HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

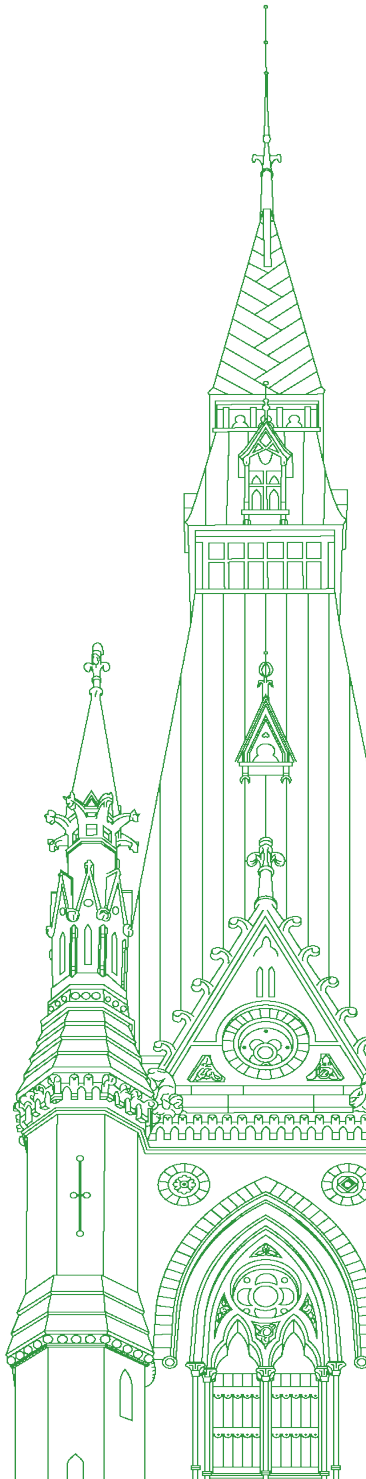
44th PARLIAMENT, 1st SESSION

Standing Committee on Veterans Affairs

EVIDENCE

NUMBER 070

Thursday, November 9, 2023



Chair: Mr. Emmanuel Dubourg

Standing Committee on Veterans Affairs

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● (1535)

[*English*]

The Chair (Mr. Emmanuel Dubourg (Bourassa, Lib.)): I call this meeting to order.

Welcome to meeting number 70 of the House of Commons Standing Committee on Veterans Affairs.

Pursuant to Standing Order 108(2) and the motion adopted on Monday, October 3, 2022, the committee is resuming its study on the experience of women veterans.

[*Translation*]

As far as interpretation, you have a choice, at the bottom of your screen, between French, English, and floor audio.

Although this room is equipped with a high-performance audio system, feedback can still occur. This can be extremely harmful to interpreters and cause them serious injuries. The most common cause of feedback is an earpiece getting too close to a microphone. I would therefore invite all participants to handle their earpieces very carefully, to avoid handling them as much as possible and to make sure they speak clearly into their assigned microphones.

I would also remind you that all remarks should be directed to the Chair.

In accordance with our routine motion, since some witnesses and members are participating in the meeting virtually, I am informing you that all connection tests have been completed in advance of the meeting.

Before welcoming the witnesses, I'd like to issue a trigger warning. We'll be discussing issues related to mental health, which are liable to trigger some of our attendants, viewers, MPs or staff members qui have had similar experiences. If you feel any distress or require assistance, please let the clerk know.

[*English*]

Mr. Fraser Tolmie (Moose Jaw—Lake Centre—Lanigan, CPC): This is a point of order. There's someone taking pictures in the middle of committee. I was under the understanding that we're not allowed to take pictures during committee.

The Chair: You are not allowed to take pictures.

A voice: I thought you folks were FaceTiming and stuff, so that's why we thought it was—

The Chair: Thank you.

I would also like to inform you that we have the witnesses with us for two hours, so I'd like to let you know that we're going to take a short break at some time, a five-minute break.

I will introduce our witnesses for today.

As an individual, we have Marie-Ève Doucet, non-destructive testing technician, by video conference. We have Madam Jennifer Smith, veteran; and Stéfanie von Hlatky, full professor at Queen's University and Canada research chair in gender, security and the armed forces. From the Quinism Foundation, we have Dr. Remington Nevin, executive director.

Welcome. You will each have five minutes for your opening statement.

I'm going to start with the video conference. I would like to invite Madame Marie-Eve Doucet to start.

You have five minutes for your opening statement. Please open your mike and start.

Ms. Marie-Ève Doucet (Non-Destructive Testing Technician, As an Individual): Good day.

My name is Marie-Ève Doucet. I am 42 years old. I presently live in Chicoutimi, Quebec with my 10-year-old special needs son and my husband, who is still serving.

I accumulated over 20 years of service on the CF-18 Hornet as both an aviation and a non-destructive testing technician. I was medically released in 2021 from Bagotville, Quebec.

I would like to focus our discussion today on my service-related exposure to hazardous chemicals. I believe that the chemicals I was exposed to during my career not only caused my medical release and my poor health today but were also the cause of the ongoing problems with my son.

In 2018 I was diagnosed with a grade 2 pineocytoma, a tumour of the pineal gland. In 2020 that tumour spread from my brain to my spinal cord. I have already had extensive surgery and maximum radiation treatments. Due to the ongoing progression of my cancer, I recently started to begin chemotherapy treatments.

I thank the committee for giving me the opportunity to speak. I don't know for how much longer I will be able to continue to advocate for myself on these important issues that I know also impacted other women in the military, especially from my trade.

You have probably never heard of my type of brain cancer before. It's a very rare and unusual condition, making up less than 1% of all brain cancers. What is known about it suggests that this type of cancer tends to be due to one of two things, either genetics or occupational and environmental exposures. Cancer of any kind does not run in my family. I therefore have no evidence of any predisposing genetics for this cancer or any other cancers.

This leaves us with the logical alternative that, after 20 years of significant exposure to multiple carcinogenic chemicals and ultrafine particles that are known to negatively affect the central nervous system, it was my workplace in the military that aggravated if not directly caused my present cancer, and also negatively affected my unborn son during my workplace pregnancy.

CAF does not presently keep a list of our workplace chemical exposure in our medical files. I think they should. Maybe then, when I filed a VAC claim for brain cancer on March 3, 2021, I wouldn't have received a refusal decision on March 24, a mere three weeks later, due to lack of proof of my medical condition being related to or to the case of chemical exposure of my workplaces.

For my appeal, I was informed that I had to provide them with information that was impossible for me to obtain; therefore, I couldn't move forward. Like so many other veterans before me and after me, I was caught in a Catch-22 situation. There was no way for me to win. I had to abandon my appeal.

Demanding that the impacted veteran provide researched proof for determining a cancer's original cause, as requested by VAC, is an unfair expectation or ask. I also believe that women are disproportionately burdened by this systemic unfairness, as the entire adjudication system was set up for men and to support men. Quite understandably, the foundational research for military-related chemical safety and harm has been done on men. There is still little to no government-sponsored research on how women may, if at all, present medically in different ways from men after having workplace chemical exposures.

Even though I was medically removed from continued work directly on aircraft while pregnant, I still had o continue working inside that same aircraft hangar with constant exposure to many known occupational hazards, including jet fuel fumes, ultra fine air particles and noise and vibration. Once again, I have absolutely no genetic predisposition to neurodevelopmental or any other disease in my family.

My child was the only one in my family born with issues. The pediatrician diagnosed him with autistic-like socialization, communication challenges and dyspraxia, a condition impacting his motor skills, coordination and overall development. Most of the cost of his ongoing therapy in the present has come from our own pockets.

I will always wonder if my son's issues are from the chemicals and ultra fine particle exposure I was ordered to sustain while working while pregnant.

● (1540)

Moving forward, I ask the committee to recommend that all reasonably sustained chemical exposures in military women causing even plausibly-related medical conditions be presumptively approved as service related.

I ask the committee to recommend this proactive approach until such time as government has a strategic military research plan in place, specifically for veteran women. Such a research plan would hopefully be able, once and for all, to prove the workplace safety of these military-specific roles and environments, versus expecting the impacted veterans to individually prove their harm.

I also request the committee to recommend that DND, CAF and VAC come together to investigate the possibility of military women's workplace hazard exposure causing direct harm to their offspring.

Thank you.

● (1545)

[*Translation*]

The Chair: Thank you very much for your testimony, Ms. Doucet. I wish you much courage.

