House of Commons
CANADA

Standing Committee on Health

HESA • NUMBER 040 • 2nd SESSION • 40th PARLIAMENT

EVIDENCE

Wednesday, October 28, 2009

Chair

Mrs. Joy Smith

Standing Committee on Health

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● (1530)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): Good afternoon, ladies and gentlemen. I'm going to have to ask all of you as committee members to please take your seats.

We're going to have to change the times a little bit today because the bells will ring at 5:15 for votes. So we'll have our first round of witnesses from 3:30 to 4:45, and the H1N1 briefing from 4:45 to 5:15. When the bells ring, I have to suspend the meeting. We have to go for votes, and then we'll come back for our subcommittee on neurological disorders.

Also, committee, I have a motion that the proposed supplementary operational budget request in the amount of $32,000 in relation to the committee's study on the H1N1 preparedness and response be adopted. Would the committee adopt that, please?

(Motion agreed to)

The Chair: Thank you.

Thank you to the witnesses for coming today. We're so pleased you all could make it.

We have with us the Grand Chief of Manitoba, Ron Evans. Welcome. Glen Sanderson, senior policy analyst, welcome to our meeting. We also have the Indigenous Physicians Association of Canada, Dr. Marcia Anderson, president; the Society of Rural Physicians of Canada, Dr. John Wootton, president-elect; and Cecelia Li, medical student, McGill University. Welcome.

We will have a 10-minute presentation, and following that we will have the questions and answers. We will start with Grand Chief Ron Evans, please.

Grand Chief Ron Evans (Grand Chief, Assembly of Manitoba Chiefs): Thank you, Madam Chair.

I want to thank the House of Commons Standing Committee on Health for the invitation to appear once again before this committee to discuss our H1N1 preparedness and our response in Manitoba and to provide an update to our last visit to this committee.

As I stated in August, the Manitoba first nations are affected by the H1N1 virus disproportionately in comparison to the general public. In our initial analysis of the first wave, we identified a host of contributing factors, including overcrowded living conditions, poverty, lack of access to medical supplies and services, conflicting information, and a lack of access to running water, which all combine to make an ideal breeding ground for H1N1.

In the interest of time, I will outline our priorities and accomplishments in beating back this flu.

In June, under the direction of the Assembly of Manitoba Chiefs executive council, I requested all Manitoba first nations to declare a state of emergency on the H1N1 pandemic in order to hold the federal government responsible and accountable to fulfill their fiduciary responsibility towards first nations.

The Manitoba first nations set out the building blocks for the Manitoba first nations incident command system to respond to emergencies. We initiated an aggressive educational campaign where we printed and distributed H1N1 posters to approximately 16,500 first nations homes and businesses in Manitoba. We aired radio commercials targeted at H1N1 prevention strategies. We put a priority on H1N1 updates and aired them weekly on the Assembly of Manitoba Chiefs' half-hour NCI FM radio show. The network has 140,000 listeners, including all 64 first nations communities and every major centre in Manitoba, including the city of Winnipeg.

In July we completed preliminary training of personnel from every first nation for the incident command system, and we built on our advocacy initiatives for pandemic preparedness.

In August the chiefs and assembly passed a resolution at Nisichawayasihk Cree Nation, which is Nelson House Cree Nation, that directed me, as the grand chief, and the health staff to advocate for Manitoba first nations to be the first priority for the H1N1 pandemic vaccination. We've done that.

In September there were shocked northern chiefs who revealed publicly that Wasagamack First Nation received body bags in shipments of medical supplies. In response, the health minister called for an investigation. In the end, the investigation raised questions about the government's ability to coordinate communications to respond effectively to a national health emergency. It also demonstrated that first nations have a right to be consulted regularly about preparations for their survival in the midst of a pandemic.

In October the health minister publicly released the findings. Headquarters in Ottawa had advised nursing stations “to order big” on pandemic supplies. And nurses took that directive to mean stockpiling three to four months' supplies, which included body bags.

From the beginning I have said that this crisis is about people, not politics. I was distressed to see some feedback that used our people, even our children, like props in a political theatre.

We are the most vulnerable living in conditions of poverty. It's not helpful for our people to be given this kind of information, with pictures of our children being used as props, and body bags, especially when we're trying to convince and encourage them to get vaccinations. We feel as first nations communities that we should be working together to encourage all our citizens to get vaccinated. We should not be using people as pawns for political gain. This is a collective responsibility we have as leaders, as elected people, to make sure the Canadian population is vaccinated. We find it very disgusting and unacceptable that our people are used for this purpose. We ask that we all take collective responsibility to ensure that everyone is vaccinated, not frighten people or discourage them from being vaccinated.

● (1535)

I want to give you an update. In Cross Lake, one of the largest first nation communities in Manitoba, 2,000 people were vaccinated just yesterday, and maybe the whole community will be vaccinated today.

There are some hockey players who have come in contact with the H1N1 virus. This is a very serious issue, and we should all be supporting each other in combatting this virus.

We also designed flu kits. We designed them as a first line of defence against H1N1. They were delivered with the help of the province and generous private sponsors. All 15,500 of them have been delivered to every home on every first nation in Manitoba. Then last week, federal approval of the H1N1 vaccine turned a welcome corner and we started moving ahead to protect people, not argue about politics.

As first nations and aboriginal leaders in Manitoba, we were among the first to take the vaccination so we could lead the way and give our people the confidence and comfort they need to get the H1N1 vaccine shot.

The federal government worked with the province and the first nations to organize a series of mass vaccination clinics, which are taking place. Thirty-seven communities will have clinics set up this week, 25 will be next week, I believe, and the balance will be the week after.

The first week of a four-week campaign rolled out just the other day, on Monday. Today, the province's northern medical unit stands ready to support northern nursing stations with staff and medical supplies, and we are in better shape to face the future.

We have in excess of 50,000 first nations people with health centres that do not provide any primary care. Without transportation, there is no access to emergency medical care for our people. Too many of our communities are remote, rampant with poverty, poorly equipped, and with little infrastructure and even less health care. In my last appearance I requested that the Government of Canada fund annex B, the government's own pandemic preparedness plan. I'm pleased to say that we have made partial progress in implementing annex B.

My overarching concern remains that we are not ultimately addressing the very conditions that make first nations populations high risk. I continue to advocate for the political will. We work hard to reverse the impoverished conditions of our people, and we expect nothing less from all political representatives. We have an opportunity to address the pervasive issue of living conditions among first nations communities. H1N1 is a wake-up call for us to do that.

Thank you very much, *ekosani, meegwetch, wopida, mahsi cho*. Those are the five languages of the Manitoba first nations.

Thank you very much. *Merci beaucoup*.

