagues' testimony from your last three meetings, and I was able to sit in on your meeting when you were in Montreal at RÉZO. I think the speakers have done a great job of setting the foundations for this study. By now, you know that our health is not great. Across the board—physical, sexual, and in terms of mental health—on all fronts we fall short. And this is only what we know with the limited data we have. If we were truly leveraging the research and data tools within the federal government, we'd know so much more.

Let's talk about what the feds can do about this. First off, my buddy had some mental health issues that were not being discussed at home or at school. Recent investments in mental health had been made, but they're modest and they frequently do not address the unique situation faced by queer people. Our mental health impacts so many other aspects of our health, and it's far more costly to treat the problem than prevent it. Treatment is almost always more expensive than prevention.

The feds should increase their investment in mental health and earmark specific funds for sexual and gender minorities. The mental health fund at the Public Health Agency is a program that could be expanded to include, or be mandated to target the agency's funding calls towards, organizations doing queer work.

● (1555)

We also need to reduce stigma in this country. It's killing us. First, the stigma, fear and shame reinforce minority stress and trauma, but that same shame and stigma prevent us from accessing the services we need. The result is high rates of HIV and STIs, substance use, depression, anxiety and suicide.

The federal government has the ability to impact stigma in several ways. The first is equality under the law—and we're getting there, but there's still work to be done. Then there's the overuse of the Criminal Code on things like substance use, which we're seeing having devastating impacts on drug users in this country, and also the criminalization of HIV non-disclosure. Both contribute to stigma in our communities. Then there's the fed's role in education and awareness. The government sponsors social marketing around substance use, anti-racism and healthy eating. It could do more around sexuality and gender. That could be funded either using a health lens through Health Canada or an equity lens through Women and Gender Equality.

We also need dedicated funding. There are many examples of dedicated funding for various populations. There is the harm reduction fund for drug users, the mental health of black Canadians fund, which is fantastic, but we need similar funds for queer people. Whether it be through the Public Health Agency funding or CIHR and their health centres, we need more dedicated queer funding for programs and research.

I know that you've heard this many times over the past few weeks, but we have to do something about the way we collect and use data in this country. That would be a quick fix, but we also need to find innovative approaches to fill those gaps.

I know this committee has studied pharmacare and made recommendations on it, but I want to make an additional plug, namely that whether it be for HIV meds, HPV vaccinations or hormone therapy for trans people, a national pharmacare program would go a long way to improving access to prevention tools. Short of that, there are some creative ways the feds could fund treatments in provinces that don't cover them. For instance, federal funding has been used to help address gaps in provincial access to hepatitis C treatment. The federal government could expand this strategy to ensure that queer people are able to access the medications they need, regardless of where they live.

And for me that's the role of the federal government, to ensure equity and access for all Canadians, because queerness, or being a sexual minority, doesn't impact just one community. It crosses racial, ethnic, religious and political lines. Gays, lesbians, trans and queer people are living in and coming from every community in this country, regardless of which riding you represent. Why should queer people have to move to the city to get the appropriate health care they need?

Our data shows that the further outside an urban centre you go or live, the less likely you are to be out to your doctor. And we also know that if you aren't out to your doctor, you're 10 times less likely to be tested for HIV, much less receive the kind of health services you need.

I was doing interviews in B.C.'s interior and after a long day I stopped in the city of Castlegar to grab some coffee. That's where I met Todd. Todd was a lively fellow, clearly gay, clearly out and proud. I went into my community researcher mode and I started asking him questions. My city-slicker attitude was what are you doing here in Castlegar? His response was that he had been to the city, done Vancouver and Calgary and he always came back here. Castlegar is his home and he loves it here. I thought this is why I'm doing this work. That's why this study is important, so that folks like Todd don't have to move to the city to be safe, to find competent health services and to live free of discrimination.

I want to share a quote with you and then I'll wrap-up, Mr. Chair:

> Over our history, laws and policies enacted by the government led to the legitimization of much more than inequality – they legitimized hatred and violence, and brought shame to those targeted.

This was part of the government's apology to LGBTQ2 Canadians in 2017.

Chair, and members, this is your chance to right some of those wrongs, to change laws and policies that continue to lead to poor health outcomes for queer, trans and two-spirit people. I challenge you to do so, and I offer my organization's support and expertise. I look forward to talking with you about how we can make communities safer and healthier for queer Canadians.

Thanks.

● (1600)

The Chair: I think you should run for office.

Mr. Jody Jollimore: Thanks. Maybe not, actually.

Is that a compliment, though?

Voices: Oh, oh!

Ms. Marilyn Gladu (Sarnia—Lambton, CPC): Yes.

The Chair: Joël Xavier, you're up. You have 10 minutes.

[*Translation*]

Mr. Joël Xavier: Good afternoon, everyone.

I want to begin by thanking all the committee members. I am very happy to be here. The fact that we have an opportunity to discuss these issues together and to ask ourselves questions is really important for democracy. Thank you very much for giving us this opportunity. I also want to thank the support staff here today, as well as the interpreters and other language professionals who make it possible for me to express myself in my language. Thank you very much.

My name is Joël Xavier. I am Franco-Ontarian by birth, but a Quebecker by adoption. I am a gay man and a trans individual. Yes, we can in fact represent two letters of the acronym. It is possible. In life, I have had an opportunity to be both trans and gay. Some may say that I am doubly stigmatized, but I think I am doubly lucky. As a Canadian citizen, I am personally, professionally and educationally affected by these issues. Currently, I sit on the board of directors of the Quebec LGBT council. It is in that capacity—as an administrator, a board of directors member—that I will make my presentation today.

[*English*]

You can ask questions afterwards in English or French. It's fine.

[*Translation*]

The Quebec LGBT council, as a group, represents 35 organizations that defend LGBT+ rights and interests in Quebec in a context of social transformation. We have a consultative approach, which means that we consult our members and report on their projects, interests and priorities. We advocate, on a provincial level, for rights and the defence of interests. We cover all of Quebec and a population consisting of francophones, anglophones and allophones. Our perspective is intersectional. As my colleague said earlier, that means we take into account the way social and health determinants can be crossed and have an impact. That is important because we are not only LGBT. We are also individuals with a life, a certain age, cultural heritage, and so on.

Our consultations and research enable us to see, like you surely do, that the relationship between LGBT+ individuals and the health care system is not doing well. It is difficult for us to access health care. There are a number of structural and interpersonal causes, as well as causes such as regional remoteness. Like my colleagues have said, most services are available only in major urban centres. But we feel that people shouldn't have to move to Montreal or to Quebec City to receive care as LGBTQ individuals. Our community encompasses all layers of society. We should not be considered as exceptions, individuals who are very particular and difficult to understand. We are Canadians like everyone else.

This loss of trust is not new. Although many advances have been made in terms of rights, and people are becoming increasingly informed, there is a lack of research concerning namely the expertise of people who belong to the LGBTQ community themselves and stakeholders on the ground. It is difficult to obtain information to defend our rights. We feel that more money should be dedicated to research. I am also thinking of the men, women and non-binary individuals I know who are in their sixties and carry with them all sorts of traumatic experiences. Difficulty trusting the health care system is an experience we are going through. If we are told that we are strange, that we have something bad in us and our identity is considered pathological—which is still done in Canada—it is certain that we will not trust the health care system. A lot of time and efforts are needed to overcome those difficulties. For trans people, especially, access to health care is still very difficult.