[*English*]

I'd now like to invite Ms. Jennifer Smith, veteran, for five minutes, please.

Ms. Jennifer Smith (Veteran, As an Individual): Good afternoon, Mr. Chair, and the committee. It’s a privilege to be here today, and I thank you for this opportunity.

My name is Jennifer Smith, and I am 52 years old. I present here today as an individual, one without rank, without a retired title, medals or other special commendations. I identify solely as a woman veteran, a distinction that's as complex as it is seemingly simple. Since being forced to escape CAF as a necessity of survival, the term “veteran” is a title that I struggle to connect to, or find any pride or honour in.

In 1990, I was just 18 years old. I was healthy, vibrant and had a promising athletic career ahead of me, but I chose to serve my country.

I started regular force basic training with CAF, and I was at CFB Cornwallis. I was one of only seven women in a platoon with nearly 100 men. Sexual harassment by male recruits and instructors was daily, including dehumanizing jokes, sexual gestures and lewd sexual comments. My bras and underwear would be displayed in front of the platoon and run up the flagpole and out the barrack’s windows.

This pattern of sexual harassment persisted through basic training and continued into my Naval QL3 trade training, where I was singled out again as the only female in the group.

During my time in the military, I was repeatedly physically and sexually assaulted, including being raped by a drill instructor at basic training, gang-raped in barracks by other male recruits and sexually assaulted during a dental procedure by the military dentist.

I was a navy “hard sea”—combat—trade recruit. This was at a time when these occupations had just been opened to women, and I was terrorized in that trade. I was never safe, and I had a string of death threats against me because I was a woman.

Prior to my Atlantic fleet posting, I was taken by multiple assailants—all military members—blindfolded, tied up, and forcibly confined for what I believe was three days. I was stripped naked, deprived of sleep, repeatedly raped, sodomized, water boarded and submerged in ice water. During this ordeal, I was repeatedly told that females were not wanted aboard a warship, and that I had better figure out a way to quit the military if I wanted to live. They stuck a bayonet into my chin and told me how they would kill me, saying, “A sailor can slip and fall off the ship during night watch easily and silently.”

I left the military after 13 months for fear for my life. I was given a one-way ticket to my originating city and nothing else—no contacts, no supports, nothing. I had been dumped at an airport and abandoned to navigate a life that had been irreparably altered by the devastating violence I experienced in CAF.

Although over 30 years ago, the brutal attacks, lack of safety and constant psychological abuse have severely impacted all aspects of my life. I have severe and chronic PTSD and depression, chronic and severe pain due to physical injuries, chronic infections, sexual, urinary and reproductive issues, and stomach and bowel conditions.

I am unable to function day-to-day and spend much of my time in my darkened bedroom, severely isolated, and unable to look after even my most basic needs. I have been homeless for extended periods; multiple hospitalizations have impacted being with my children, and I am alone as I am unable to feel safe in a relationship.

Since connecting with VAC five years ago, I have not felt supported, understood or heard by the VAC system. Because I left the CAF in 1991, my pension is the lowest it can be, meaning I have ongoing financial hardship that will worsen as I get older. Because I live alone and have no family or spousal assistance, I do not qualify for benefits such as caregiver allowance or attendant care. When I was homeless, I couldn’t receive many benefits and services because I didn’t have a stable address.

A repetitive pattern with VAC has been to ask for an updated assessment from a nurse or OT, have recommendations made, and then to have no follow-up. Months later, when I ask for the services I need, I am told I need another assessment.

● (1550)

The assessments are very difficult due to my trauma history as each assessor comes into my ever-changing housing arrangement and asks questions about my history, even though the history and numerous assessments have already been completed—VAC has this information.

I have yet to receive support to pay for a personal support worker to help me with basic tasks of life, for example, getting out of my bedroom, eating, and showering. I have been judged as difficult and uncooperative because I don't fit into the boxes that the VAC system expects.

The details of my experience and the extent of the lack of support are difficult to describe in a short speech. I hope that what I have said has an impact.

Based on my experiences I have a few recommendations for VAC that can be addressed later in questions.

Thank you.

The Chair: Thank you, Ms. Smith.

If you are able to, you can tell us what those recommendations are. I will allow you a few minutes to do that. Please go ahead.

Ms. Jennifer Smith: Thank you, Chair.

This is brief and, again, feel free to ask me to expand on them if you like. I have many lived experience examples.

One, I would increase benefits for women living alone who are often without a caregiver or family member.

Update the claims process to better reflect women's physical health issues, including female-specific forms for sexual, urinary, and reproductive issues. I've included in evidence one of the medical questionnaires, and I can go into that further in question period.

Specially train a group of case managers in regions of Canada who are knowledgeable of women's issues, including that of housing insecurity and homelessness, and military sexual trauma.

Create systemic changes to ensure that medical and psychosocial recommendations made to help women veterans are acknowledged and followed.

Finally, invest in women veterans-specific research, preferably carried out by women veterans themselves.

Thank you, Chair.

The Chair: Thank you very much. We are so sorry to hear the story of what you went through. It really took a lot of courage to come to share that with us. Thank you so much.

Now I'd like to invite Mrs. Stéfanie von Hlatky for five minutes please.

Professor Stéfanie von Hlatky (Full Professor, Queen's University, Canada Research Chair in Gender, Security, and the Armed Forces, As an Individual): Thanks, Mr. Chair.

I also want to acknowledge the testimony of Madame Doucet and Madame Smith and to thank them for it.

My research to Queen's on the topic of this study has focused on the differentiated impacts of military service on women, and also on the military-to-civilian professional transition.

Every year, thousands of service members leave the military, typically in their late 30s, to join the population of Canadian veterans. Almost 75,000 veterans are women—over 16%—which mirrors their representation in the Canadian Armed Forces.

Recognizing this, all programs in support of veterans should take into account the changing demographics of the Canadian veteran population. This means a focus on the growing participation of women in the Canadian Armed Forces. Not only are there more and more women in the military, but also since the late 1980s, they no longer face formal employment restrictions in the military and can compete for all roles, including combat roles. Their representation among regular force officers has even gone past the 20% mark.

We have more women, yet the military is still struggling with gender integration. As my colleague Maya Eichler has noted, tracking the proportion of women veterans is important but tells us little about the specific challenges they encounter on the road to civilian life, as it overlooks gender norms and inequalities based on gender. It's important to draw this parallel between women in the armed forces and women veterans because the experience of women while in the military influences their experience as they transition to civilian life.

As we focus on improving services and programs for veterans, I would invite us to think about the military-to-civilian transition as a distinct but related phase of the military career cycle. For example, when the federal government offers programs for mental and physical health, it is important to identify women's differentiated needs and how these needs may have been shaped by their experiences while in the military. For example, women are more often exposed to cumulative stressors over the course of their career, which may include intense operational experiences, combined with sexual harassment and military sexual trauma, and separation from family as a primary caregiver.

Some not-for-profit organizations have developed programs to support women military veterans and other marginalized groups who experience PTSD related to sexual trauma, deployment and other causes. The government has recognized the importance of using a GBA+ and intersectional lens to identify areas of policy reform as the military responds to the recommendations in the Arbour report, as it aims to respond to unhealthy attrition in the Canadian Armed Forces retention strategy and, increasingly, as it designs veteran support programs.

These approaches have even led to greater coordination between the Department of National Defence and Veterans Affairs, allowing service members to engage in longer-term preparation for transitioning to civilian life. However, much more, of course, needs to be done. Efforts should continue to improve continuity between a life of service and a life after service, as well as public facing efforts that recognize the changing demographic of veterans.

A challenge with this kind of research continues to be the availability of data, given the lack of gender-differentiated research on military-to-civilian professional transitions. The few Canadian studies that have been published are based on interviews and exit surveys done with female military personnel, and are consistent with cross-national trends. They identify professional challenges that are specific to women, who have reported that they never felt fully integrated into the military and that their ability to be promoted while in the military, or their ability to find good jobs after leaving, was hindered by the lack of experience, brought on by exclusionary professional environments while serving.

Even more generally, drawing from the evidence provided in exit surveys as members leave the military, the CAF retention strategy emphasizes that “certain dissatisfiers associated with voluntary release may be more prevalent amongst women than men”. The report cites the lack of fit with the military lifestyle, dissatisfaction with the advancement and promotion system, training and development requirements, as well as workload demands. The document recognizes that gender bias “can negatively affect access to opportunities for leadership roles, career advancement, and the preponderance of women as role models or mentors to aspiring leaders within the CAF.” This, in turn, has an influence on the well-being of serving members and newly releasing members, as well as on the professional opportunities that come after a career in the military.