● (1540)

The Chair: Thank you very much, Grand Chief.

We'll now go to Dr. Marcia Anderson from the Indigenous Physicians Association.

Dr. Marcia Anderson (President, Indigenous Physicians Association of Canada): I would like to begin by thanking the members of the Standing Committee on Health for the opportunity to stand on Algonquin territory and speak to you today about H1N1 in first nations communities.

My name is Marcia Anderson, and I'm Cree-Saulteaux from Manitoba, with clinical training in internal medicine and public health. I've been the president of the Indigenous Physicians Association of Canada for the past three years. As an organization of physicians and medical students who hold the vision of healthy and vibrant indigenous nations, communities, families, and individuals, we have been watching with great concern as H1N1 has circulated the globe.

At this point, we are all aware of how H1N1 disproportionately affected first nations people in the first wave, which was particularly striking in Manitoba, where 37% of all cases and 60% of those admitted to the ICU with H1N1 were first nations people. According to PHAC data, first nations were also disproportionately represented among pregnant women who were infected with H1N1. This should not have surprised us, given that in past epidemics of influenza there have been mortality rates four to seven times higher in indigenous peoples, and that each year first nations people are hospitalized for seasonal influenza at four to five times the rate of the general population. Further, we now know from Australia's experience with H1N1 that aboriginal and Torres Strait Islander people were hospitalized and died at ten and seven times the rate of the general population, respectively.

I consider it a success that aboriginal ancestry has been defined as a characteristic that makes people eligible for priority group one vaccination in Manitoba. I find it concerning that the federal government has not clearly identified all first nations people as higher risk for severe illness, as evidence has shown that urban first nations people are also disproportionately affected. There has been a lack of targeted and focused communications on the risk of H1N1 illness for first nations people that explains, at a literacy appropriate level, why the risk is higher and what to do. This is particularly striking as it pertains to pregnant first nations women. I cannot help but wonder if, had this been clearly recognized as a risk factor, more resources would have been made available to mitigate that risk.

First nations organizations in Manitoba have been setting up command centres at the community and regional level to support first nations communities in their H1N1 planning and response. I commend them for this, and I am aware that a proposal has been submitted for the support required to establish these systems and to ensure that the individuals are appropriately trained. It is my belief they should receive an equitable level of financial resources to support this new role for these representative organizations. They have done an excellent job in representing and advocating for their communities, filling gaps in communication pathways, and identifying the logistic and operational realities that many who work in the provincial public health system were not familiar with.

I also believe we need to provide an equitable level of public health expertise to the first nations incident command system as exists to national, provincial, and regional incident command systems. In Manitoba there is a single federal regional medical officer of health to serve 64 widespread communities, and that is simply inadequate even at the best of times. Perhaps consideration should be given to providing resources for the Assembly of Manitoba Chiefs to contract one to two public health professionals who can assist with finalizing the plans in the communities that have not finished them, and implementing them across the province as we are entering this second wave.

I will finish with two suggestions for addressing the risk of H1N1 in first nations communities.

First of all, an independent evaluation of the health care system response to the first wave of H1N1 in first nations contexts that can identify the effectiveness of different elements of the response, including adequacy of resourcing, communications, working structures, and working relationships, and clinical care, should be done. This is absolutely necessary to understand how to improve the health care system response, particularly inasmuch as we don't know if we as a system contributed to increasing the risk of severe illness or mitigated that risk. I will note that on a CBC *The National* interview, with respect to the health system response to H1N1 in aboriginal and Torres Strait Islander peoples, a senior Australian health official stated that he didn't feel they should have done anything differently, that the gap was only 10 times. It could be considered a successful outcome, because if they had not done so well the gap would have been wider. I hope that none of us would consider such a significant inequity acceptable and evidence of a job well done.

● (1545)

Second, the elevated risk for respiratory infections, including H1N1, is chronic and well known, and evidence shows that reasons for this include poverty, overcrowded and inadequate housing, higher rates of non-traditional tobacco use, and underlying medical conditions, which themselves are also due to underlying socio-economic inequalities. We must see a commitment to addressing these underlying social and structural inequities if we want to see a different outcome. I have heard Sir Michael Marmot, chair of the WHO commission on the social determinants of health, remind us that there is plenty of money to address underlying inequalities in social conditions. We saw the clear evidence of this with responses to the economic crisis. We have chosen to bail out banks and car manufacturers and have chosen not to ensure that all have access to appropriate shelter and to a safe and potable water supply.

If we truly want to see the gaps in health close for first nations communities, whether we are talking about H1N1, seasonal influenza, tuberculosis, diabetes, or heart disease, we must choose differently. We must have an explicit goal of health equity for indigenous peoples in Canada, and we must ensure that every policy and program decision is evaluated for how it will impact the gap in health for first nations, Inuit, and Métis people.

Thank you.

The Chair: Thank you very much.

Now we'll go to the Society of Rural Physicians and Dr. John Wootton.

Dr. John Wootton (President-elect, Society of Rural Physicians of Canada): Thank you, Madam Chair.

I appreciate the opportunity of appearing before you. I have Cecelia Li with me, whom I dragged into this. She's a medical student who's currently doing a rural rotation in Shawville, just down the road. She's part of the group that is the relief, the cavalry coming over the horizon, and we hope to interest her in rural practice. She brings a fresh set of eyes to the problems.

I've been in rural practice for 25 years. I'm the president-elect of the Society of Rural Physicians, and there are other members, colleagues of mine, across the country. When I got the the invitation to come to speak to you, I put out a call to my colleagues to give me some front-of-the-line reaction to the question of preparedness in their communities. This is unavoidably a bit anecdotal, since we haven't done a scientific survey. But I heard from people working in first nations communities and from health care teams in more southern rural communities. I'll list them for your interest. I heard from people in Lacombe, Alberta; La Loche and Wynyard, Saskatchewan; Sioux Lookout, Haileybury, and Smiths Falls, Ontario; Invermere, the Queen Charlotte Islands, Fort St. John, and Golden, B.C.; Glenwood and Freeport in Nova Scotia; and Goose Bay, Labrador.

As a general impression, what I heard was that there are preparations being made. Nevertheless, they are being added to from the shortages that already occur, and these are mostly human resources shortages of nurses, physicians, and other health care providers. In some places, it's going to make a difficult situation worse.

The one that worries people is that if the pandemic, as it has in the first wave in some communities, produces large numbers of people who require intensive care, transport, and facilities to care for them, things will become very difficult. This is why the Society of Rural Physicians has for many years lobbied for increased education of physicians who intend to practise in rural areas. We favour dedicated rural streams so that the skills required to look after patients close to their home communities can be strengthened. This way, when difficult times arise, particularly difficult times when everybody's in the same boat, some of those skills can be applied where the people live.