If you read the briefs and testimony concerning bills 35 and 103, in Quebec, you will see that a lot of work remains to be done. Since 2009 in Quebec, certain gender affirming surgeries, for trans individuals, have been paid for by the government through the province's health insurance plan, RAMQ. However, to have access to those surgeries, trans individuals must still provide a psychiatric assessment and pay for it themselves. It can cost up to $1,000 or even more to obtain a psychiatric assessment before having access to gender affirming surgery. That is not the case for someone with cancer who undergoes a mastectomy. That person will not be asked to provide a psychiatric assessment. So inequalities exist in that respect. There also factors that render the system ineffective.

Simply in terms of the general health of trans individuals, we see in an Ontario study—but the same thing is seen in Quebec—that about 30% of trans individuals still do not go to emergency services for a medical emergency because they fear discrimination. As a result, our health problems build up because we are afraid of health care providers. Without access to that care, our health deteriorates. We end up going to the hospital when we are really forced to. That leads to costs for the system. As my colleagues were saying, the lack of prevention leads to long-term costs for the system.

We have a few recommendations to make. How much time do I have left?

● (1605)

[*English*]

The Chair: You have three minutes.

[*Translation*]

Mr. Joël Xavier: Okay.

With regard to trans people, it would be important to inform the health care community and make it aware of the specific issues faced by LGBTQ+ people. The health care community must empower LGBTQ+ people, like me, who have had trouble realizing that they aren't alone and that they have the right to demand good health care, like all Canadians.

It would be important to develop transferable guidelines for health care facilities for LGBTQ+ people, but especially for trans people, and to consult trans people in the development of these guidelines. It would also be important to create an advisory committee with people who have expertise in the field in order to develop guidelines, and to be in constant communication with government authorities.

Last but not least, I wanted to talk about the situation of intersex people in Canada. In Canada, intersex people still undergo surgeries without their consent. The term “intersex” means that at least one aspect of the biological sex isn't in line with the medical system's expectations for what the female or male sex should be.

From birth, surgical procedures are often performed that aren't necessary for the proper functioning of the child's urogenital system. These procedures are still being performed in Canada without the consent of the children, who are under the age of consent. The procedures have quite serious consequences later in life, especially in terms of pleasure. We all have the right to pleasure and sexual pleasure. In addition, there are sometimes medical complications or complications related to people's reproductive capacity and fertility.

It's important to stop performing surgeries on intersex people without their consent. There are many intersex people. We often think that intersex people are an extreme minority. However, we're told that there are as many intersex people as there are people with red hair. So, there are many intersex people. I think that my time is almost up.

I want to thank you for your time and attention. I hope that this marks the beginning of a wonderful conversation. I'm very happy to be here, to be able to speak in my language and to represent Quebec. Thank you, everyone.

● (1610)

[*English*]

The Chair: We're so happy to have you here.

In your first sentence you said “I'm a transgender gay man”.

Mr. Joël Xavier: Yes.

The Chair: Can you explain that to me?

Mr. Joël Xavier: Sure. For trans folk and other people, even those who are not trans, the first and most important value is self-determination. If you tell me you're a man, I'm going to respect that you're a man. Right?

The Chair: Yes.

Mr. Joël Xavier: Okay, so your sexual orientation is about who you are and who you're attracted to. If I'm a guy and I am attracted to guys exclusively, then I can identify myself as a gay man—even though I was assigned female at birth. I'm trans, and that means I'm not the same gender as the one my mom picked out for me. She was wrong, sorry. I happen to be exclusively attracted to men, so I'm a gay trans man. Does that kind of make sense?

The Chair: It does, but I hadn't run into that before.

Mr. Joël Xavier: Yes, there are a lot of us.

The Chair: How many?

Mr. Joël Xavier: Over 50%. Yes, there are a lot of us. We're like... a lot of us.

There are a lot of straight trans people as well, so just because you're trans.... We have sexualities as well, so there are straight trans people, as well as gay and bi trans people.

The Chair: We're learning. Thanks very much. I appreciate that.

Now we go to Ms. Walker.

Ms. Rachel Loewen Walker (Executive Director, OUTSaskatoon): Thank you, Mr. Chair, and members of the standing committee for having us here today. My name is Ms. Rachel Loewen Walker, I'm a cis queer woman and I've been the executive director of OUTSaskatoon for the last five years.

OUT is a queer, trans and two-spirit community centre that's been operating for 28 years on Treaty 6 territory in Saskatoon, Saskatchewan.

Before I continue, I'd like to introduce the chair of OUT-Saskatoon's board of directors, Martha Smith.

Ms. Martha Smith-Norris (Board Chair, OUTSaskatoon): Thank you for inviting us to be here today.

To expand on Rachel's description of OUTSaskatoon, I'm proud to share that with a staff of 12, our services include a daytime and evening drop-in centre, free counselling, more than 10 evening and daytime support groups, two educators who provide diversity training to schools and businesses across the province, and more than 35 community events per year.

As well, we operate a weekly sexual health testing clinic and a monthly PrEP clinic in partnership with an organization called Saskatoon Sexual Health. In 2017, we opened Pride Home, a long-term group home for LGBTQ2 youth aged 16 to 21.

Before Rachel continues, I want to share one story about the value of community centres in improving the health and well-being of LGBTQ2 people.

When my gay daughter JQ first came out, she was only 12 years old. As she was struggling—and I mean struggling—to become herself and looking for a sense of community, we discovered this wonderful organization called OUTSaskatoon. In particular, my daughter loved attending Rainbow Coffee every week, a queer youth support group that provides leadership workshops, sexual health education, and arts and cultural activities for teens aged 15 to 19. As JQ explains now, seven years later, her experience at OUTSaskatoon helped make her the confident, healthy, socially engaged person that she is today. Not only that, but now JQ is part of our mentorship program for Pride Home and is passing along the support she received to a new generation of youth.

● (1615)

Ms. Rachel Loewen Walker: Thank you, Martha.

In preparing for today, we read through the transcripts of the meetings that came before, and listening today, we are impressed with the breadth and rigour of all who have appeared before this committee. In light of this, we won't repeat evidence that's already been given. Instead, we're going to focus primarily on the fundamental value of queer, trans and two-spirit community centres or service agencies as access points to both a supportive and safe community, and a larger continuum of health care.

We have four recommendations, as indicated in our submitted brief.

First is the creation of a dedicated federal funding portfolio for LGBTQ2 community centres and networks. Like other provinces, Saskatchewan has been experiencing great legal and political victories in recent years thanks to engaged community organizations and individuals. That said, the experiences of queer people in Saskatchewan and throughout the Prairies are unique, but are often under-represented in national research and programs. Not only that, but the political climate in Saskatchewan creates roadblocks to our community, including minimal provincial supports and no provincial strategy, whether in education, health care or social services.

The lion's share of the support for LGBTQ2 people in all of these areas comes from the few—actually only four—community-based centres spread out across the three prairie provinces. Surprisingly, OUTSaskatoon is one of the largest LGBTQ2 community centres in the country, a fact that is directly the result of our efforts to serve a geographically and culturally vast community through an outwardly facing, one-stop shop. That is something that I know other witnesses have expressed a need for in this study.

Community centres provide the social connections for people who are isolated. They provide education for those who hold on to divisive beliefs. They provide the counselling and health care needed to improve mental health outcomes, which means reducing anxiety, depression and loneliness. We see these benefits taking place every day.

As an example, last year we watched an individual move from coming in for counselling for depression to applying to be a volunteer and now volunteering in our drop-in centre, providing peer support to others going through the same thing.

We've also seen huge steps forward in the last year to increase partnerships between queer centres, including two national gatherings of centre leaders, one taking placing in Saskatoon and one in Ottawa just a few months ago.