● (1555)

In a co-authored article with Meaghan Shoemaker, we note:

> These experiences that women face while serving, from social isolation and stigmatization by their peers to outright harassment, are important to address for a successful military-to-civilian transition, as they impact mental health.

It continues:

> Moreover, part of service members' social networks carries over with them as veterans, which provides additional peer support during transition. Women’s experiences where professional exclusion and workplace harassment were the norm shed light into the difficulty of securing peer support both during and after service.

My past research at Queen’s on this topic, through an initiative called the Gender Lab, aimed to connect these dots between the professional experiences of women and men while in the military to their professional experiences after the military.

It's the right thing to do. We need to stay focused on understanding how we can improve the well-being and transition of veterans, enhancing service provision in the process. Understanding that professional fulfillment contributes to mental health, there is also an opportunity to improve the employment prospects of veterans in a range of sectors given that former military personnel represent a skilled, trained and experienced labour force.

Our research focused on doing an environmental scan of veteran services and programs, as well as conducting interviews and focus groups with members of the armed forces who were considering leaving the military or who had recently released. In addition to the programs offered by Veterans Affairs, there are provincial-level services in health care and employment, in both the public and private sectors, which are designed for veterans, as well as a programs emerging from charities and the not-for-profit sector.

A few findings to highlight from our research indicate that, given the diversity of veteran service providers, attempts at coordinating what is being offered to veterans as well as identifying potential gaps are essential. In one of our publications, we suggest that a collective impact model would be favourable to encourage collaboration across the different sectors and partners involved in veteran service provision.

While the literature has recognized the importance of employment training to improve the labour force participation of veterans, we cannot just put the burden—

● (1600)

The Chair: Mrs. von Hlatky, please conclude.

Prof. Stéfanie von Hlatky: —of the transition on veterans. We can also work to better prepare employers for veterans' integration into a new workplace culture. While programs that encourage the employment of veterans abound, so do harmful stereotypes about military service, which might impact the hiring prospects or integration of veterans in their new workplace.

I'll stop there, but I emphasize that my last point is about the broader cultural environment of society.

Thank you.

The Chair: Thank you very much, Ms. von Hlatky.

Now I'd like to invite Dr. Remington Nevin, for five minutes, please.

Dr. Remington Nevin (Executive Director, The Quinism Foundation): Thank you very much, Mr. Chair.

My name is Dr. Remington Nevin. I'm a former U.S. Army physician and preventive medicine officer, trained in epidemiology and drug safety at Johns Hopkins. During my 10-year active duty military career, I conducted research and published extensively on various topics in military medicine, including mental health and malaria.

I now serve as executive and medical director of the Quinism Foundation, a charitable organization that supports research and education on the adverse effects of the class of anti-malarial drugs known as quinolines, which include the drug mefloquine or Lariam. For many decades in western militaries it was widely used to prevent malaria.

Malaria is, of course, a mosquito-borne disease that can infect military personnel deployed to certain tropical areas, particularly in Africa and the Middle East, where many Canadian veterans have served in recent decades.

It is this issue that I wish to speak to today, the prevention of malaria and the use of anti-malarial drugs in military women—particularly those of child-bearing age. This poses unique challenges, which, in my opinion, have not yet been adequately addressed by policy-makers.

Most of my testimony today is drawn from my chapter in the book *Women at War*, which discusses these issues in greater detail and contains references for many of the statements I make.

The primary point I make in this chapter, and which I wish to make to the committee today, is that the widespread deployment of women of child-bearing age calls into question western militaries' traditional one-size-fits-all policies for the prevention of malaria.

For historical reasons, most preventive anti-malarial drugs were tested predominantly among men, and therefore in many cases direct human safety and reproductive hazard data are not available to inform their rational use in women.

For example, the Canadian product monograph for atovaquone-proguanil, a popular anti-malarial drug marketed as Malarone, notes that “there are no studies in pregnant women”, and that the safety of the drug combination in pregnancy “has not been established”. Likewise, the Canadian product monograph for doxycycline, another popular anti-malarial drug, warns that it “should not be administered to pregnant women”.

These warnings are particularly relevant in that U.S. military experience has shown that women of child-bearing age are at high risk of pregnancy during deployments, where the use of these or other drugs has typically been mandatory.

For example, while in Afghanistan I and a colleague, Jen Caci, found that in an eight-month period in 2007, there were 49 pregnancies identified among 3,298 U.S. military women. That's equivalent to a rate of pregnancy of 22.3 per 1,000 women-years or over 2% of deployed women per year. For various operational and personal reasons, many of these pregnancies were not diagnosed until well into the first trimester and occasionally well beyond that.

If the Canadian experience is similar, this means that among Canadian military women, some degree of unintentional and potentially prolonged fetal exposure to anti-malarial drugs and other preventive measures, such as insect repellants, with unknown reproductive toxicity will have occurred. In many cases, such potentially toxic exposure will have occurred as a direct result of traditional one-size-fits-all policies that mandate the use of these measures under command direction.

The deployment of large numbers of women of reproductive age and the risk of pregnancy that accompanies these deployments provide an opportunity for western militaries to re-examine previous one-size-fits-all malaria-prevention policies and to consider adoption of malaria-prevention strategies that are customized to the individual.

As I describe in my book chapter, in many cases these can include a transition away from mandatory or command-directed use of anti-malarials and towards an emphasis on mosquito-avoidance measures. Such customized measures can reduce the risks potentially posed to the developing fetus while also reducing the risk that these measures may pose to the women service members themselves, such as we have seen, for example, with the mandatory or command-directed use of mefloquine.

Mr. Chair, thank you very much for the opportunity to address the committee on these issues. I'd be happy to answer any questions.

● (1605)

The Chair: Thank you very much, Dr. Nevin.

Thank you to all the witnesses.

Now, we're going to start the first round of questions of six minutes each.

I'd like to start with MP Cathay Wagantall.

Go ahead for six minutes, please.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): Thank you so much, Chair.

Thank you all for being here and for your bravery in presenting your circumstances. We have a lot of work to do at this committee, and you will make a significant difference to that, so thank you very much.

My focus right now is on you, Dr. Nevin. In 2015 you wrote a research paper, “Issues in the Prevention of Malaria Among Women at War”, and my colleagues and I look forward to hearing your findings about how that can have significant implications, as we're hearing, on the health care of Canadian female military service members today.

However, I think it's really important for the current members of this committee to also know the concerns of our armed forces with respect to the anti-malarial drug mefloquine, which has been the required drug of first resort for Canadian Armed Forces members—both men and women—in the last three decades.

In 1992 on a deployment to Somalia, Canada's elite airborne paratroopers received the then-unlicensed drug as part of a drug study. Military personnel were told they must take the drug or face disciplinary actions. Very clear protocols were set forth, yet few, if any, were followed by either DND or Health Canada. Although the drug was administered, no proper testing was done and no results were noted.

In January 1993, Health Canada, in advance of its own research being completed, approved the drug for civilian use in Canada. Three months later, a young Somali boy was murdered on a Canadian base in Somalia. This event would later become known as the Somalia Affair.

After the 1993 federal election, Jean Chrétien's Liberal Party initiated a highly visible inquiry. However, a year later, in 1994, just as data was being collected on the role mefloquine played in the event, the Chrétien government abruptly shut down the inquiry just ahead of the 1997 election.

This report, the 1997 Somalia inquiry report, should be read by all members of this committee. The abrupt shutdown was questioned in 1999 at the Standing Committee on Public Accounts when former MP John Cummins stated that he was in personal possession of an October 1997 departmental note to the then-defence minister advising the DND to mislead the Somalia inquiry on the status of mefloquine and advising him to mislead the public as to where DND got the drug.

While the Liberal government continued its cover-up, ignoring its veterans while requiring service members to continue to take mefloquine, the U.S. military responded to the Fort Bragg murder-suicides of 2002, in which four military wives were killed and two of the partners that killed them then committed suicide. There was research into the potential impact of mefloquine on those partners who were required to consume mefloquine while in Afghanistan.

Dr. Nevin, I have two questions that I'll put together for you. What was the 2009 decision made by the U.S. military because of their research? We know that many of our other allies were also using mefloquine at this time, and in response to the U.S. decision, I believe, they held inquiries of their own that responded to the concerns of their veterans. I'm wondering if you're aware of which other countries made changes to the use of this drug within their forces and what they did specifically.