One of the other comments that I got from rural communities is that we shouldn't lose perspective on this pandemic. Many public health experts are still not sure what the severity of H1N1 will end up being. Communities that have a lot of other essential services to provide need to be able to continue to provide them. Physicians are also telling me that it's a wake-up call. We haven't been paying attention to infectious diseases in other years in the way we should have. It's well known that seasonal influenza also causes a lot of morbidity and mortality among slightly different demographic groups. But because these epidemics are not so widely publicized, not as much effort is put into combatting them. I think they are saying yes, H1N1 is a significant problem and we have to respond to it now, but let's not pack that experience away into a suitcase afterwards; let's learn from what we've had to do to combat this one.

● (1550)

Another possible perspective of interest to committee members is the federal-provincial one. As you know, health is a provincial responsibility, so all the provinces have rolled out slightly different pandemic plans, slightly different vaccination strategies, and slightly different target groups. For people who live on borders and for physicians who communicate amongst themselves across borders, that produces a fairly confusing picture. I work in Shawville, which is just up the river from here in Quebec, and my patients are very confused, because the news they hear is about the Ontario program, which is vaccinating with a different vaccine for the seasonal flu, and at a different time than Quebec has chosen. I'm not here to debate who's right; I'm here to assert that the plethora of different programs is guaranteed to cause confusion, both in health care providers' minds as well as in patients' minds.

I'd make the comment that the need to do all of this province by province must in the analysis have led to a great deal of wasted—or not wasted, but certainly duplicated—effort. Perhaps there's a lesson to be learned from this about a more coordinated planning process.

I mentioned the worst-case scenario, the concerns about there being a lot of people requiring ICU care. Already in Quebec they're talking about 200% to 300% of ICU capacity being reached. That's going to stress rural physicians with limited resources and limited backup, if we come to that point.

Looking into the future, there are some things that the Society of Rural Physicians is very interested in pursuing. One is ensuring that at times like these there are adequate human resources in rural areas. It's an ongoing issue. We've worked very hard to make the case that the quality of care provided in rural Canada should not be different from the quality of care provided elsewhere, but only organized differently; and that the providers of that care need to be educated differently, and that we need a presence in the universities and in the residency programs and in our teaching communities to ensure that this happens.

Finally, I think I can guarantee for you that rural physicians have community connections second to none and that they will step up to the plate and do whatever is required under the circumstances. Hopefully, we'll come out of this stronger than before.

Thank you.

● (1555)

The Chair: Thank you very much.

We'll now go to our first round of questions, with seven minutes for questions and answers.

I'm going to be strict with the time, so don't bother to ask me whether you can have extra time; it won't work. We want to cover as many questions and comments as we can today.

I understand, Monsieur Oliphant, that Dr. Duncan is going to share your time, so I'll give you a signal when you're halfway through.

Mr. Oliphant, would you begin, please.

Mr. Robert Oliphant (Don Valley West, Lib.): Thank you.

Thank you all for coming and for taking time at an important point in your careers to be here today. Having been a patient at Pontiac Hospital years ago, I am particularly glad that you're here, Dr. Wootton.

Also, Grand Chief Evans, I want to begin by saying that if the paper you held up has come from our party, I want to first of all extend apologies if it is in any way offensive to you or to anyone. I had not seen it until you just held it up now, and I heard the concern in your voice. I take it seriously. If it was done by our party, I want to assure you that I am convinced it was done to try to raise attention to the dire needs of vulnerable communities, particularly in our first nations and Inuit communities. It was, I hope, done with the best intentions, and I hope you will accept that apology, if indeed we did that.

That being said, I have a question. Technically, the most important thing I've heard so far is from Dr. Anderson: the concept of evaluation and the sure-and-steadiness of an evaluation from the first wave of H1N1, and how we have perhaps failed in doing one.

If there is advice you can give further, I'd like you to elaborate a bit more. If you have an intuitive evaluation already that is not yet scientific, that would be helpful for us. And can you address how we may advise our government about how to do a more appropriate evaluation of what we did?

● (1600)

Dr. Marcia Anderson: Thank you for that question.

I have worked with the public health system in Manitoba, because in part of my day job I am a provincial public health employee. I have a unique relationship, I think, with some of the different people, because I am a western-trained public health physician, but possibly because of my background and my interests and my previous research experience with first nations, I feel that I've developed a trust relationship with a number of the different representatives who have sat at our tables. Also, when I received the invitation to come here, I e-mailed them to ask them for any feedback I could represent on their behalf.

As far as the evaluation goes, the feedback I've had in the past and what I've witnessed myself is that there are many tables designed to provide a forum for communication. But on the first nations representation side, there has been a lot of frustration, because merely having the forum hasn't necessarily led to meaningful discussions or to resolutions of the issues. Things seem to have to come up again and again prior to there being any satisfactory resolution, if there is one.

What I've seen and heard more broadly from my own family members, friends, and community members indicates a significant lack of trust in the public health system as well.

Intuitively, I think we have had some wins. I mentioned one before: the aboriginal ancestry being recognized as a risk factor in Manitoba. So I think there would be positive findings also, but I think there was a lot that could have and should have gone better.

In terms of how an evaluation could be done, my suggestion would be that we consider an approach at arm's length from government. A professional organization such as ours would be willing and could consider leading some type of organization. The second most common specialty among physicians in our organization after family medicine is actually public health. We have a number of physicians who work in different federal and provincial public health systems with the requisite expertise as well as a number of very highly qualified researchers and appropriate international links that could help develop a really solid scientific methodology.

I think it could use a combination of standard epidemiological techniques, really getting to those rates, which would require open access to the data that PHAC and the provinces hold. It would also need to include other methodologies to collect information about the quality of working relationships, such as key informant interviews. Obviously a key factor would also be the organization of response structures and some feedback from the first nations on how they feel they were represented in those response structures, so that we could build better linkages and better representation among those.

Mr. Robert Oliphant: It would be as part of a system, I know.

Dr. Marcia Anderson: Yes, it would be really a system-level evaluation.

The Chair: You have seven minutes left, Dr. Duncan.

Mr. Robert Oliphant: Can I respond to that?

The Chair: Yes, absolutely.

Mr. Robert Oliphant: Thank you.

Grand Chief Ron Evans: I want to express why this is very disturbing. It talks about body bags and flow kits. The investigation was done and the information was put out there—what happened with the shipping of the body bags. I want to believe that everyone here has read the report, and we accept the findings of the investigation.

The other misinformation is that a question is put: were the Conservatives wrong to ship body bags instead of flow kits to first nations? The flow kits were shipped by us, the Assembly of Manitoba Chiefs, with the help of the provincial government, so it's wrong information as well. If this came after the investigation, then we need that clarified. It has Dr. Carolyn Bennett's name on it.