Through these gatherings we've created a network called Enchanté Canada, whose mandate is to build and maintain a thriving network of two-spirit, gender, and sexually diverse community groups, and that hopes to support the development of many more centres than exist today—and especially, I want to stress, in more rural and remote areas where such services are all but absent. As well, the 2Spirits in Motion Foundation has formed to create a safe and supportive environment for two-spirit peoples across the country.

These networks both demonstrate the pivotal role that community centres have in the spectrum of health. Their value cannot in decreasing reliance on primary health care cannot be overstressed.

The $20 million included within the new federal budget for capacity building and the community-level work of Canadian LGBTQ2 service agencies will support the life-saving work that is already taking place. We recommend that these funds be distributed by the Department of Women and Gender Equality in order to better integrate social, mental and physical health while prioritizing gender, sexual and cultural diversity within future initiatives across the country.

Alongside the alarming statistics about our communities, as have been widely studied and canvassed in this study, queer, trans and two-spirit people also represent rich and diverse cultural groups. We are innovative in our methods of care. We are progressive in our labour practices, programming and policy development. There is much for other sectors to learn from the queer community, particularly in relation to meaningful engagement with principles of intersectionality, decolonization, anti-racism, feminism and disability rights as many LGBTQ2 organizations work hard to incorporate these into their daily work.

At OUTSaskatoon, we have spent years building reciprocal relationships with indigenous communities, and this has made our work and our centre better.

To this end, our second recommendation is for a commitment to meaningful reconciliation and decolonization, including the central positioning of two-spirit people in organizations within this work.

● (1620)

Ms. Martha Smith-Norris: Our third recommendation is for the inclusion of LGBTQ2 needs and voices within federal and provincial housing strategies, particularly for youths and older adults. Pride Home holds a special place in my heart, and so moving to the topic of housing, I only want to amplify what has been said by other witnesses.

At OUTSaskatoon, we've conducted community-based research into housing for seniors and for youths, and both areas need attention. Our findings in Saskatoon show that 40% of queer youth have experienced homelessness or face barriers to housing, and this is greatest for two-spirit and indigenous queer youth. We created Pride Home because we found that some youths had nowhere to go after Rainbow Coffee, due to being rejected by their families and due to the homophobia and transphobia in other shelters.

One of Pride Home's greatest strengths is that it does not adhere to a gender binary, and as well, we're able to provide wraparound supports throughout Saskatoon's existing community programming. The problem is that despite this model aligning directly with Housing First recommendations for youth homelessness, we've struggled to access sustainable funding for Pride Home, as both federal and provincial dollars earmarked for housing and homelessness are for capital projects and not staffing or operations. We can apply to get $1 million to build a brand new home, but we cannot apply for the $100,000 a year that it takes to support those youths living in the home.

We don't need more research into youth homelessness nor the barriers that LGBTQ2 seniors face. The evidence is vast, as Egale and Dr. Abramovich have already testified. We need investments and we need action.

For the queer community, housing strategies must include non-gendered and inclusive housing at the same time that they include education for existing housing agencies, shelters and residential care facilities, so that our communities can safely access all services.

We recommend that designated funds within Canada's homelessness strategy “Reaching Home”, and any future housing strategies, address these gaps in service.

Ms. Rachel Loewen Walker: Our last recommendation is for the development of a national strategy for comprehensive health care for trans and gender-diverse people. Already you've heard powerful testimony on this front. The only addition we will make is that while in some of the larger cities in Canada, people can access trans-specific health care services, in Saskatchewan and especially in rural areas, there are often only a handful of doctors in the whole province who will do this work well.

What this means is that trans people are nowhere near receiving the services they need. A national strategy could draw on existing best and promising practices for many of the models you've already heard about in this committee, and then work with under-serviced areas to create regionally tailored strategies through mentorship or partner models. This would enable Canada to be a leader in trans and gender-diverse health in all regions, not just our big cities.

To close, I want to stress that community-based centres are effective strategies for improving health outcomes on all fronts. Integrated models such as these move us beyond viewing our community through a deficit framework and instead towards building the health and well-being of LGBTQ2 people of all ages, all backgrounds and all abilities.

Thank you.

The Chair: Thanks very much. You have certainly brought a lot of information to our committee.

Rachel, when you introduced yourself, you said you were a cisgender gay woman.

Is that correct?

Ms. Rachel Loewen Walker: Yes, a cisgender queer woman.

The Chair: A queer woman.

Okay, sorry.

Ms. Rachel Loewen Walker: Yes.

The Chair: Now we're going to start our questions. You'll probably need some English translation.

We're going to start with the very distinguished Mr. Ayoub.

[*Translation*]

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

First, I want to thank everyone for being here and for your presentations. We're still learning about the LGBTQ+ community and the community sometimes referred to by all the letters of the alphabet.

On a more serious note, I have a background in the municipal sector. I was the mayor of a city for which I'm currently the member of Parliament. My constituency is located in the Montreal suburbs, which have a very discreet LGBT community. As a member of Parliament, I wanted to know the needs of this community. I realized that the community has extensive needs and that these needs are mostly being met in downtown Montreal.

The issue that affects me the most is the search for identity of the young people going through this process. They have many questions during adolescence, but the answers aren't always within their reach and they aren't supported in the process. The young people are often sent to Montreal when they're rejected by their parents and families, and possibly by society. The housing issue has already been mentioned. The young people also have trouble finding housing very quickly.

What are some ways to address the community's issues outside the major cities? Some services are available in the major cities, but how can the situation be addressed outside the cities?

Who wants to respond? Go ahead, Mr. Xavier.

● (1625)

Mr. Joël Xavier: For the Conseil québécois LGBT, the inter-regional aspect is very important. Most people in Quebec don't live in Montreal. We must deal with the regional realities. There are also prejudices against the regions. Even though there are generally fewer services in rural and remote areas, these people shouldn't be denied access to services.

Last year, the Conseil held a successful inter-regional forum of LGBTQ+ organizations. I would urge you to work with the various organizations that organize this type of inter-regional forum. We invited all kinds of players, stakeholders and community representatives, because not every region has an organization dedicated to the LGBTQ+ community. It depends on the regions. Sometimes, volunteers take care of the community.

In the discussions, some possible solutions came to light. However, the forum was also mainly an opportunity for people from Montreal and from outside Montreal to pool resources. These types of inter-regional forums should be funded. The forums provide resources and tools to workers in different regions, and the workers can then support young people.

In this type of forum, it's very important to invite young people to speak for themselves. We're a little less young, and we don't necessarily know their points of view.

Mr. Ramez Ayoub: Sorry for interrupting you, but—

Mr. Joël Xavier: That's fine.

Mr. Ramez Ayoub: —I have only seven minutes, and I want to hear from the other witnesses.

[*English*]

Madam Walker, I would like your input, if I may.

Ms. Rachel Loewen Walker: Sure.

One of the things about Saskatchewan is that because it's so big and cities are relatively far apart, you don't need a huge centre or a huge staff. You need a place to gather and people who are going to support you when you walk in the door. You need people to talk to who know what you're going through. There are lots of smaller networks of people doing work within the queer, trans, and two-spirit community spread out across the province. What OUT-Saskatoon does is that we regularly send big parcels of resources and information to whoever asks for it. We travel a lot, sometimes eight hours north to do education in many different northern communities. We're usually invited to schools. In doing so, we're also working to empower the teachers in those regions so they have resources so they can actually start running a GSA in a school, for example. Often, GSAs are one of the first points in communities that otherwise don't have access or don't have a community centre. Those are ways to both build capacity and to provide support from places where we maybe do have more resources.

● (1630)

Mr. Ramez Ayoub: Mr. Jollimore.