Could you succinctly respond to that?

Thank you.

Dr. Remington Nevin: Mr. Chair, I thank the member for the question.

The member is, I believe, referring to the 2009 policy decision made by the U.S. Army. I believe that was in response to some research that I had published that had demonstrated that the drug had been used improperly on a large scale, particularly in Afghanistan. The drug had been prescribed to a growing number of service members with mental health contraindications. I think the U.S. Army was quite happy to dispense with the use of the drug. It had developed, by that point, plenty of experience with the drug's very unpleasant and dangerous adverse effects, and subsequently the rest of the U.S. military followed suit.

By 2013 when the U.S. Food and Drug Administration had mandated a boxed warning on the mefloquine product insert, the U.S. military had issued a policy that mefloquine be essentially a drug of last resort only, and that the two drugs that I referenced previously—atovaquone-proguanil and doxycycline—be used primarily in almost all circumstances.

I believe the Canadian military by this point had also moved away from mefloquine as a first-line drug, as did militaries around the world. I recall that when I was overseas I spoke with some French officers, and this was in the mid-2000s. They had long since abandoned the use of mefloquine because of operational experience with very unpleasant side effects of some operational significance associated with the drug. Germany, I believe, completely banned the use of the drug in their military around the time of our boxed warning. Essentially few countries if any make any significant use of mefloquine today. The drug remains on many formularies. It may be used by old-timers who have had favourable experience with the drug, but it would be very unusual for new troops to be issued mefloquine on deployments today.

● (1610)

Mrs. Cathay Wagantall: Thank you very much.

Dr. Nevin, it was your research that brought new hope to Canadian veterans and serving members who'd been suffering with a physical brain stem injury due to mefloquine toxicity while being told that their issues and prescribed treatments were due to PTSD.

You testified at this committee on May 1, 2019, along with several Canadian veterans injured by mefloquine, contributing to our study and our report on the effects of mefloquine use among Canadian veterans. Of course, that report from the 42nd Parliament is available. It is report 14. The Conservative Party of Canada also submitted a supplementary report.

Can you please share the eventual changes and your perspective on the changes Health Canada and the surgeon general and commander of the Canadian Armed Forces health services made in 2016 regarding the use of mefloquine in Canada after a significant amount of challenge at this committee and also from veterans?

The Chair: Excuse me, Dr. Nevin. I can give you only 20 seconds to respond.

Please go ahead.

Dr. Remington Nevin: I would say that what is missing from those reports is an acknowledgement of the most important thing with mefloquine and that is that the use of the drug must be discontinued at the onset of psychiatric symptoms. It is this critical warning that I think has been ignored and that has still not been acknowledged by Canadian officials.

The Chair: Thank you very much.

For the next question, for six minutes, I invite MP Randeep Sarai.

Mr. Randeep Sarai (Surrey Centre, Lib.): Thank you, Chair.

I want to thank all of the witnesses, but specifically Ms. Doucet and Ms. Smith, who had to share their personal experiences, which we all understand is very difficult.

My first question is for Ms. Smith. It appears as though we opened up the Canadian Armed Forces to women and they were plopped in with no support mechanisms, no systems, no checks on how biology would come into play and no complaint methods—a real "cluster-F", if you want to call it that. Pardon my language, but I really feel for you. What you went through in a very short period of time was unacceptable.

You gave five great, concrete recommendations. Can you maybe help us more? Based on your own experience, how would specially trained case managers who deal specifically with sexual trauma be helpful?

Also, with regard to medical records and having to repeat the trauma over and over when you go to a different case manager or when a file goes from CAF to VAC, if you could make some recommendations or some solid suggestions, that would be very helpful so that we can make those changes going forward.

Ms. Jennifer Smith: My goodness, there's a lot to unpack there.

With respect to case managers being trained specifically on military sexual trauma and housing insecurity or homelessness, I think there's just this ingrained, unaware bias that presupposes that women have spouses or that they have support systems in place. When that is not the case, having case managers meeting the veteran without these pre-existing biases and suppositions would help build rapport and trust between the case manager and the veteran.

So many veterans, including me, are just not heard at all. With respect to homelessness, I had a case manager I repeatedly told I was homeless. Let's expand that to be a more inclusive definition—housing insecure—because women veterans, as we know, do exist. They are not invisible. They are out there. They do present in a much different way from what we're typically led to believe. They are couch surfing or perhaps staying in different shelters.

I had a case manager who said that VAC did not have a housing mandate and to just look on Kijiji. That was as far as I got with that. I skipped around from couch to couch, to short-term Airbnbs, to my car, and I was being denied services because I didn't have a fixed address. I know that maybe doesn't necessarily answer that question directly, but there needs to be more awareness and more special training. These are specific topics.

● (1615)

Mr. Randeep Sarai: Sure. I appreciate that.

Also, in terms of your medical records or your previous records, do you have any suggestions on that and could you elaborate on how that could be better? We'll be told one thing by somebody else, but you're somebody who has actually lived through that, with respect to how those are transferred from case manager to case manager or from CAF to VAC.

Ms. Jennifer Smith: Right.

I've moved around. I've had several case managers, five different case managers, in the province of Ontario. That can take months. Even going from the Toronto office to Ottawa took six months. I had no case manager. That meant no medications. There was no continuity of care. That meant finding another doctor. Case managers get reports, but they want to do it all again. They say, “Tell me the story again” even though they have all the reports and all the information. It's all filled out on your claim forms too. That information is there. It seems a little lazy for them to just keep depending on and burdening the veteran to rehash these traumatic things over and over again instead of doing their homework. The information is there. They have it. I would recommend that if they have additional questions or they feel that maybe one of their questions wasn't answered enough, then they could ask the veteran to elaborate on that.

Thank you, Chair.

Mr. Randeep Sarai: Finally, really quickly because of my time, you talked about how you would like to have things led by women. Do you mean having a group to deal with women veterans to lead a team?

Could you answer that just quickly in 30 seconds?

Ms. Jennifer Smith: If you want to have round tables on women veterans, you have to include the people who are most impacted. You need the lived experience of women veterans during these discussions. I've been talking about women veterans' homelessness for over five years now since I've been a VAC client. I've talked to the Veterans Ombudsman. I've talked to various non-profit organizations, City of Ottawa housing and the social housing department. They tell me it doesn't exist or that they don't have a mandate. In those five years, I have not been contacted once for a round table. Nobody has reached out to me to ask me about my lived experience. Instead they have veterans on their round tables. They are women veterans, but they don't have the lived experience of the topic at hand.

The Chair: Thank you very much, Mr. Sarai.

To all witnesses, if you have additional information, feel free to send it to the clerk of the committee.

[*Translation*]

I'd now like to invite Mr. Luc Desilets to take the floor for six minutes.

Mr. Luc Desilets (Rivière-des-Mille-Îles, BQ): Hello, dear colleagues.

Thank you to the witnesses.

Ms. Smith, Dr. Nevin and Ms. Doucet, I thank each of you for your respective service.

Ms. Smith, you have exceptional resilience. I have a great deal of empathy for you, after everything you said. I find it very troubling. I'm a little bit ashamed to be of the same sex as those who caused you so much pain. You're brave, as the Chair just said. I'm uncomfortable asking you questions.

Did you file a complaint?

● (1620)

[*English*]

Ms. Jennifer Smith: Yes and no. I have given this information to several.... I've spoken about it in Federal Court. I've given this information to many, many high-ranking officials. I've even provided the names of some of my attackers as well as pictures. Again, I've never been offered the opportunity. I still don't know what avenue I have to go forward with this. I've been told to write it down on a claim form. I feel that this goes beyond that. This is criminal activity. I know who did it. I know some of the people who did it. I'm just wondering why no one has come to me or reached out to me. I've given the information. I haven't been asked if I want to go forward with that or been presented with some options. That has not happened.

I'm still waiting.

[*Translation*]

Mr. Luc Desilets: Am I to understand that you'd like to file complaints about all these assaults?

Mr. Chair, is there a problem with the interpretation?

[*English*]

The Chair: Could you repeat the question, please?

[*Translation*]

Mr. Luc Desilets: Am I to understand that you'd like to file complaints about all these assaults?

[*English*]

Ms. Jennifer Smith: Yes, I'm guessing the question is, would I like to make a complaint?

Yes, I think that I would. I think it warrants it. I don't know what the outcome would be. I stand for accountability for people and accountability for institutions. Yes.