I don't know when you sent these out to your communities.

Hon. Carolyn Bennett (St. Paul's, Lib.): It was before.

Grand Chief Ron Evans: I just hope they were sent before all these things happened. We just shipped our flow kits in the last couple of weeks. Obviously our experience tells us that these things went out after the investigation was revealed, and that's what's troubling. Then it appears our children are being used for the wrong purposes, although we do appreciate any help we can get to raise our issues. We'd like that to be done in a good way. That's why we need to raise that. It's really troubling to our people with the—

● (1605)

Mr. Robert Oliphant: We'd like you to know that the printing and mailing timelines in this place are unbelievably slow. If they arrived on doorsteps you can rest assured they were done about two months ago. That's the reality of what we live with here. Yours are much faster.

The Chair: Thank you very much.

We'll now go to Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour (Repentigny, BQ): Thank you very much, Madam Chair.

[*English*]

Time is running out. No?

The Chair: No. I give you every benefit, Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour: Thank you very much.

[*English*]

The Chair: There are no presents today.

[*Translation*]

Mr. Nicolas Dufour: At our last meeting in August, we talked about the H1N1 crisis and first nations communities. Obviously, there was a deep-seated problem well before the crisis: the level of poverty, which is sometimes extreme. I was not trying to be radical, but I even likened it to the third world. When you see the sheer scope of the problem—the ability of communities to access clean drinking water and the state of certain buildings, for example—one might compare it to the third world, unfortunate as that may be.

I fully agree: the problem goes much deeper and has to do with access to drinking water. Without clean drinking water, a necessity of life, it will be extremely difficult to combat H1N1.

Mr. Evans, I do not mean to rub salt in the wounds, but I admit that I was very surprised by the document you showed us. Unfortunately, the rules of the House prohibit us from handing it out to the other committee members because it has to be translated first. You referred to the document a little bit.

[*English*]

The Chair: Monsieur Dufour, can I intercede? We can send it to your office, so we'll do that.

[*Translation*]

Mr. Nicolas Dufour: Thank you, Madam Chair.

[*English*]

The Chair: Thank you.

[*Translation*]

Mr. Nicolas Dufour: We heard about how the problem was made into a political issue. I am shocked by the information you gave us. Where did it come from, and what is in the document?

[*English*]

Grand Chief Ron Evans: Thank you very much for that.

This was brought to our attention by, obviously, those who received it somehow. I guess it's mailed. Of course, I'm not with government; I don't quite understand how these things work. I don't know how your system works, whether it's in two weeks or a month that you may get these things out. Nevertheless, it was brought to our attention. Every time something happens out there that disturbs our people, they bring it to our attention. So that's how we receive information, and then we have to find ways to deal with it.

So we received this just the other day, and then we questioned when it actually happened. The reason we bring it at this time is that our flu kits went out just within the last couple of weeks. On the investigation that was done for the body bags, actually the report came out way before we were sent the flu kits. So we assumed that this came out not too long ago. That's information that is not used for the right purposes, we thought, and so we needed to at least bring to the attention of those who are sending this kind of information out that it's really not acceptable for information to be used for those purposes.

It's a serious issue out there. It really deals with the health of people. It should be about the people first, and politics should not even factor into it. We have a relationship with the provincial government where they helped us with getting the flu kits into the communities. We did it, and then we worked out the logistics after that, and that's the way it should be.

● (1610)

[*Translation*]

Mr. Nicolas Dufour: Indeed, both opposition parties and the government side are trying to send a clear message that we need to encourage people to get vaccinated and to work together, all politics aside. Unfortunately, however, what you showed us is very counterproductive.

I want to come back to vaccination. According to a number of polls across Canada, a high percentage of Canadians are worried about getting the shot.

Do you have any poll results, statistics or other indications to show where first nations people stand on that? Ms. Anderson touched on it a little earlier, but, in your opinion, do a large percentage of first nations people fear getting vaccinated?

[*English*]

Grand Chief Ron Evans: Thank you for that question.

There was a concern initially, but as leaders, the other day in our province the president of Manitoba Metis Federation, David Chartrand; as well as Dr. Kettner, our public health officer in Manitoba; Dr. Postal; I myself; and another health professional took the flu shots. I believe that at least it gave people some confidence in the vaccine themselves. Therefore, the numbers have actually increased in the last few days.

As I've stated, in the community of Cross Lake there were 2,000 vaccinated yesterday. Cross Lake is a population of, I think, 6,000 people, so they're probably just about done today or, if not, in the next few days.

In the communities where this took place, it has really increased in terms of the people coming out to get vaccinated. So we're encouraged by the response and the turnout in the last 24 hours. We're very grateful and pleased to see the turnout in the communities in Manitoba.

The Chair: Thank you.

[*Translation*]

Mr. Nicolas Dufour: I understand. Are there still communities that are unprepared or ill-prepared for vaccination?

[*English*]

Grand Chief Ron Evans: No, we've worked very well with the province and the region, with the first nations and Inuit health branch. We have regular meetings, almost daily, just to make sure we're working together cooperatively, to make sure there's a schedule and that we're actually meeting the expectations of the communities as well as ourselves as leadership.

So I certainly feel at this time that what could be done is being done. And we're also beyond that. I think we're going to be able to start moving beyond that to make sure that in the future our communities are much more prepared than they were this past spring.

The Chair: Thank you very much, Grand Chief.

We'll now go to Ms. Hughes.

Mrs. Carol Hughes (Algoma—Manitoulin—Kapuskasing, NDP): Hello, and thank you very much for being here. I think it's really important that we hear from you.

Some of your feedback has been quite interesting to me, and you've indicated some of the resources that you need. My riding itself is made up of 17 first nations and very many rural communities, and I understand some of the concerns that are being experienced in the area.

My first question is to you, Chief Ron Evans.

Previously, questions were raised by first nations as to whether health funding arrangements were flexible enough to allow communities to direct program resources in order to address the influenza outbreaks. From talking with some of my first nations communities, I know they've indicated that they have very few resources to redirect and they had difficulty even to have someone as the main key person to deal with H1N1 without additional funding from the federal government.

Given that this would actually be an extraordinary cost to first nations, I'm wondering how it has impacted. Have you been able to get additional dollars from the federal government to deal with this situation instead of dipping into your own resources, whether it is for communications or whether it is to ensure preparedness within the community? Could you elaborate on that aspect?

● (1615)

Grand Chief Ron Evans: Thank you for that question.

As chiefs, we've had meetings with INAC officials in the region and we've also had discussions with some of the school divisions, even the band-operated schools, to work out those kinds of details. It's pretty complicated, but we were able to work out solutions at this time. Discussions are being held at this time.