Mr. Jody Jollimore: We know that as their home communities become safer and more accepting, fewer queer people are migrating to urban centres. It's much more common for LGBT2Q people to live in the suburbs and maybe spend the rest of their lives there, or to live in other smaller places in the country.

We can't expect there to be a clinic that specializes in queer health in every small community in our country, but what we can work on is some of the structural change that needs to happen around education and training for health care providers. Maybe we won't have a specialized queer clinic in your suburban community, but at least we can have a few doctors or health care providers who understand the needs of queer people.

There are very specific health needs for queer people. That can be trained. That can be done through education programs in universities or colleges, and I think there's a federal government role to play in leadership around that.

[*Translation*]

Mr. Ramez Ayoub: I have one last question.

We talked about the missing statistics. Now that the long-form census is back, would you like it to contain more specific questions so that additional data can be collected? We used to be in the dark about a great deal of information, but what's the current situation with the census?

Mr. Girard, you seem to want to answer this question.

Mr. Gabriel Girard: Yes, that sounds like a good idea. However, I don't have a specific question to suggest at this time.

I'll let my colleagues say whether they have any questions to suggest.

Mr. Joël Xavier: It would be important to include transgender people in the census since they've never been included. If we don't have this information, we can't decide where to send the money.

Mr. Ramez Ayoub: Thank you.

[*English*]

The Chair: Thank you. Your time is up.

Now we'll go to Ms. Gladu.

Ms. Marilyn Gladu: Thank you, Chair, and thank you to all the witnesses for being here today.

I have questions for all of you, but I'll start with Jody and see how far I get in my seven minutes.

Jody, you were talking about some statistics on how the health of LGBTQ people is worse, with 130 times the rate of AIDS, 20 times more anal cancer, and four times more suicide. You talked about mental health issues. You mentioned a specific program. Can you tell me a bit about that program and why it's effective? It's a mental health program.

Mr. Jody Jollimore: I was probably talking about a funding program with the Public Health Agency of Canada. They have a mental health fund. They recently did a call for LOIs—letters of intent—and they're currently deciding on who will get funded in that program. It's an excellent example of the federal government supporting agencies to do that work.

Sometimes I think the feds can skirt their responsibilities around health care by saying, “oh well, this is a provincial jurisdiction”, but there are numerous examples of where the federal government is providing funds to front-line organizations to do that work, and that mental health fund is one of them. Also, it's my understanding that under this there are subcategories. I think there's a mental health fund for black Canadians and for other populations.

Ms. Marilyn Gladu: Okay. There is a specific part that's LGBTQ focused.

Mr. Jody Jollimore: There is not a specific part.

Ms. Marilyn Gladu: No, there's not. Okay.

Mr. Jody Jollimore: Right now, the fund—

Ms. Marilyn Gladu: There should be.

Mr. Jody Jollimore: Certainly, like everybody else, we can apply to the fund, but there's no specific stream. That's my argument. There should be a specific stream, because of course then we would be more apt to have queer reviewers reading it, and we wouldn't have to go into the general stream.

Ms. Marilyn Gladu: Okay. Sounds good.

My next question is for you, Gabriel. In terms of talking about the way the government collects and uses data, if you could tell us anything, what would you say the federal government should be doing in terms of the way it collects and uses data?

[*Translation*]

Mr. Gabriel Girard: Thank you for your question.

As Mr. Jollimore very clearly stated, we need research programs that focus on the health issues of sexual and gender minorities. Unfortunately, these programs aren't being devised at this time. We need targeted programs that show a willingness to develop this field of research. This requires funding for research, but also the recruitment of researchers from the communities concerned to conduct, develop and publicize the research.

I think that the CBRC in British Columbia is a good example of what can be accomplished in terms of community-based research and of how the research can be institutionally recognized. There are also examples of community-based research in Quebec. I think that the research institutions and staff are ready, but research funding or research programs that focus on LGBT health should be established.

[*English*]

Ms. Marilyn Gladu: Very good. Thank you.

I'll go to Joël, and we'll talk about surgeries.

My sister-in-law is transgender and had to go to Quebec to have the surgery.

Mr. Joël Xavier: Me too.

● (1635)

Ms. Marilyn Gladu: Where else in Canada is that surgery available? Do we know anything about how much it costs? How many doctors in Canada actually would be skilled to do that?

Mr. Joël Xavier: In Canada right now, funding for surgeries is by provincial jurisdiction, so it varies from province to province.

In terms of who can perform surgeries, it depends which surgeries you're speaking of, because there are many different options available to us. In terms of genital surgery, of reconstructing the genital anatomy, right now there's Montreal.

Ms. Marilyn Gladu: That's it, in the whole country?

Mr. Joël Xavier: Yes.

Women's College Hospital in Toronto is looking into providing surgical options in Ontario.

B.C. has, in the past, and I think they might be thinking of doing it again—but correct me on that, Jody.

Depending on the province, not all provinces will pay for interprovincial, out-of-province surgeries. This greatly disadvantages trans women especially, who face a lot more risk of violence if they don't have genital surgery. For trans men, it's also problematic because there's only one surgeon in Canada who does genital surgery.

There is a diversity of techniques available, so it would be important to be able to fund out-of-country surgeries as well, or fund physicians, surgeons in all of Canada, to be able to access education to have access to different surgical techniques to make sure that the techniques available to citizens are the most up-to-date and the best for each person's individual circumstance.

Ms. Marilyn Gladu: Excellent.

Rachel, I'm interested in Pride Home. I come from an area that has a large rural part in the riding. Can you give some examples? How big is this group home? How many people would come and take advantage of it? Are there transportation barriers or other barriers that need to be addressed as well?

Ms. Rachel Loewen Walker: We have six beds in the home, and it's supported by a live-in mentor. There is a suite in the basement. It's a pretty big house, with six bedrooms, and every bedroom has its own bathroom. It has wonderful privacy. Then there are shared living spaces: kitchen, dining room, as well as heated garage in which they do all kinds of art projects, and then another gathering space in the basement. It's a wonderfully sized house.

We've had 14 youth in the home throughout the last two years, but it is long term. If someone moves in at the age of 16 and this is the best place for them until they are 21, that's fantastic. We've had a number of youth age up from Pride Home, and then we help them work with intentional landlords to find safe and secure housing following that.

In terms of transportation, we were actually donated a car, which is wonderful. For the youth living in the home, the wrap-around supports include mostly getting them to take the bus, but barring that, definitely driving them to appointments.

Accompanying, navigating and witnessing those appointments is one of the things that our full-time staff member, who also supports the home, does most. She goes with them to appointments so that people are using the correct pronouns and names and they know how to navigate those pieces.

We have had youth move into the home who are not from Saskatoon. I think we've had four from outside of Saskatoon, one from a first nation that was about four hours away. Now there's a group home taking shape in Regina as well. I know Prince Albert is looking to develop a similar model. It's starting to really grow across the province and we're seeing a lot of positive outcomes as a result.

Ms. Marilyn Gladu: That's my time.

The Chair: Mr. Davies, you have two minutes.

Mr. Don Davies (Vancouver Kingsway, NDP): Thank you, Mr. Chair, and thank you to the witnesses for being here.

I have so many questions to ask and so little time.

Jody, I'll begin with you. I have a few questions for you.

I know since January 1, 2018, British Columbians at high risk of HIV infection have been able to receive pre-exposure prophylaxis, or PrEP, daily oral antiretroviral medication that prevents new HIV infection, at no cost. However, according to doctors and patients, this hasn't completely removed the barriers to accessing the drug.