[*Translation*]

Mr. Luc Desilets: Why do you say, “if I could”?

Ms. Jennifer Smith: Could you please repeat the question? It's not working.

Mr. Luc Desilets: Maybe you haven't selected the right channel for the English interpretation. You should be hearing the interpretation now.

To repeat the question, why do you say, “if I could”?

[*English*]

Ms. Jennifer Smith: Why did I say, “if I could complain”? Would I complain?

It hasn't been made clear to me that I can. No one said, “Yes, you can. There is a mechanism or a path for you to go down if you want to make a complaint.”

Nobody has said that, so I'm just assuming there isn't.

[*Translation*]

Mr. Luc Desilets: And yet, in your remarks, you alluded to a number of crimes and criminal acts. You're aware of them. Being in the army doesn't mean one is above the law. This isn't a question I'm asking, but rather an observation I'm making.

I think that you still made a number of compensation claims for physical injuries and health issues resulting from your years of service in the army. You mentioned that in passing earlier. What is the status of these compensation claims?

[*English*]

Ms. Jennifer Smith: I've submitted 10 claims so far for physical injuries, along with my mental health and the PTSD. It took five years for me to even know that I could claim for those other injuries. I first presented to VAC and told them the story in much more detail. There are 40 pages of details of 13 months of service.

VAC at no time said, “Here's an injury report. File a claim for this. This is important.” I found out by word of mouth, years after the fact. I'm still playing catch-up to find out what I can even claim. I thought that was a VAC responsibility.

● (1625)

[*Translation*]

Mr. Luc Desilets: So you're currently aware that you can make compensation claims.

Just answer yes or no.

[*English*]

Ms. Jennifer Smith: Yes. I am doing that now. The point is—

[*Translation*]

Mr. Luc Desilets: That's perfect. Thank you very much, Ms. Smith.

Ms. Doucet, the situation you described is rather unique. You've established a link between the health issues your child has experienced since birth and your own exposure to certain chemicals, particularly during pregnancy.

When you worked in that hangar, were you offered a transfer to a workplace away from these chemical products?

Ms. Marie-Ève Doucet: No. In fact, I wasn't really given any options. Normally, women are removed from the floor for medical reasons. The problem is that the ventilation system circulates the air throughout the hangar, so whether you're working on the planes or in the offices on the higher floors, you can smell the jet fuel.

Normally, the hangar is ventilated before hosting outside guests. All the doors are opened so that the noxious fumes are evacuated and can't be smelled. There are even walls that can open completely. Everything is closed back up just before the parade or the arrival of the dignitaries.

Aircraft are designed to allow for some leakage in case of fuel expansion. So we place some kinds of containers under the planes to gather the fuel and prevent it from contaminating the floor. When we arrived in the morning, these containers were full. Vapours rise, so even those working in the offices above were exposed to them.

All things considered, there aren't that many options. We could conceivably be sent to procurement or other units where there wouldn't be any direct exposure to all sorts of chemicals. There's probably a way to use us in other areas of the base instead of working in the hangar.

Mr. Luc Desilets: Thank you, Ms. Doucet.

The Chair: Thank you, Mr. Desilets.

[*English*]

For the last six minutes of this round, I'd like to invite MP Rachel Blaney, who is with us by video conference.

Go ahead. You have six minutes, please.

Ms. Rachel Blaney (North Island—Powell River, NDP): Thank you, Mr. Chair.

I would like to thank the folks who are here today to testify. I really appreciate what you've shared with us, particularly the very personal realities that you've had to share.

My first question is for Ms. Doucet.

I understand that you were exposed to hazardous chemicals.

Were you provided with any personal protective gear? Was any information shared with you about the hazardous chemicals and their impact or specifically about the impact of those chemicals affecting you while pregnant?

Ms. Marie-Ève Doucet: Yes.

The PPE that we were provided with.... Obviously, it's a man's trade, so it was normally made for men. It did not fit me properly. For example, with regard to the hearing protection, to this day I still cannot fit one of those earplugs in my ear. My canals are too small for it to fit.

[*Translation*]

We didn't have access to custom earplugs.

[*English*]

The military didn't pay for them, so we had to pay from our own pockets if we could afford them. Normally, we're supposed to use things like double protection. That would be earplugs plus the shells.

For the chemicals we used those little rubber gloves that you can buy commercially. When you're working on airplanes, most of the time the fuel drips on your head, so even if you wear gloves you get covered with fuel. The fuel drips down your arms. We had to put rags in to prevent the fuel from running down inside our armpits and on our chest. There's no protection made for that. The gloves won't keep the fuel from dripping on you and unfortunately that's just the way it is. You're working above your head and the fuel falls down. There's no real protection except for glasses.

When we had a supervisor who was on the ball, they would tell us to wear our eyewear, or they would ask where our glasses were if we didn't wear them. There's not much protection from the fuel particles and jet exhaust fumes and heavy metals that they're filled with.

We didn't have any masks and we were not provided with them. When we walked from one hangar to another hangar behind six jets that were running and spitting out heavy metals, we walked right through it.

When we had training, they would tell us that we were supposed to wear safety goggles and gloves, but we were not provided with equipment that would fit women or small women or that would really work to protect us.

● (1630)

Ms. Rachel Blaney: Thank you for that.

I really appreciated your recommendation that all the chemicals you are exposed to should be listed in your medical file, so there can be follow up on the impacts of those chemicals on your body. I'm definitely going to push for that recommendation.

One thing that I've heard from other testimony is that there's no research done on service and pregnancy for women or women who want to become pregnant.

I'm wondering if you feel that this needs to be a higher priority moving forward, so that there can documentation at the CAF that can be transferred over to VAC so that services meet the needs of women.

Ms. Marie-Ève Doucet: Yes, I do believe this is critical.

Women in the military will keep on getting pregnant. It's just the way of life. If it affects our kids....

I would be curious to see, if we compare the military population with the civilian population, how many would kids have neurodevelopmental issues. I feel like the numbers are completely out of whack. I know so many military people who do have kids with ADHD and all kinds of neurological developmental issues, like my kid does. I don't see that in all my civvy friends. Every once in a while you'll see one.

I think there should be research done to compare how much of an impact it has on us.

Ms. Rachel Blaney: Yes, I really agree with that.

I will turn to Ms. Smith. I only have a moment.

You talked about the importance of having continuity of care. Could you expand on what that means for you and what that might look like?

Ms. Jennifer Smith: Thank you, Mr. Chair, for the question.

Continuity of care really is important so that there aren't gaps in care and so the veteran feels supported as they move through their life.

Whether they're having to relocate because of financial reasons or personal reasons.... When I moved from Ottawa to Winnipeg, I was given a three-month supply of medications and a finger crossing in the hope I'd get a case manager before that runs out. That was even after giving Winnipeg VAC a heads-up. Six months ahead of my move, I let VAC know that I was coming and to please set up my files, etc.

Really, continuity means you are caring for the veteran and you care what happens when they leave one office and arrive in another one. That's important. If you're talking about building trust and rapport, I think continuity of care is at the base of that.

● (1635)

The Chair: Thank you, Ms. Blaney.

I'd like to welcome MP Sidhu by video conference. She will replace MP Bryan May.

I propose we suspend for five minutes, so we can have a coffee and then come back.

● (1635)

_____(Pause)_____

● (1645)

[*Translation*]

The Chair: We will now resume the meeting.

Let's begin the second round of questions right away.

Ms. Cathay Wagantall, you have the floor for five minutes.

[*English*]

Mrs. Cathay Wagantall: Thank you so much, Chair.

I do need to go back to Dr. Nevin, but first, Ms. Smith, I'm going to bring something up that I hope is okay with you, from what I heard in your testimony. If you're not comfortable answering it, I understand.

You talked about your experiences, and you alluded to the fact that the intention was to force women out of the military, through the threats to your life and the abuse you experienced. That seems to be an elephant in this room on the basis of the whole military sexual trauma issue, because DND didn't see it as due to service.

Am I...?

Ms. Jennifer Smith: I don't know what DND was thinking.

There was the tribunal. The human rights commission tribunal had determined...just months before I was aggressively recruited into the trade that I went into, although I wanted navy.

The tribunal said that, yes, it was open to all women—all trades, combat trades. I chose the navy, and I chose to be in a combat naval trade. As I mentioned in my testimony, I was the only woman, the only female in that group to go through the training. My ship was the first mixed-gender warship to be deployed on—I'm blanking on that acronym—NATO exercises.