In terms of getting some additional help with funding, we were able to get the support we need to get some coordinators in the communities for each particular region. I think we're getting about 10. It almost touches on what Dr. Anderson said about people focusing all their energies on pandemic preparedness, on planning, and on getting the communities ready so that the information then comes to us. That way we know what we have to bring to the attention of the federal government in terms of what they need to do to fulfill their responsibilities.

Mrs. Carol Hughes: Again, my question is whether you have received a commitment from the federal government that they would be prepared to put additional resources in there for you. Have you?

Grand Chief Ron Evans: Yes. We're able to access the resources that we need to begin to do that.

Mrs. Carol Hughes: Okay.

Marcia, did you want to add anything?

Dr. Marcia Anderson: One of the organizations that responded to me mentioned that they had put in a $10 million proposal for additional resources to set up their incident command systems and to do the appropriate training, and the only commitment they've had thus far is that they'll have a response soon. That's as much as I know.

Mrs. Carol Hughes: For this response demand, are we talking about medevacs? Are we talking about additional nurses, access to hospitals? I'm trying to get some sense as to whether first nations communities, especially remote first nations communities, actually have additional human resources now to deal with the issues that may come up with regard to their medical needs.

Dr. Marcia Anderson: That specific proposal was for four incident command system-related personnel in each community. That would roll up to the regional and provincial level. It didn't address the direct health service delivery needs of those communities.

I do know that the provincial government and the federal government have been talking with the first nations representatives about, for example, the medevacs, which is quite a concerning aspect as we head into winter and freeze-up, but I don't know any more details about that.

Mrs. Carol Hughes: Are there more concerns with regard to rural communities? Both for first nations and for rural communities, has there been an issue with getting the N95 respiratory masks? Are there more barriers there that you feel that we need to look at?

Dr. John Wootton: I don't think it's an issue of supplies; it's mostly an issue of manpower. In most rural communities the essential services are covered by people who are working flat out already. If 30% of them are sick, then there will be difficulty covering emergency departments.

I had one note from Golden, which is in the Rockies and gets a lot of accidents off the highway. They have an anesthetist who had to go with a patient on a transfer, and the community had no anesthetist for the time it took to go and come back.

If the pandemic is mostly volume, rural communities will cope better than if the pandemic produces a lot of very ill people. That is where the rubber is going to hit the road. If there are very ill people, and the people looking after them are ill, they're going to run short and have to stop doing other things that are critical. That's the scenario that is most worrisome.

To give a personal observation from my rural community so far, Cecelia Li and I ran a flu clinic this morning to keep people away from the emergency department. Most of what we saw was anxiety, not H1N1. There's a great deal of reassurance that's required.

If people do the self-help and stay home unless they're critically ill, the volume should be manageable. However, if people get very sick, they're going to come to the facilities. It's the coping capacity of those facilities that will be stretched, and I have not heard of their getting any extra resources to do it. In fact, they're probably getting more work added to existing resources.

● (1620)

The Chair: Thank you, Dr. Wootton.

We'll now go to Mrs. McLeod.

Mrs. Cathy McLeod (Kamloops—Thompson—Cariboo, CPC): Thank you, Madam Chair.

I'd like to thank all the speakers.

The rural, aboriginal...how things are happening in terms of dealing with H1N1 is extremely important to us, as a health committee.

I'm a new member of Parliament. I've been here for one year now. I know that politics has some rough and tumble to it, but I always thought there was a boundary of what is appropriate. What you indicated today is quite nauseating to me. I feel quite sickened for us, as parliamentarians. Not only is an apology in order for the House, but I think it's more important for first nations communities in Canada. For me it is a very shocking and sickening exhibition of what politicians do.

Having said that, I think we should head into more informed kinds of questions.

My first question is to Dr. Anderson. We talked earlier about the different provincial and federal government responsibilities, and off-reserve first nations typically fall under the jurisdiction of the province. I know in my province they're working very hard to reach out to that group. I'm wondering if your organization is supporting the provinces in any way with that off-reserve work.

That would be my first question.

Dr. Marcia Anderson: We have not, to date, played that role. We have encouraged representative organizations, for example, the northern and southern chiefs in Manitoba, who have played that role quite well. We would be willing to have an enhanced role in the H1N1 response, and we have offered to work particularly with the Government of Manitoba, since that's where I'm located, in this and other ways as well. I do think that professional organizations like our own, and the Aboriginal Nurses Association of Canada, for example, could have a strong role to play there, but we have not done so to date.

Mrs. Cathy McLeod: Thank you.

We've heard from Dr. Wootton, and he indicated he brought a student who might have fresh eyes and thinking.

Would she feel comfortable sharing how it has been for her, or what she's seeing?

Ms. Cecelia Li (Medical Student, McGill University, Society of Rural Physicians of Canada): I'm unfamiliar with the situations in Manitoba and first nations communities. Being a McGill medical student and coming from downtown Montreal to Shawville—and I've been here for about a week now—I agree with what Dr. Wootton said previously.

One of the things I see, for sure, is that in terms of the resources, I don't see a lack of supply in, say, the number of masks or the number of hand sanitizers available. It's mainly about staff. I think there's definitely a shortage of staff relative to the number of patients we need to serve. In case of a serious pandemic occurring in the hospital, that would be a major problem.

● (1625)

Mrs. Cathy McLeod: I guess my next question is, in this extraordinary time, do we have medical students jumping into clinics en masse? Are we really seeing a mobilization of some of our resources that perhaps wouldn't typically be used?

Dr. Wootton.

Mr. John Wootton: Mostly we're trying to pull all the retired nurses back into the fray.

Already in rural Canada, when we have residents and students, we give them a lot of responsibility, so they certainly take some of the load that is appropriate to their level of training. The Society of Rural Physicians really tries to take the long view on all of this. This is a crisis this fall, but what's really important is what happens over the next 10 years in rural communities with respect to their health human resources. This isn't the first and won't be the last type of crisis that stretches the human resources on the ground, and if those are very marginal to begin with, it will be a matter of lurching from crisis to crisis.

The society really has an interest in developing strategies to increase the interest in rural Canada, to increase the level of training that occurs in rural Canada. I must say, actually, we've been fairly successful over the last 10 years in promoting things like the new medical school in Sudbury and Thunder Bay. Those are the things that are going to pay off in the long run, and we have to keep our eye on the ball and make sure we do more of that.

Mrs. Cathy McLeod: I do know that we have embarked on a health human resource study, and I think we will perhaps be able to take some of the lessons learned from this particular pandemic crisis that will also help inform the work of our health human resources, for sure. I appreciate your comments about the longer term.