In a 2018 article in The Globe and Mail, you're quoted as saying:

> Now that cost is not a factor, it's actually getting people on the medication that's going to be the next big thing. Sometimes people think, “Oh, there's a program, so the work is done.” What we're saying is, it's really not. For us the work is just beginning.

Could you outline for us the remaining barriers to accessing PrEP and what you suggest we'd do?

● (1640)

Mr. Jody Jollimore: I appreciate that background research.

There are a couple of things. One of the barriers is being out to your health care provider. As I said, we have research outside of Vancouver that shows us that in smaller communities up north, upwards of 60% of people are not out to their health care provider. If you're not out, you're not getting the kind of services you need, much less prevention tools for HIV, because you wouldn't be considered high-risk for HIV.

That's one thing. I think that, through cultural competency, having health care providers ask the right questions, making them seem open, is certainly one way to deal with that.

Then there's the pervasive stigma. A health care provider can be as open and competent as possible, but if the individual feels that their sexuality or their sex life is somehow inappropriate because of something they experienced as a child or as youth, bullying or all of this trauma that we know happens at a very young age in queer people's lives, it impacts their ability to come out and to live freely later in life. Certainly those upstream barriers are really important.

I know it's not a federal jurisdiction, but we have a real problem with sex education in schools in this country where queer students are not learning about their sexuality. They're learning from porn, and that's not the place where we want young people learning about sexuality.

With regard to other upstream factors around violence or childhood trauma, we need to invest in the types of programs that would ensure that, by the time people are at their sexual debut and ready to make those decisions, they're able to either come out or at least acknowledge that their sexuality is at risk.

Mr. Don Davies: That segues nicely into my next question, which has to do with self-testing.

My research shows that it's estimated that more than 9,000 Canadians are living with undiagnosed HIV. This is where most new infections originate. We also know that Canada is committed to the UN goal of having 90% of all people living with HIV knowing their HIV status by 2020, so I would think we would want to remove all barriers to testing, including stigma, as you said, and lack of access to clinics.

We understand that self-testing is both feasible and accurate and is being used in other countries, which has led to an uptake in testing. I'm thinking particularly about marginalized groups that may find it difficult or uncomfortable to reveal they are having.... Perhaps they are men who are having sex with men or people in rural communities where their aunt might be in the clinic.

It's difficult. I understand that in the U.K., three HIV self-testing kits can be delivered directly to your mailbox, but I understand that's not available in Canada. Do you know why it's not available in Canada? Would you recommend that we urge Health Canada to approve self-testing kits?

Mr. Jody Jollimore: Certainly there is a push to get more testing options approved in Canada. I think you heard some of that testimony by Dr. Mark Gilbert a couple of weeks ago, and I know there is a brief coming forward that will also talk about the various testing options.

Self-testing or home testing is certainly one. There is peer testing and then there are the types of technologies, let alone how they're administered.... There is dried blood spot testing where it's a simple finger prick, and you put in a few drops of blood, and then you can send that off to a lab to be tested. There are oral kits. For instance, if you cross the border and go into America, there are a number. You can either just spit into a tube and they can use saliva, or you can take a self-sample and—

Mr. Don Davies: Can you get those here?

Mr. Jody Jollimore: You can't get them here. It's my understanding that there are a couple of obstacles. One is the market. The companies behind it don't necessarily see it as marketable option to go through the regulatory regime in Canada. The federal government could expedite that regulatory regime, and some of these tests are actually being made in Canada. The company is in Richmond, British Columbia. They're making instant tests, and they're not being sold in Canada. They're selling them around the world, so there's also a little bit of an economic issue here where we could be supporting homegrown businesses to do more of that.

Mr. Don Davies: We hear of stigma, stigma, stigma all the time, and it's obviously a huge issue. You went through some of the federal government's—maybe I can put it this way—"contributions to stigma". We know about the Criminal Code, the criminalization of HIV disclosure and other things, but one thing that was not mentioned is the continued ban on men who have sex with men from contributing blood. I've heard enough evidence at this point to come to my opinion that there is no scientific basis for that. In fact, to make a discriminatory assumption that a gay man is engaging in high-risk sex activities when, with a heterosexual man, that assumption is not made shows the absurdity of that, yet this government still has a one-year ban precluding men who have sex with men from donating blood.

Is that not a form of federal stigma that we could easily remove, particularly if it has no scientific basis? How does it impact gay men? Does that affect them? How do they feel about that ban?

● (1645)

Mr. Jody Jollimore: The data has not yet been made available, but it should be within a couple of weeks. It was a major part of our last Sex Now survey, which was actually funded by Canadian Blood Services to study just this question. I can tell you, without giving away anything, that overwhelmingly gay men are against this policy and feel that they should be able to donate blood as others do, and that will be witnessed in the data.

To say that there's no evidence for this is not accurate. There's certainly prevalence. I mentioned that they are 131 times more likely to have HIV, so there was a reason, particularly with the blood scare and whatnot. Is there evidence today? Probably not, but we need a better solution. My issue with this—and I probably would be going against some of my colleagues on this—is that I don't think it's a political issue. I actually don't want you all deciding who gets to donate blood and who doesn't. I'd rather the professionals at Canadian Blood Services make those decisions. While I think it's important that we move towards a non-discriminatory policy—and certainly I think that looks like a gender-blind, behaviour-based screening model—I wouldn't want to see that imposed as a political decision. I think that needs to remain a public health decision.

The Chair: The time's up.

I've been giving blood all my life. I went to give blood a little while ago and they said “You can't give blood. You're too old”, so there you go. I don't know if they've changed that or not, but they said they wouldn't take my blood, and my blood's good.

Mr. Ouellette.

[*Translation*]

Mr. Robert-Falcon Ouellette (Winnipeg Centre, Lib.): I want to thank everyone for joining us today.

I have a few specific questions that may help to enlighten our analysts.

What's online mapping? Can you explain how this educational tool would work?

Mr. Gabriel Girard: We want to develop this tool for LGBT people, and MSM in particular, since we mainly work with that community. The tool would give them access, through a website, to a map of the points of service for LGBT people. This would provide a list of services for members of the LGBT community.

Mr. Robert-Falcon Ouellette: Does this tool exist?

Mr. Gabriel Girard: It doesn't exist. We currently have directories. Several community organizations have resources, but the resources are often made up of various pieces of information in our possession. We want to systematize the information and make it available to a broader public so that people can access the information more easily.

Mr. Robert-Falcon Ouellette: Should this tool also be available in English?

Mr. Gabriel Girard: Absolutely, yes.

Mr. Robert-Falcon Ouellette: The tool should be available across Canada.

Mr. Jollimore, you've conducted a great deal of research and collected many statistics.

Are drugs easily accessible to people who are, for example, unemployed or who don't have a drug plan at work?

[*English*]

Mr. Jody Jollimore: When you say drugs, I'm assuming you mean prevention drugs or treatment for HIV?

[*Translation*]

Mr. Robert-Falcon Ouellette: Yes, that's what I mean.

[*English*]

Mr. Jody Jollimore: It depends on the province. Some provinces have co-pays. Others have completely free access to medications. For instance, in British Columbia we have a very robust, well-funded program that allows anyone with HIV to access medications free of charge. There are actually some other anomalies about B.C. that allow you to access those through the BC Centre for Excellence in HIV/AIDS, so that increases confidentiality and things like that.

Outside of B.C., it depends on the province. If there's a co-pay, yes, we know that this can be prohibitive for folks who are looking to treat their HIV or prevent their HIV with PrEP. We're seeing that even a few hundred dollars a month is unaffordable for some people.

[*Translation*]

Mr. Robert-Falcon Ouellette: This can have a major impact on the health of Canadians.