You really have to understand that the navy in particular is highly.... Particularly at that time, there was no way they were.... They accepted women going to sea on supply ships in supportive roles, but definitely not as a combat sailor.

There are a lot of superstitions, hundreds of years of superstitions that come into the navy, and being out at sea, you're in international waters. In fact, we know that recently, sadly, someone did fall off a ship, and no one knew until it was too late. It does happen, but yes, 100 per cent, being a women was....

Mrs. Cathay Wagantall: Thank you.

I really appreciate that.

Ms. Jennifer Smith: I hope that answered your question.

Mrs. Cathay Wagantall: The goal here is to change this culture, and we have to be direct about what it is that we actually have to change, so you're very brave. Thank you so much.

Dr. Nevin, just briefly, I have to leave here shortly. That's the life of.... You plan your steps, and then somebody changes them for you.

Your focus is on women serving in the military and the need for proper care for them, specifically in regard to anti-malaria drugs.

Can you broaden out your opening statement a little bit on what you see as the concerns and the needs within our military? I know that the U.S. is somewhat ahead of us on these things.

Dr. Remington Nevin: Mr. Chair, I thank the member for the question.

As I mentioned in my opening brief, the deployment of large numbers of women of reproductive age provides an opportunity—but, really, it forces the issue. It forces, or should force, militaries to reconsider, if they haven't already, their previous one-size-fits-all policies, including for the mandatory command-directed administration of anti-malarial drugs.

Just for some context, in Somalia, the use of mefloquine was ordered, and there were, for example, formations where every service member would be observed to take the drug on a weekly basis. Of course, that sort of policy of mandatory command-directed administration of a drug that may have reproductive toxicity to female service members with undiagnosed pregnancy is simply not acceptable.

The fact that we have large numbers of women now who are deploying to areas where we use anti-malarials, I think forces—or should force—militaries to reconsider these former strategies for malaria prevention.

It may be that anti-malarials aren't required at all in certain deployments. It may be that alternative malaria prevention measures might be appropriate.

The most important thing among all these possibilities is that these be customized to the individual service member—that malaria prevention be considered a medical treatment, just like any other medical treatment, and not a command-directed measure.

● (1650)

The Chair: Thank you very much.

I'd now like to invite the Honourable Carolyn Bennett to go ahead for five minutes, please.

Hon. Carolyn Bennett (Toronto—St. Paul's, Lib.): Thank you very much.

Thank you for your testimony. Thank you to the veterans particularly. This has been really important to us. I think we want to make sure that when you leave here, there's nothing you wish you'd said that you could have said. As you leave, if there are things you want to follow up on, we would love to hear from you.

In terms of prevention, it seems that even as you were deployed, you didn't have information as to what was expected, that it should be zero tolerance—or to whom you would go if there were any incident. The same thing then happened to you as a veteran. You didn't actually know what the structure was in terms of making things safe for all of you.

I guess my hope is that as we come up with the recommendations, you can help us with what would have been helpful when you were first deployed. I think we are worried about, as you say, whether it's in international waters or it's in other countries, where the enforcement takes place. As we've heard from RCMP, sometimes the person who's the most in charge is the perpetrator. How do you know where to report? In other countries, certainly what we're seeing is that there might be a peer support person as well as the case manager, or a buddy or somebody trained to be able to partner, even with new recruits or with people newly leaving the forces and with proper training and all of that.

Do you think it would have been helpful if you'd been given a peer support person who could walk you through this, particularly at the time when you were moving and didn't have a case manager? It seems that there could still be people who have been through it themselves who could give you advice. I'm just wondering what you think of that idea.

I'm appalled that the meds stop when you change province. As a physician, I just can't believe that this can happen. I think what we've heard here is the idea of presumption is something that gives some dignity to the veteran, that of course the meds should continue, that of course things should continue until there's a different assessment. But the assessment shouldn't require you to have to tell your story again and again and again. You want people to read it.

In terms of round tables, I think we've heard from other people about the minister having an advisory committee of women vets. We would also love to hear about that. You seem to have a case history of everything that went wrong in the system. Someone like you, who really has told the story of a system that's failed you, would be very helpful, I think, in terms of any minister pushing to do better.

● (1655)

Ms. Jennifer Smith: I'm not quite sure what the question was, other than—

Hon. Carolyn Bennett: Could a peer support person have helped?

Ms. Jennifer Smith: I've been asking for a personal support worker—which is essentially that—with my caregivers from the day I became a VAC client and was assessed, and all of that. So we've been asking since 2018. It's not been provided. VAC will not. They say they don't do that. They say maybe the community has some people—which is out of pocket for the veteran—or maybe the regional health authority does.

Hon. Carolyn Bennett: But you also didn't get help with housing.

Ms. Jennifer Smith: Correct.

Hon. Carolyn Bennett: Because people are supposed to have a wife, you actually didn't have any extra support as a single woman.

Ms. Jennifer Smith: No. That's right.

Actually, I have spoken to several people at VAC in administrative positions, and they have told me that the presumption is that the veteran has informal supports baked in. Any funding such as VIP services or whatnot is really just to be an addendum to to that. It's not actually to pay for the services that the veteran needs. It's just like, “Well, if you need a little top-up on what your spouse brings in,” or, “If your kids can shovel the walk this winter, then we can kind of give you a little bit more to top that up.”

If you do not have those informal supports, as I have said to Veterans Affairs over and over again, so succinctly, telling them that I am 100% reliant on external paid services, that still results in my not getting the services.

I am just marking time until I die, basically. I mean, it sounds dramatic, but it's true. That's the truth of it.

The Chair: Thank you.

Now, we're going to have two short interventions, for two and a half minutes each.

[*Translation*]

Mr. Desilets, you have the floor.

Mr. Luc Desilets: Thank you, Mr. Chair.

Ms. Doucet, during your pregnancy, did you get any kind of support from the Canadian Armed Forces?

Ms. Marie-Ève Doucet: I was treated by a military doctor, but that's it.

Mr. Luc Desilets: Did you get any special support during childbirth?

Ms. Marie-Ève Doucet: No, I kind of fell through the cracks, because I moved to Ottawa during my pregnancy. When I first arrived, I had a hard time finding a doctor. There are even some tests that I wasn't able to take because there was no follow-up.

So, as far as specific tests are concerned, I didn't get any during my pregnancy.

Mr. Luc Desilets: When your child came into the world and you identified some complications, was Veterans Affairs able to give you a helping hand and refer your case to a specialist?

Ms. Marie-Ève Doucet: No. It's only when he was 2 or 3 years old that we became aware he had neurological problems. When we moved here, in Bagotville, the pediatrician thought he was autistic. So we did some tests, but we had to go through the civilian system. We didn't deal with Veterans Affairs Canada at all, nor with the military system.

● (1700)

Mr. Luc Desilets: Thank you very much.

Ms. von Hlatky, are cases like Ms. Smith's, for example, recorded? Do you keep any statistics on them?

Prof. Stéfanie von Hlatky: The Canadian Armed Forces have recently started compiling this data every two years. We know that these sexual misconduct issues are exposed cyclically and that, unfortunately, they're never definitively dealt with. After hearing all of these stories, we see that it's not only a failure of military leadership, but also an abuse of power. So when we're talking about a sexual misconduct crisis, I believe it's just the tip of the iceberg. These stories compromise the entire military structure.

Mr. Luc Desilets: I'd like to ask one final question.

Ms. Doucet talked about her child having unique challenges, and it seems as though she's being forced to prove the existence of a link between those challenges and her time in the Canadian Armed Forces.

Are you aware of any studies comparing the incidence of such problems in the civilian population and the military population, for example women giving birth to children with birth defects or other health issues?

Prof. Stéfanie von Hlatky: I don't work in the field of health, so I won't comment on that.

What I can talk about is the cultural adaptation that's required when transitioning from the Canadian Armed Forces to civilian life. In the armed forces, people have access to all kinds of services, whether relocation services or health care. In the civilian world, they have to adapt to a whole new environment that can be quite confusing. When faced with challenges such as those experienced by Ms. Doucet and Ms. Smith, navigating this new reality can be even more difficult. The lack of support in that respect is especially unfortunate.

Mr. Luc Desilets: Thank you so much.

The Chair: Thank you very much.

[*English*]

I now invite Ms. Rachel Blaney to go ahead for two and a half minutes, please.

Ms. Rachel Blaney: Thank you, Chair. I appreciate that.