Do I have time left?

The Chair: You barely have time. I'm going to cut you off very shortly, Ms. McLeod. You have about 15 seconds.

Mrs. Cathy McLeod: Okay.

The Chair: Thank you.

We'll now go to Dr. Bennett.

Hon. Carolyn Bennett: I only want to repeat what Rob Oliphant said, that granted we really did believe we were repeating what had been said to us from your communities when we were in Manitoba in June, and then at the AFN in Calgary in July, in their request for flu kits and request for real resources, again *kitimâkan*, which I think is Cree for "I'm sorry". We would never do anything to offend.

We did believe that raising attention for the really dire needs that we saw when we were there was uppermost in our minds. You need resources. It's inexcusable in terms of the overcrowding, the lack of water, the things that we know, and the fact that you've been told to wash your hands or take a bar of soap.... I mean, I think we felt that we were repeating what had been said by your people. If that is not the case, then that shouldn't have happened.

What I really want to know is this. From the time we met in Calgary at the AFN not only did you have some very serious concerns about resources, but I think Mr. Sanderson had some concerns about the scope of practice of the nurses in the various nursing units and health centres. Has that been rectified?

Grand Chief Ron Evans: May I respond first, please?

Yes, the last time I was here I did express our disappointment with the way the federal government was responding at the time. They didn't know what was in the flu kits, and I believe that's on record.

I do thank all those who made a contribution towards raising the issue of the need to look at making the first nations, the aboriginal people, a priority when it comes dealing with the H1N1 pandemic. We certainly want to thank all those who did that for us. The only concern...and I do thank you for doing what you did. It just didn't sit well, the way it was done, and I had to express that on behalf of our people who took offence to it. That's merely what I'm doing here.

Also, as I mentioned, some of the information was not correct. The flu kits were something the AMC did. I didn't think we would want to give credit to the federal government for something that we did, right?

● (1630)

Hon. Carolyn Bennett: Grand Chief, that's what we were hoping for, that the federal government would have done that in July. That's what we were asking.

Grand Chief Ron Evans: In the information, you should use as much fact as you can. The body bag issue was dealt with, and I think we accepted the report. We understood what happened there.

Hon. Carolyn Bennett: I promise you that this went out before the results of the report.

Grand Chief Ron Evans: Well, we didn't know that. We don't know that. That's why we brought it to the attention—

Hon. Carolyn Bennett: That's fine.

Grand Chief Ron Evans: Glen, is there anything you want to add?

Mr. Glen Sanderson (Senior Policy Analyst, Assembly of Manitoba Chiefs): In terms of your question regarding the skilful work, there still is an issue and it will likely be an issue for quite some time. The grand chief alluded to it in his comments earlier. There are 37 health centres in Manitoba that do not provide primary care. The only primary care that you have access to is usually an hour or an hour and a half drive away. Now, if you have no access to a vehicle in terms of an emergency.... The health centre is open from 8 a.m. until 5 p.m., and after it's closed, there is no access to primary care at all. If you have no vehicle, you can't get out. And we deal with a lot of poverty in our communities.

Is it okay if I answer some of Carol Hughes' questions?

We received a letter in the early part of June from Jim Wolfe in the regional office of the first nations and Inuit health branch. He directed our first nations to move their health dollars from what we have—a native alcohol drug abuse program and Brighter Futures—into pandemic planning and pandemic resources. But what it does is leave a gap in service—a huge gap. This is why we were continuously looking for more moneys for pandemic planners.

In terms of that, we submitted a proposal to the first nations and Inuit health branch. We have a preliminary response from them to employ 19 pandemic coordinators. What they would do is primarily finish writing the plans in the communities. There is not a lot of capacity in the community to do a lot of these plans, so we want to make sure we provide that resource to them as well.

In terms of medical services and supplies to the communities, the algorithms that are provided to us by the provinces.... We have supplies in the community. If we run out of supplies, they are immediately restocked by the province if we need them. So we have all those agreements in place in terms of supplies for H1N1 masks, and for whatever else we need—gowns and everything else that would be required in a nursing station for primary care. Those supplies are available to us probably within 24 hours. It's one phone call, and within 24 hours they should be in our communities. So all of those systems are in place.

We've been involved within the tripartite committee in Manitoba since the early part of the spring. As soon as the outbreak started, we were involved in the tripartite committee, where the first nations and Inuit health branch sits, INAC, the southern chiefs' organizations, as well as the Manitoba northern chiefs. And we voice our concerns. We advocate for the needs of our communities.

Many of them are being addressed in terms of the medevacs. We supported the move to a central dispatch service. Generally how it happened in the communities is the nurses themselves would make a phone call to several carriers, several service providers, and they would have one of them come in, the one that would come in the quickest. But what we've done is take that extra duty away from the nurses. We've agreed to make sure that it was centrally dispatched out of Brandon, Manitoba. All the nurses do is make one call to the dispatch centre, and then they take care of the rest. And they can continue to do their primary care in the community. So those kinds of things have been put in place.

In terms of the staffing in some of our communities, I can give you an example. There should be a contingent of about eight nurses in that community, based on the population, the need, and the service that is being provided there. They would only have maybe eight. I mean, we require eight; they're usually staffed with six. We're always understaffed. That's not a question. We are always understaffed.

As for the call from the northern medical unit in Manitoba, it's a provincial initiative. They made the call. If we need nurses on the ground, they will find the nurses for us fairly quickly. Usually within 24 hours, we should have a response and have people out there fairly quickly, both nurses and doctors.

In terms of the kits, we did a lot of fundraising for those kits, and they were designed to be the first line of defence right in the home. We finished delivering all of them last week to every single household in Manitoba. And we're very, very proud of that.

● (1635)

The Chair: Thank you so much, Mr. Sanderson. This is some very good news.

Now, Dr. Carrie.

Mr. Colin Carrie (Oshawa, CPC): Thank you very much, Madam Chair.

I want to thank the witnesses for being here, particularly Grand Chief Evans, although I do want to disagree with you, sir, on one statement you made. You said you're just a first nations leader. Well, I think you're an excellent example of a leader, and I think all of us around the table could learn from you.

When you came before us in August, you brought forward your community's interests and you brought them forward very articulately. I think the governments involved have done their best to respond, and I want to commend you for working together and throwing yourself out there in front of the nation for your people. I know that's not an easy thing to do.

I know you've worked very hard to get proper information out to your people, and that's why I must say I share your disgust and I'm very upset with the document that you showed the committee today. I want to ask the chair to make copies available to all committee members.

I feel the committee is supposed to be working in a non-partisan way, especially with something like this. Dr. Bennett, I do hope you apologize to the committee members for this, because I feel this is disgusting. I think the Liberal Party leader should apologize publicly in the House and let us know where these documents were sent. Because if there is any information in there that is misinformation, I think everyone on this committee would like to have that brought forward.