[*English*]

Mr. Jody Jollimore: Absolutely, yes.

[*Translation*]

Mr. Robert-Falcon Ouellette: I have a question for Joël Xavier concerning education. Mr. Jollimore spoke about it.

I want to talk to you about the specific nature of educational needs. We've already heard testimony about the Centre of Excellence for Women's Health in Vancouver and the importance of the centre.

Obviously, the needs are different in terms of sex education, for example, for cisgender people, and in terms of the levels of education and needs of people who are not only gay and lesbian, but also minorities within those groups.

● (1650)

Mr. Joël Xavier: Yes.

The sexual health needs of many people aren't being recognized, including the needs of trans people, non-binary people, bisexual people and two-spirit people. There are very few resources for prevention, sexual health and education. Very little research is being conducted with trans people. It's often forgotten that we have a sexuality. At the Conseil, we provide some training. However, there are significant needs and very few resources to meet those needs across the country at this point.

I know that CATIE, Canada's source for HIV and hepatitis C information, provides two guides. The guide entitled *PRIMED* is for trans men, and the guide entitled *Brazen* is for trans women. These guides talk about our sexual health realities. The guides are available, but not everyone will pick one up.

Mr. Robert-Falcon Ouellette: Also, not everyone will read the guide.

Mr. Joël Xavier: That's right. It's not sufficient as a resource.

Right now, as you said, we really need funding for sexual health education and community-based participatory research with trans people to develop suitable tools that reflect our realities. One interesting thing about trans people is that, like non-trans people, we really do have a variety of sexual practices and genital organs. This must be taken into account.

Mr. Robert-Falcon Ouellette: My question may be a bit different.

Mr. Joël Xavier: This is the right place.

Mr. Robert-Falcon Ouellette: You're from the Conseil québécois LGBT.

Mr. Joël Xavier: Yes.

Mr. Robert-Falcon Ouellette: In Nunavik, in the far north of Quebec, do these same issues arise in the Inuit community?

Mr. Joël Xavier: I can't answer this question specifically. It's an excellent question. I'm sure that there are trans people, non-binary people and queer people in that region.

It would be extremely important for Inuit and other nations to implement culturally appropriate measures that respect traditional teachings.

Mr. Robert-Falcon Ouellette: What's Bill 35? I looked it up online. When was it introduced?

Mr. Joël Xavier: It's a Quebec bill. Before 2016, in Quebec, we needed to undergo genital surgery to have the right to change our name and gender. As a result, there was forced sterilization in Quebec before that time. In Ontario, this came a little earlier.

Many of us may have wanted children. However, in order to have access to employment and education, we were forced to undergo sterilization.

Mr. Robert-Falcon Ouellette: I have a few questions left for Ms. Walker and Ms. Smith regarding indigenous peoples.

Saskatoon is a small large city. You were talking about rural and remote areas.

Can you talk about the needs of indigenous communities in Saskatchewan, and perhaps in northern Alberta and in Manitoba? What do these communities need in terms of all the community services that you're describing?

[*English*]

Ms. Rachel Loewen Walker: That's a good question.

When we talk about and work with indigenous groups, we describe it as “indigenizing queer” and “queering indigeneity”. It's a reciprocal relationship because there's lots of education within indigenous communities about trans, two-spirit people. There is lots of colonization that has really changed the way folks think about two-spirit people, and so we do lots of work on that front as well as ensuring that our queer communities are welcoming and intersectional.

It involves a lot of travel to northern communities—not just northern, but southern ones—and to different first nations around the province, and especially working with schools. As I said earlier, one of the greatest ways into a community is working with the school, working with classrooms, helping them, supporting them to create groups of GSAs. However, 90% of the youth who have been in Pride Home are indigenous, and those I have mentioned who have come from out of Saskatoon have all come from first nations around the province. From the narratives they share with us, their experience has been really difficult. They've not been able to access supports in their own communities.

● (1655)

Mr. Robert-Falcon Ouellette: Have you influence on—

The Chair: Sorry, your time is up.

Ms. Rachel Loewen Walker: Yes, huge.

Mr. Robert-Falcon Ouellette: Sad, Bill, sad.

The Chair: I am sorry.

That finishes our seven-minute round. Now we will go to our five-minute round, starting with Mr. Webber.

Mr. Len Webber (Calgary Confederation, CPC): Thanks to everyone for being here today—Jody, you in particular. I think this is your second time here. In Montreal you were with us as well.

Mr. Jody Jollimore: Yes, I was with you unofficially in Montreal.

Mr. Len Webber: Thank you for your time and your valuable input.

I'm going to start with Joël first.

It was brought up by my colleague about surgeries.

Mr. Joël Xavier: Yes.

Mr. Len Webber: You mentioned there should be funding for out-of-country surgeries as well. Are there any other jurisdictions around the world that are experts on surgeries for transgender people?

Mr. Joël Xavier: There are quite a few. There's also the World Professional Association for Transgender Health, which organizes conferences where people can go and learn. It is not a perfect organization, but it is a nice hub to have access to this information. I'm thinking of Belgium, Thailand and the United States. There are a lot of surgeons in the U.S., which might be less costly, too.

Mr. Len Webber: I see. Thanks for that.

Rachel and Martha, I have a couple of questions about Pride Home.

First of all, Martha, I want to also ask a little bit about JQ, if that's okay.

Ms. Martha Smith-Norris: Of course. She gave me permission to speak about her.

Mr. Len Webber: Okay, good.

Ms. Martha Smith-Norris: She also gave me advice about what I should say.

Mr. Len Webber: Good.

I understand that she came out as a gay woman at 12 years old.

Ms. Martha Smith-Norris: Yes.

Mr. Len Webber: What was your reaction?

Ms. Martha Smith-Norris: I think my reaction was completely supportive, open and welcoming.

Mr. Len Webber: I suspected that.

Ms. Martha Smith-Norris: Given my background, it was something that was very easy for me to accept. To tell you the truth, she actually told me.... We were in a bookstore. We always used to go to bookstores and she had been looking around the adolescent and teen section. She came up to me and said, "You know, Mum, there are no books about gay adolescents and teens. There are no novels and no other books."

I said, "Oh, that's interesting. That's a big gap. We should talk to them about that." Right after that, when we went home, she told me that she was gay.

She was only in grade 8 at the time. My main concern was just about her age and about what she would be facing in her school and in her community, but that is exactly when we discovered OUTSaskatoon. We went online and we found this fabulous organization that was immediately welcoming to her. It provided the kind of support that we talked about, through the youth group called Rainbow Coffee, which meets every week for this age group.

She would look forward to going to Rainbow Coffee every week. That's what she would look forward to for the following week.

I will add that a lot of other parents, as we know, are not as supportive and helpful and open to their children coming out. We do see that at OUTSaskatoon all the time. That's part of the reason why we needed to develop Pride Home for those children who have literally been rejected by their families.

Mr. Len Webber: Does Pride Home make an effort to reach out to the parents to try to enlighten them on the reality?

Ms. Rachel Loewen Walker: Yes. We do lots of mediation. We always say that anyone who walks through the door is welcome to services. Whether it's a mother and daughter who are struggling after the daughter comes out and they need counselling together, or they're supportive and they're figuring how to do it. We do lots of mediation both in our counselling program and in Pride Home, because the best thing is to rebuild that relationship so that they have a long-term....

Mr. Len Webber: It's for their own mental health, to have the support of parents.

Ms. Rachel Loewen Walker: Yes, absolutely.

It makes a huge difference. That's why they're in the home—one hundred per cent. It's because they do not have the support of their families.