Perhaps I can come back to Ms. Smith. I think it's important that we go back to the housing insecurity she talked about. We know that at this point, about 16.2% women are serving our country, and yet on the other side, we're seeing that about 30% of the veterans who are unhoused or are in housing insecurity are women. That's telling me that something is significantly not working on the VAC side that we need to address.

I'm wondering if you could share with the committee a little bit about your difficulties in accessing services and connecting with VAC when you had housing insecurity. Perhaps you could explain where the gaps are so that we can start looking at how we can see that remedied.

Ms. Jennifer Smith: Certainly.

As I mentioned earlier, I had almost 30 years of experience without being a VAC client, not even knowing that “VAC” was even a thing, that it existed. Once becoming a VAC client, I was housing insecure in all its forms. Again, various non-profits, or VAC, said that they didn't have a housing mandate, so I should look on Kijiji. City of Ottawa social housing said there was a list about 5,000 people long, but there was housing out there. She looked at her laptop and said that tons of stuff was coming up. Again, it was not addressing things like the barriers that a woman veteran with a trauma history would find in that housing.

As well, there's the veterans' house initiative. While I applaud what they're attempting to do, when I spoke with the person in charge there, when they were still fundraising, I asked if any trauma awareness was being built in or how that worked. I was a case of, I see that you have 40 units, and yes, you're telling me that it's open to both men and women—but there's no way that I, as a woman veteran, would even want to enter into that building. It's communal living. If you look at the pictures online, you can see what this housing system looks like. It really replicates almost exactly the environment in which many servicewomen were sexually assaulted. Just safety-wise, think about the basement laundry and all the places where danger exists and danger lurks.

I don't think they've gotten it quite right. It's crossing fingers and hoping that, now that we're all adults and we've all learned, this must somehow mean that the housing is safe for women. We do know that women veterans are choosing to live in their cars rather than applying to stay at a place like the veterans' house initiative. I think that's unfortunate. It definitely needs to be worked on. I would recommend women-specific housing for veterans.

● (1705)

The Chair: Thank you, Ms. Smith.

Now we will go Mr. Dowdall for five minutes, please.

Mr. Terry Dowdall (Simcoe—Grey, CPC): Thank you, Mr. Chair.

I want to echo the comments on your being here today and telling your stories. They're horrific stories. It's sad.

Basically, we've been working on this study for quite some time. It's long overdue. To my mind, there are two parts to this study. One is Veterans Affairs and how we are treating you today, and then, it seems, it's the CAF itself and how you were treated prior. I think there should almost be a study during those points.

Do you think there should be something going on in the department every year to follow up a little bit some of the stories we're hearing? What we're doing here is sort of like dealing with it afterwards. It would have been nice, if you'd had that problem or those issues before your 13th month, if there had been something for you at six months. Do you know what I'm saying?

That's a question for you, Ms. Smith.

Ms. Jennifer Smith: Yes, I think so.

Certainly, how they're doing it now is an improvement to when I released. You got a one-way ticket and, boom, I'm at the airport: Now what? Nineteen years old and completely shattered....

Now, with the introduction of transition services, CAF has recognized that this is helpful in preventing and maybe heading off some of those—

Mr. Terry Dowdall: A little earlier...?

Ms. Jennifer Smith: Right, a little earlier, and identifying where problem areas might be, but to say that “now you've finished up your transition services and everything should be fine” I think is naive. Yes, there should definitely be some follow-up, but meaningful follow-up. I myself, if I can use myself as an example again, am on a so-called three-week rotation of being called by my VAC case manager for no other reason than to make sure I'm still breathing.

I'm still not getting services. I'm still not getting the supports. I still live in my room and struggle to eat or to shower—to do anything—and my quality of life is zero. I mean, I thought it was important to be here today, but it's really going to kick the hell out of me.

Mr. Terry Dowdall: One of the other recommendations you had was to increase the benefits for women. I know that we have a housing problem everywhere, as you know. Are we not sort of creating our own housing problem?

Ms. Jennifer Smith: Who is?

Mr. Terry Dowdall: The government, with the benefits and increasing....

Ms. Jennifer Smith: Yes. As a single woman, I'm responsible for the entire burden of home ownership or home maintenance. As a disabled veteran, I don't have any assistance to help with that, and because I am single, I don't quality for the caregiver benefit, which is a tax-free monthly benefit that is very helpful for the people who do get it. For attendant care, it's the same thing. I don't qualify for that.

Yes, I think these benefits and these supports—

Mr. Terry Dowdall: There's a need to look at some changes, for sure.

Ms. Jennifer Smith: —absolutely need to be re-examined.

● (1710)

Mr. Terry Dowdall: I want to get one more quick question in, if I can.

This question is actually for you, Dr. von Hlatky, on what you said, which I thought was quite interesting: the reasons for volunteer leave between men and women. I don't know if you can elaborate on that a bit more. I think it seems that it would be a fairly large issue that you'd want to look into. Why the volunteer leave and the difference....?

Prof. Stéfanie von Hlatky: The reasons cited in the exit surveys when we compare the women and the men respondents tend to differ. It just stresses the importance of having a gender-differentiated approach when we think about transition, so that when we are looking at the women veteran population we take into account those cumulative stressors and the reasons that are more prevalent in that segment of the veteran population compared to men.

I think it's fair to say that, in the past, veteran services, whether provided by VAC or the third sector of not-for-profit organizations, have been designed by men, for men, and led to outcomes that are very suboptimal for women, just like the housing facilities that were described by Ms. Smith. Representation of women's voices and recognition of those experiences are critical right in the design phase of those support services.

Mr. Terry Dowdall: On the other part, the transition of veterans and the broader cultural environment of society, how can we change that?

Prof. Stéfanie von Hlatky: On the prevalence of stereotypes and tropes that prevail in society when it comes to the way we perceive veterans, for women veterans the way that might manifest itself is complete lack of recognition of service, because—

Mr. Terry Dowdall: But how can you change their side to fix that?

Prof. Stéfanie von Hlatky: Awareness-raising in the public-facing campaigns of Veterans Affairs is about having more women represented, absolutely. When employers have preferential hiring programs for veterans, it's really about socializing these programs with employers and employees to provide a welcoming environment and, also, tailored onboarding tools for veterans, who will transition to a dramatically different employment space...examples like that.

The Chair: Thank you, Ms. von Hlatky.

Now let's go to Mr. Casey for five minutes, please.

Mr. Sean Casey (Charlottetown, Lib.): Thank you, Mr. Chair.

I'm going to stay with Dr. von Hlatky to begin.

We've heard some really compelling lived-experience stories here today, and given where you sit as the Canada research chair in gender, security and the Armed Forces, I can't help but think there must be something you heard here today to which you could say, “This is where my research can help.”

I'd like to start with the testimony of Ms. Doucet. She identified very clearly a problem with the necessity or the difficulty of establishing connection to military service and also the lack of research to allow her to make that connection, especially as it relates to the impact on her child. Can you speak to how your research can impact and help people with that kind of a story?

Prof. Stéfanie von Hlatky: Again, not being in the medical or health field, I want to point to research that's conducted by organizations like CIMVHR, the Canadian Institute for Military and Veteran Health Research where—

Mr. Sean Casey: —which is also based at Queen's.

Prof. Stéfanie von Hlatky: It's based at Queen's. It provides national research opportunities through a wide-ranging partnership. I will say that when it comes to the cultural competency argument I made earlier, it also applies to health care providers.

When you have a veteran patient coming to see health care providers in the civilian system, that familiarity with the veteran experience might not be there. Queen's and the gender lab that I referenced earlier—in, for example, the work done by Dr. Linna Tam-Setto,—have developed tools for health care providers to develop that cultural competency to be able to interact with veteran patients through a gender-sensitive lens.

Those types of approaches, in which you build tools to empower practitioners, are consistent with the recommendations I gave for that supportive environment for veterans, especially women veterans, when they're seeking support services.

What I'll also say is that through the research, we did an environmental scan of the types of services that were provided outside of VAC, because to me there are obvious gaps. I don't think we can necessarily expect VAC to fill all of those gaps. That's not a realistic expectation, so a lot of non-profit organizations have popped up to fill those gaps. It would be great if Veterans Affairs, for instance, had a really up-to-date directory, by city or by region, in which the service providers that have emerged—for instance, through charities and not-for-profits—were listed so that this up-to-date information would be at your fingertips.

Those are the types of small adjustments that can maybe bridge some of those glaring gaps that have been made evident by the stories that were shared today.