I know the minister is working very hard with all communities and with this challenge we've had of the information changes. As the science changes, we do have difficulty communicating with different communities, particularly first nations and remote communities. As the science has changed, the minister has been very adamant about trying to get the information out as quickly as possible.

I was wondering, sir, at this time if there are any more recommendations you could make to Health Canada in regard to communicating better with the first nations community. Now that we're into the second wave, are there things we could do better at the community level?

Grand Chief Ron Evans: Thank you, first of all, for your encouraging comments. I take them to heart and I want to thank you for that.

As to what could be done further, because of our appearance here the first time and the things that have happened, a lot of things have improved in terms of communication, in terms of awareness of the H1N1 virus and the seriousness of it and the need to address those issues.

We're going into the second wave. As I've reported in my presentation of the things we have done, but more so because of the 19 pandemic coordinators Glen has mentioned, we're going to be able to really have the plans in place to be very effective in preparing for other pandemics.

This is a wake-up call for all of us, but more so for the first nations, about the need to prepare. We had talked about pandemic preparedness before the H1N1 outbreak, and I don't know many people really believed there'd be such a thing as a pandemic outbreak, but now we're going through that experience.

In terms of the future, what we're learning from all this is the need to deal with those issues that make us vulnerable. I hope those things are not lost once we all come through this pandemic outbreak, through the second wave. Once we're out of it, I hope we can continue to focus on the need to deal with those issues that make us the most vulnerable when it comes to pandemic outbreaks. But not only that, we need to have the federal government and the governments work with first nations in the way we're actually working with governments at this time with this H1N1 outbreak. If we keep that kind of cooperative working relationship, I think we can deal with those issues.

● (1640)

Mr. Colin Carrie: When you were here last, we heard from Health Canada that 90% of first nations had a pandemic plan, and I was wondering—

The Chair: I'm so sorry, Dr. Carrie, I have to be fair. Your time is up.

Monsieur Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you very much, Madam Chair.

I want to thank the witnesses for being here this afternoon.

Ms. Anderson, could you tell us how many members your association has, and whether all of them plan to get the H1N1 flu shot?

[*English*]

Dr. Marcia Anderson: I can answer part of that question. We have—

[*Translation*]

Mr. Luc Malo: You can give me their names, but you cannot answer my second question?

[*English*]

Dr. Marcia Anderson: That's true. I haven't personally asked all of them or done a poll.

We have more than 150 members: first nations, Inuit, and Métis. We have members on both coasts, east to west, as well as in the far north, so first nations, Inuit, and Métis are all represented at the training level—so medical students, right up to retirees. That was the easy part of the question.

With regard to the second part, I don't know if they are all going to get vaccinated or not. I do know that several have called me for advice on the vaccinations, with the intent to get themselves and their families vaccinated.

[*Translation*]

Mr. Luc Malo: What is the prudent advice you gave your colleagues?

[*English*]

Dr. Marcia Anderson: It's the same advice as I gave my own grandmother and grandfather, both of whom are first nations and have chronic diseases, which is to get in line as soon as you can.

[*Translation*]

Mr. Luc Malo: Thank you.

Grand Chief Evans, could you tell us whether you have seen much improvement in communications between the Canadian government and first nations since the communications protocol was signed by the Government of Canada and first nations in late September? Mr. Sanderson may also be able to answer that question. Earlier, I said to my colleague that there were a certain number of answers we needed to hear.

[*English*]

Grand Chief Ron Evans: With regard to the protocol, that's something that was done between the Assembly of First Nations and the federal government. As far as I know, that remains to be seen. In regard to that particular protocol, I believe there is a meeting coming up. I guess it will determine exactly how well it's working.

But right now, in terms of what we're doing and in terms of the things that need to be done, it's working well for us. I don't speak for the rest of the first nations, of course, but in Manitoba the communication lines are open. I don't know what's happening at the national level with the other first nations. And I guess this is where the protocol will be tested.

Mr. Glen Sanderson: In terms of the protocol nationally, we're not involved. Well, at least I'm not involved in that. I'm involved in the provincial tripartite group. We have really good protocol on communication, on everything. I get a daily tracking sheet of medevacs, of people coming into the rural hospitals, the city hospitals, the nursing stations, all displaying ILI. I get a tracking sheet every day. We have medevacs; they're on there as well. People who are admitted into ICUs are all there as well. I get updated every day and I pass the information on to the people who need to know.

[*Translation*]

Mr. Luc Malo: Grand Chief Evans, when you appeared before us in August, you said that your H1N1 flu kits had been paid for mostly by private partners and by your provincial government. You said you hoped that Health Canada would get involved. During your remarks earlier, you said that there had been results on that front.

Could you share them with us? I got the sense that you were not entirely satisfied. Could you tell us what the Government of Canada did to help you in terms of kit distribution?

● (1645)

[*English*]

Grand Chief Ron Evans: Thank you for that question.

With regard to the flu kits, at that time in August when I was here, we didn't have any flu kits, but we wanted to get flu kits to the communities. We wanted the support of the federal government to help us assist the first nations and be able to do what we've done in the last couple of weeks. The provincial government didn't have a problem with it. They helped us when the private sector stepped up. It wasn't political; they just did what they felt they needed to do for the first nation citizens in Manitoba.

Last time I was here, I spoke about the need for annex B to be funded, because it's the federal government's pandemic plan for first nations. I spoke strongly because our communities are not ready. Even though the communities had plans, you can have the plans, but if you don't have the resources, that's all they are: plans. They're difficult to implement without the resources. Since then what we've done is really work hard to make sure we had people who could actually focus.... As opposed to volunteers or taking people out of other programs to make them pandemic coordinators, we now will have pandemic coordinators who will specifically work with those communities to make sure about what needs to be done with their plans. Wherever the shortfalls are or whatever needs to happen, we will now have that information, so we can be very specific as to what exactly needs to happen in each of those first nation communities. That's where we are.

We believe that's a good first step, and then we'll see what happens once the coordinators are actually at work.

The Chair: Thank you, Grand Chief Ron Evans.

I want to thank all our guests for coming today and for your very insightful comments.

I'm now going to suspend the committee for two minutes so everyone can clear, and then we'll go into the H1N1 briefing. Everyone's welcome to stay and listen to that, if they'd like to do that.

Thank you.

Hon. Carolyn Bennett: Madam Chair, with due respect, the vote is not until 5:45. It does not take us more—

The Chair: We're dismissed.

● (1645)

(Pause)

● (1650)

The Chair: Could you take your seats, please? We now have to go into the H1N1 pandemic part of the meeting.