Mr. Len Webber: You have about six people in the home at a time?

Ms. Rachel Loewen Walker: We have six right now. It's full. It's always full.

Mr. Len Webber: You talked about needing sustainable, dedicated federal funding. What is your budget in a year?

Ms. Rachel Loewen Walker: It's $100,000 to run Pride Home.

Mr. Len Webber: Okay.

Ms. Rachel Loewen Walker: It's nothing. OUT's budget is a million, but it's $100,000 to run Pride Home in a year. It's all we need.

Mr. Len Webber: Any ideas of how many other Pride Homes are in Canada?

Ms. Rachel Loewen Walker: Well, I know shelters have been created. You've heard already about Sprott House in Toronto. Pride Home was the first long-term home for LGBTQ2 youth. Since then, there's Lulu's Home in Regina, as I mentioned.

There are different models. Across the country, everyone I talk to says, "Oh my gosh, we need that. We're doing this." It's definitely a very pressing contemporary issue that people are working on in different ways and in different jurisdictions.

● (1700)

The Chair: The time's up.

Did you have something more to add to that?

Ms. Martha Smith-Norris: I was just going to add a few words about the model we have developed. I think it is quite special compared with what else is available, because the youth are accepted into the home between the ages of 16 and 21. They can live in the home until they're 22 or make other living arrangements.

They come to the home, of course, voluntarily. It's a youth-centred model. They actively participate in the decisions that affect them. They are supported by all of the wraparound services that OUTSaskatoon provides, including counselling and other educational and social services. They're guided by a live-in mentor and a full-time staff person.

As you can imagine, all of that does cost money, so that's why we....

The Chair: Okay, now we're moving to Mr. McKinnon for five minutes.

Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.): I want to talk about intersectionality, so I believe this is a question for Mr. Girard. It seems to be a sociological sort of thing.

As we go through meeting after meeting and we talk to all of these organizations, I am somewhat overwhelmed by the intersectionalities. If you look at the LGBTQ2 acronym itself, all the categories it embraces and all the different ways they intersect, and then you add age groups, racialized groups, language, culture and you name it, it seems overwhelming. How do we...?

I guess I'm looking for some guidance on how to navigate this complexity. Where do we focus our resources, or can...? We can't necessarily do every permutation and combination. Is there some way we can focus our efforts to deal with things in a meaningful way?

[*Translation*]

Mr. Gabriel Girard: Thank you for your question. I'll try to answer it as clearly as possible. My colleagues will be able to supplement my response.

Intersectionality is a very useful approach to understanding the intersections of gender and sexuality, which can be found in the LGBTQ+ acronym. It's also a useful way to understand that the people in this community aren't only LGBTQ+, but also people of colour, seniors and youth. There are several other socio-demographic factors that come into play, including employment and income level. Obviously, this leads to complexity, and it isn't always easy to make public policies that address complexity.

Nowadays, we have a great deal of research data. Even though the data is insufficient, it enables us to pinpoint where the intersections create specific areas of vulnerability. We could focus on the population group of young, non-white, racialized transgender people. These people are subject to racism and transphobia for a variety of reasons, and they're young and they have fewer resources. I'm also referring here to the complexity in the targets, because we can also assume that older transgender people face specific issues.

Intersectionality is really a reading guide to help us pinpoint the main areas of vulnerability. Of course, this approach isn't a policy per se. However, it can help us guide the allocation of resources and better understand the health needs of specific communities.

[*English*]

Mr. Jody Jollimore: I just want to say—and I think this is building on Gabriel's point—that not all intersections are created the same. You're right: there is a plethora. There could be many combinations, but we know that certain intersections are having worse health outcomes than others.

I think that's what we're trying to underscore to this committee. Certainly what we're hoping that the report will underscore for the minister is that there are certain areas that the federal government can act on, and that's where we're really seeing the poorest health outcomes.

Mr. Ron McKinnon: I'd like to invite the other witnesses, if they wish to respond.

Ms. Rachel Loewen Walker: Absolutely. I think one of the linchpins of intersectionality is self-determination and recognition of people's ability to define who they are, to identify themselves and not to be assigned to pre-determined categories.

If we think about it, even sitting around this room, we are much more diverse than our categories of language enable or allow us. Intersectionality does not mean that we need to create a million separate or unique programs. It means that we need to create programs that enable people to be these diverse intersectional selves.

As well, it means that we need to take equity into account. It means that we need to focus more on those groups—I am also following up quickly on an earlier question—such as two-spirit youth, for example, who definitely have drastically more negative health outcomes than Caucasian queer youth. That's intersectionality.

The research we can conduct points us towards those areas where we need to put more resources and focus more attention to bring the levels of health care up.

● (1705)

Mr. Joël Xavier: If I may add to that, one thing that would be helpful would be that instead of building a system that's made for white cisgender young people, start building a new policy or a new thing with the experience, first, of people who are typically the most marginalized. Asking those people, paying them for their knowledge, hiring them, giving them opportunities to express themselves, using them as key informants before even starting to develop a policy, and really centring those experiences means that the end product will actually be much more universal.

The Chair: Thank you very much.

Now we go to Ms. Gladu.

Ms. Marilyn Gladu: Again, thank you to the witnesses. I have some difficult questions; I think they're difficult, anyway.

We've talked a lot about the stigma people experience in the LGBTQ area. If we did develop medical services or mental health services specific to the LGBTQ, should we be advertising them as such? Or would that not be a good thing with respect to the stigma?

Ms. Rachel Loewen Walker: I would say it's both/and, right? If you don't advertise them well, people won't know they're there. This mapping project is brilliant. Let's do that 100%. We need to be able to find things both within our communities and without. It's really great for everybody to see well-advertised and supportive services specific to those who are queer, trans and two-spirit. At the same time, there are also wonderful opportunities for people to have anonymity. Sometimes it's about having two different entrances to an office, because we have that too; we have people who do not want to walk through our door because it's terrifying. I'm sure everyone here experiences that.

So it's about figuring out ways for people to access services, whether it be online or anonymously. Finding things online is actually a really great way, but I think it's both.

Ms. Marilyn Gladu: Jody.

Mr. Jody Jollimore: I think targeted programs are what we need currently, because we see gaps in the way care is generally delivered. The goal would be to get to a place where it doesn't matter if you're a physician in your riding or in the centre of Toronto; your competency would be sufficient enough that you could deliver care. Until then, of course, we need to invest in targeted programs.

Now, it's not one size fits all. Some folks will want to go to a very queer centre, one with rainbows and things like that, but others may want a discreet entrance. That may not change even once we deal with the stigma and shame; it's just a difference in terms of how we offer the services and the uptake.

Ms. Marilyn Gladu: Okay.

Here's the next tough question. We've been talking about LGBTQ and all the health issues. Are there different health-specific concerns for lesbians versus trans people versus gay men?

Ms. Rachel Loewen Walker: Yes, there are. I know that the committee has heard a lot about gay men, so I won't speak to that. We're starting some work on gender-based violence. That's one area, so I can speak to that. We're finding that trans women in particular are at greatest risk. I would not even use "risk" language; they experience the most gender-based violence, as do women. In fact, bisexual women experience heightened gender-based violence, which is something we need to figure out: Why is that going on?

There's also the invisibility. For women, bi women, trans women, gender non-binary and trans men there's greater invisibility, which includes, as you've already heard within testimony, less research on these populations and less services dedicated to these groups. So we know less about what exactly is going on and we need to know more.

● (1710)

Ms. Marilyn Gladu: Gabriel.

[*Translation*]

Mr. Gabriel Girard: I'll speak very briefly, because you've already heard a great deal about the concerns of gay men.