● (1715)

Mr. Sean Casey: Ms. Smith gave some powerful testimony. I'll ask you the same question about it. She touched on housing insecurity, military sexual trauma and the impossibility of transitioning when you're an island. How can your research impact people with that lived experience?

Prof. Stéfanie von Hlatky: I want to speak to the professional and social exclusion that women in the military have experienced that then carries over into their transition to civilian life. One thing we did at Queen's was to organize veteran transition workshops tailored to women, in which not only was the agenda of the workshops co-developed with women veterans, but also that our objective in hosting these workshops was to create a peer support network so that women would be able to meet other women with similar experiences and break that cycle of social exclusion they had experienced while in the military, and most likely while transitioning. Hosting these veteran-focused workshops was one way we could translate the research we do in a university setting in support of a community of women veterans. We had fairly localized workshops with women from Ottawa, Kingston and the nearby region.

Mr. Sean Casey: Thank you.

The Chair: Thank you so much, Mr. Casey.

We have 10 minutes left. We will have two interventions, but before that, let me say welcome to MP Kurek who is replacing MP Wagantall.

Mr. Fraser Tolmie, you have five minutes. Go ahead, please.

Mr. Fraser Tolmie: Thank you, Chair.

I would like to thank the witnesses for coming today and sharing. Some of the testimony we heard from the witnesses is very troubling, and not easy to hear, and certainly from this chair. I will maybe touch on that a little bit later on.

Time and time again at this committee we hear testimony from witnesses. Time and time again we hear about the machine, about Veterans Affairs and the military and how they fail to support veterans needing care.

Ms. Smith, you mentioned this care.

Care, for me, implies feelings. It implies comfort. Care implies support. Care implies understanding.

When I go into a doctor with symptoms, I'm working with them so that I can tell them what I am experiencing and find a course of action so I can be healed. It seems as though when I hear testimony from veterans like Ms. Doucet that the cart is before the horse. You're jumping through hoops explaining and re-explaining and trying to prove why you aren't well and why you got sick, instead of what is ailing veterans. In my opinion, that's not care.

Ms. Doucet, you made a recommendation that for anyone who has worked in the military with any form of chemicals, VAC should recognize this exposure to chemicals as a cause of symptoms.

Could you please expand on that? It is something I believe we should be supporting.

Ms. Marie-Ève Doucet: It's because for a lot of diseases, the causes are not clear. So if there were a list of everything someone in a particular trade was exposed to, then maybe they could be given the benefit of the doubt that having been exposed to something on that list.... Those chemicals evolve constantly. When I joined, I was using chemicals that are no longer used because they are just too dangerous—things like a fuel filled with benzene. Now the fuel is not as toxic as it was. I was exposed to that, but I have no proof.

I don't know. It would make sense that we have something we can go by to explain our diseases. So many veterans are affected by weird diseases that it's hard not to make a link, and yet we can't prove it.

● (1720)

Mr. Fraser Tolmie: Right.

That takes me back to that point of what I was saying. You seem to have to explain why as opposed to what you have experienced.

Are there any other areas of exposure that you think should be automatically recognized for someone who goes through VAC?

Ms. Marie-Ève Doucet: There's the exposure, yes, but there's also the mental aspect for sure. Obviously, 20 years ago, for a woman who joined the military, things were not necessarily easy. There are also the environmental factors on air force bases like Bagotville, Cold Lake and some others, where there are ultrafine particles that have effects on not only us veterans in the military but also our families.

I think all of that should be taken into consideration.

Mr. Fraser Tolmie: I have only a minute left. I thank the chair for letting me know that.

Ms. Smith, I'm not sure if this format is the right one to hear your testimony, where we give you only five minutes to be able to speak. I know that this was very, very difficult for you. It was very, very difficult for me and others around here. I just want you to know that what the chair shared with us about anyone needing any support afterwards was a genuine comment by him. We do mean it.

I want to say thank you very much for coming here and being brave and telling us what you went through.

Thank you.

The Chair: Thank you, Mr. Tolmie.

Thank you for the reminder to our witnesses that we will surely provide assistance, such as someone accompanying them, or a dog, or for travelling. If they let us know, we will take care of that.

For the last questions, we'll invite MP Wilson Miao to go ahead for five minutes, please.

Mr. Wilson Miao (Richmond Centre, Lib.): Thank you very much, Mr. Chair.

I too would like to thank all of the witnesses for being here today, especially those who have really had the courage to come to share their heartfelt life experiences with us. It's very difficult. This is the first-ever study of women veterans in this committee. It's especially difficult to hear so many stories. I believe there are more out there that we haven't heard. This is very important, especially in this week leading into Remembrance Day.

Through our previous studies, we heard about women feeling invisible. Now we want more stories to be heard, especially to find out how we can actually improve our current VAC system and the military. How are we supposed to recruit more into our military to serve our country when we're hearing so many untold stories of trauma and consequences? It's really hard, not just for everyone here in this committee but also for those who are watching this from around Canada.

I would like to thank all the guests for being here. It shows how important this study really is.

Through you, Mr. Chair, I have some questions for Ms. Smith.

Thank you again for sharing your experience. I know it's very challenging and hard. It takes a lot of bravery to share this, not just this one time but many times.

This is what caught my attention: How come those people or those who hurt you are still out there, not serving their criminal time? Have you ever thought about coming forward and really putting those who hurt you through our legal system?

● (1725)

Ms. Jennifer Smith: Thank you for the question.

Yes, actually—and this might also address some of what Mr. Desilets was trying to ask me. At the time, there was no mechanism for me to make any sort of complaint whatsoever. Those were Wild West days. One of the members pointed out the Somalia affair. I was living through that kind of time. It was not just happening in Somalia; it was happening on Canadian bases. It was nothing to show up to work with a black eye. Nobody asked any questions. It was “don't ask, don't tell”.

In my chain of command were often some of my perpetrators, so again, there was no way to make any kind of complaint that would be in any way safe for me. I'm still nervous about my safety. I do live somewhat in a state of an anonymity as a result of that. However—

Mr. Wilson Miao: You mentioned you also got a death threat if you decided to come forward.

Ms. Jennifer Smith: Yes.

I was tortured for three days and had a bayonet stuck in my chin. Absolutely, yes. There was no doubt in my mind that they would have killed me if I went out on that deployment to the Gulf if I sailed that day. So I made a plea to the chaplain for compassionate release, and got one and was honourably released.

Since then, I've just been in survival. It's survival now.

I thought that when I came forward to VAC with my claims and my experiences, that might cue somebody to say, “Well, this is unacceptable. Do you know who did this? In the cases where you do know who did this, here are some options; or, would you like to proceed further?” That was never the case. I'm still confused about that, because I have spoken about these incidents, these experiences, in several arenas and it's never been brought up to me.

I still don't know where I go. Honestly, I wouldn't know where to go with it.

Mr. Wilson Miao: Before we end today's committee, is there a way that we can help you to get the support you need so you can bring forward these injustices?

Ms. Jennifer Smith: I would ask you that question: What can you do?

I've told you my experiences. I myself do not know where I go with this if I want to see whatever kind of justice done. I mean, you have to remember that this was over 30 years ago. Some of my attackers are dead. Some of them have lived, have great careers and second careers in the government.

I don't know, is the answer, unfortunately. I would say that if you know what my next steps could be, then I welcome suggestions.

● (1730)

Mr. Wilson Miao: I think this is also a good opportunity for us to find out great recommendations or suggestions moving forward for those others who cannot come forward, like you, within a certain time frame to get those people behind bars.

The Chair: Thank you. As you understand, it's really tough to cut off that conversation. It's really important.

Ms. Smith, even I asked the analyst what we can do in that situation. We have to think about it to be able to help you.

[*Translation*]

This brings our meeting to a close. On behalf of myself and all committee members, I'd like to thank you for your testimony.

We've heard today from Marie-Ève Doucet, a non-destructive testing technician who appeared as an individual by video conference. We also heard from Jennifer Smith, a veteran, Stéfanie von Hlatky, full professor at Queen's University and Canada research chair in gender, security and the armed forces, and Dr. Remington Nevin, executive director of the Quinism Foundation.

[*English*]

Colleagues, I am pretty sure that we will participate in Remembrance Day to honour veterans. I too will be there.

I would like to know whether the committee would like to adjourn.

Some hon. members: Yes.

The Chair: Thank you to the translators, staff, the clerk and the analyst.

[*Translation*]

The meeting is adjourned.