I want to add that gay men—I'll try to explain this by using the acronym MSM, or men who have sex with men—within the same category also have very different needs. This variety under the letter "g" must also be taken into account.

[*English*]

Ms. Marilyn Gladu: Very good.

Now I have a tricky question on blood screening. It seems to me from the testimony we've heard that when it comes to HIV, I think 50% of the people who are getting HIV now are actually women who are with men who have sex with men. Is there a screening test? We talk about how we want to make sure that gay men can donate blood. The concern would be about the 130 times the risk of AIDS or HIV. I think that risk probably also exists in some percentage of the heterosexual population. Is there any screening test for that?

Mr. Jody Jollimore: I just want to get your sources on that one, Marilyn, sorry. The 50% of new infections are women who are having sex with men who have sex with men?

Ms. Marilyn Gladu: I may be wrong about the number, but when we were going across the country, we heard testimony that when it comes to HIV infections.... And, in fact, I thought it was in Montreal that they were talking about how there's a large percentage now of women, actually, who are ending up with HIV.

Mr. Jody Jollimore: It's my understanding that gay, bi and other men who have sex with men still represent the majority of new infections in almost every jurisdiction, with maybe the exception of Saskatchewan.

Ms. Rachel Loewen Walker: Yes, that is true.

Mr. Jody Jollimore: That is true. I know there have been stats thrown around about increases like one hundredfold, two hundred-fold among women. That does happen in some areas, but we're still talking about relatively small absolute numbers.

Ms. Marilyn Gladu: Okay.

Mr. Jody Jollimore: I can't speak to the number of infections coming from heterosexual sex as a result of the partner being infected with HIV, but we definitely know that happens. I would challenge folks to look at the stats. If you look at a city like Vancouver, you see that 60% of new infections are gay men; but then when you look at smaller Prince George, you see that only 2% are gay men, because there's this large heterosexual category that doesn't exist anywhere else.

Is it possible that these people are just not out, so they're not being recorded as having MSM infections? We know that's the case because we have data that says that up to 60% of guys are not out to their health care provider. If you're not out to your doctor, why are you going to tell this public health nurse who just told you you have HIV?

The Chair: Now we go to Ms. Sidhu.

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

In Brampton we have an organization called Youth Beyond Barriers and we heard from OUTSaskatoon and about Pride Home. Ms Walker talked about Enchanté Canada.

Can you talk about Enchanté Canada?

Ms. Rachel Loewen Walker: Absolutely.

Enchanté Canada is new. It's two months old. The incorporation process is happening right now, but it's a network of LGBTQ2 centres and groups from across Canada.

In September last year, we brought 38 people from every province and every territory in Canada to Saskatoon to gather for our first-time meeting. It was an opportunity to say, what do you need? What's going on? What can we do to build this network and build our capacity? It's modelled off CenterLink, a network in the U.S. There are 280 LGBT centres in the U.S. and it's been operating for, I think, 25 years. I was attending their conferences, and so a group of folks in Canada decided that we needed something like that locally.

The LGBTQ2 secretariat was a great support in bringing us together and ESDC is the funding body from the federal government, and we receive support through that to bring people together. Our second meeting was in Ottawa in February.

Ms. Sonia Sidhu: We all know about stigma and discrimination, and OUTSaskatoon has some module to educate health workers or to train health workers.

Do you have a module for public awareness or anything that you can explain to us?

Ms. Rachel Loewen Walker: Do you mean in terms of education models?

Ms. Sonia Sidhu: Yes.

Ms. Rachel Loewen Walker: We have education modules geared for schools, businesses, corporations, the City of Saskatoon, the Saskatoon police department. We tailor it to our audience so we have many different modules. In terms of a provincial strategy, for example, what would be fantastic is a curriculum strategy. We don't have something like that, but it would be fantastic to build that in partnership with the province because it would enable all of us to get that education in at the ground level.

● (1715)

Ms. Sonia Sidhu: Can somebody talk about homophobia in homeless shelters?

Mr. Jody Jollimore: You run the homeless program.

Ms. Rachel Loewen Walker: It's a big part of why we created Pride Home. Number one, there are no youth shelters in Saskatoon so there's that gap to begin with. For the shelters that do exist for adults, there are lots of trans women who are in those shelters and their treatment is despicable. They're treated very badly, so we're often navigating with workers and trying to do that health care navigation with them to make sure that trans women are safe in the shelter.

One of the biggest things for trans people and gender non-binary people is that shelters are gendered. There's a male building and a female building, and when you look at youth group homes, they're all gendered. Start looking around; they're all gendered. For non-binary youth, they're forced to fit into a home that doesn't reflect who they are. Their workers aren't using their correct pronouns and names. Having a home that's non-gendered takes that huge barrier out of the equation. We would say that for an adult shelter, if such a thing were to be created, having a similar strategy of not having gendered floors would immediately remove one of the biggest barriers.

The Chair: Now we'll go to Mr. Davies for our last question.

Mr. Don Davies: Rachel, we've been pursuing an elusive definition of two-spirit. What definition do you use?

Ms. Rachel Loewen Walker: It's a term created in Winnipeg in 1992, I believe, by and for indigenous people because they weren't necessarily comfortable using the words gay and lesbian. They wanted language that reflected their own experiences. It's a cultural term that for some means gay. If we were to look at it, it could mean gay or lesbian.

As well, many two-spirit people use it to describe their experiences being trans or gender non-binary. It's in the way that our two-spirit elder describes...and less a term about having male and female in one's body, but more about not adhering to gender or sexual binaries, and also about living. She describes two-spirit as an experience of living in two worlds: living in a white world and in an indigenous world.

Mr. Don Davies: Whenever we talk health, I think foundationally we understand the critical importance of the social determinants of health. I would imagine that those factors become even more pronounced when we're talking about a group that may be marginalized in society. I come from Vancouver where there's been a housing crisis across the board for everybody for quite some time. It's an entrenched crisis. I'm wondering what you can tell us about the ability of LGBTQ2 people to access safe and secure housing and how that may play into their general health prospects and state.

Ms. Rachel Loewen Walker: Yes, absolutely.

The Saskatchewan Human Rights Code changed to include gender and gender identity and expression not that long ago. It was precisely because of landlords refusing to rent to trans people in Saskatchewan. That was where it started to escalate more and more to the Human Rights Commission. That's very telling.

I mentioned the words “intentional landlord”. We work with a landlord who intentionally provides safe housing for our community, making sure that his forms are not gendered and that his staff have diversity training so they're going to respect pronouns they know. They know how to support them.

Mr. Don Davies: Is it still tougher for members of the LGBTQ2 community to access housing than it would be for, say, the binary community?

Mr. Jody Jollimore: In a city like Vancouver, money is how you access housing. And we know, if you look at some of the income rates of queer people versus non-queer people, we are economically disadvantaged. So I think if you're using that as a variable, then yes, we would be disadvantaged in locating housing.

And then if we're talking about specific programs, whether or not it's seniors or youth in more institutionalized housing, then of course there are all kinds of competency issues and the ability to be out and open in those places.

● (1720)

The Chair: Okay. The time is up. That's it, folks.

On behalf of the committee, thank you so much. You're so knowledgeable about your issues and such good communicators. You've done a good job. A lot of us have a lot to learn, and you've helped us a lot. This has been one of the most interesting experiences as far as this committee goes, and we've had some dandies. It's been really helpful to us. You shared your most intimate issues and feelings. We are very grateful. On behalf of the committee, thank you very, very much.

We're going to suspend for two minutes, and then we have a little in camera business.

[*Proceedings continue in camera*]