We will have bells ringing at 5:15. Everyone's welcome to stay and listen, if they would like to do that, but we just have to get started.

We have the debriefing on the H1N1 and the vaccination issues. From the Department of Health, we have Dr. Paul Gully, senior medical adviser; and of course from the Public Health Agency of Canada, we have Dr. Danielle Grondin, acting assistant deputy minister, infectious disease and emergency preparedness branch, and Elaine Chatigny, director general from communications.

Who would like to begin? Dr. Grondin, thank you.

[*Translation*]

Dr. Danielle Grondin (Acting Assistant Deputy Minister, Infectious Disease and Emergency Preparedness Branch, Public Health Agency of Canada): Thank you very much.

Good afternoon. The last time I appeared before the committee, I promised to get back to you regarding one of your questions. You should have received the pandemic information sheet on pandemic vaccine monitoring and surveillance.

[*English*]

This is a follow-up of the promise we made to you that you would be receiving the details about the various surveillance systems to assess the secondary effects. This is to let you know that you should have it now.

As a start, I would like to briefly give you the situation in Canada with the H1N1 flu virus. As you know, we are in the second wave nationally, and as you have seen in the media, there has recently been a death reported. We are very saddened by that, but this is, unfortunately, part of this disease. It was expected. It is expected that there will be a number of hospitalizations and ICU cases with ventilation requirements, and deaths will continue. For that reason, it is very important to continue to put into application the recommendations on public health that we have made, the package of recommendations, certainly the preventive ones, which include the vaccine. This is, to stress again, a new disease.

[*Translation*]

It is a new strain of the flu. It is very different from seasonal influenza, which has been relatively stable over the past 30 years. When a new flu strain emerges, the first wave can be fairly minor, moderate, but the second and subsequent waves can often be fairly serious. That is very important to keep in mind. As you now know, the vaccine is available in all provinces and territories. Flu shot clinics are underway. We are encouraging all Canadians to get vaccinated.

[*English*]

I would also like to mention that since the last presentation by Dr. Butler-Jones there has been new guidance. This is the one that was published today and is available on the web. It's about public transportation, for people travelling in trains, buses, boats, and ships. These guidelines are not only for the people using mass transportation, but also for the staff working on these modes of transportation. It is also for the agencies and the operators. This is to complement the wealth, if I may use that word, of the various guidelines, recommendations, and information that we have put out for the health professionals, schools, people at home taking care of people who are sick, and so on. This is a complement, and again we stress the importance that it is an individual responsibility to protect oneself and one's family.

● (1655)

I would like to stop there to give an opportunity to my colleague to present, and for questions. Thank you very much.

The Chair: Thank you.

Who would like to continue?

[*Translation*]

Dr. Paul Gully (Senior Medical Advisor, Department of Health): I will.

[*English*]

The Chair: Dr. Gully.

Dr. Paul Gully: Thank you, Madam Chair.

Based on Flu-Watch, across the country we're seeing increased levels of influenza-like illness in British Columbia, Alberta, southern Saskatchewan, southern Ontario, and the Northwest Territories. What we're seeing in first nations communities reflects what we're seeing in those provinces. Most cases on reserve continue to be mild, but we continue to monitor them closely in the nursing stations.

I'll concentrate on immunization. We continue to promote immunization through our nurses, the community nursing stations, local radio, community bulletins, and chiefs and councils. It has been shown, particularly by the example of Grand Chief Evans and other leaders, that the leadership of the community will be particularly important. We're hearing that the uptake of immunization in first nations communities is good. In fact, there are line-ups in those communities just like those we've seen elsewhere.

We expect that clinics will be in place in all remote and isolated communities by the beginning of next week. In Manitoba, we expect the remote and isolated communities to be completed by the end of next week. We will have to be back for those requiring second doses, which may require individual appointments or special clinics.

Over the next few days, we will give updates and more comprehensive data, as will the agency. We're hearing that the uptake has been good. In one community in Alberta, for example, half the community, 700 out of 1,400, were immunized in one day, yesterday. I can also confirm that first nations communities will receive, on a per capita basis, their share of non-adjuvanted vaccine, which you heard made public by the Minister of Health. We are continuing to encourage uptake of immunization and the use of other forms of medicine. We want to complement traditional medicines, if that is the wish of individuals.

That's my report. I will be willing to answer questions and update in the future.

The Chair: Thank you.

Ms. Chatigny, would you like to make some comments?

Ms. Elaine Chatigny (Director General, Communications, Public Health Agency of Canada): Sure.

The Chair: Thank you.

Ms. Elaine Chatigny: I want to take this opportunity to update you on some of our activities moving forward from last week. Today I believe you all received a two-pager, a summary of some of our communications activities.

[*Translation*]

I wanted to show you this document. I would be happy to have it updated systematically. You will be able to see everything that the Public Health Agency of Canada is doing in terms of H1N1 social marketing and communications to reach Canadians and those concerned.

[*English*]

As you can see, we've undertaken a huge number of activities in the last six months. When we look at the traffic on our website and the amount of interest in our preparedness guide, we have to go to another reprint. We are running out of them. We launched the guide just two weeks ago.

There's a huge amount of interest. The level of awareness of H1N1 is extremely high when you consider that six months ago no one had ever heard of H1N1, or pandemic H1N1. We're seeing a high rate of awareness across the country.

People are asking questions about the vaccine and whether or not they'll get vaccinated. It's a reflection of a lack of information. I think people are currently in the process of making decisions about their health and assessing the choices they have. I think the information campaigns, all the outreach, all the interviews that Dr. Grondin and Dr. Butler-Jones have provided, the ongoing three-times-a-week media conferences we're holding, are just a few tactics that clearly demonstrate that a lot of information is being provided to Canadians.

I can say that Tuesday, after the clinics started across the country — some got started on Monday—we saw a threefold increase to the fightflu.ca website that we manage at the Public Health Agency. An all-time high was 60,000 visits. We got 196,000 visits on Tuesday. That's 22,000 visits an hour on our website. Canadians know about fightflu.ca. They're coming to our website in high numbers.

They're visiting up to three pages per visit, which is very good; they're spending more time on those pages. That means they're reading the information; they're going deeper to find good, reliable information. And interestingly, our metrics show us they're not going to the vaccine safety fact sheet, they're going to other fact sheets on risk benefit and other information, because they do want to make a well-informed decision about their health and the health of their family.

So from the perspective of whether or not our communications strategy is working, I think there's ample evidence that Canadians are going to the clinics and they want to get vaccinated.

The national strategy is also a cascading strategy. I mentioned that last week. It's not just the federal government that provides information to Canadians; it's in partnership with the provinces and territories and the local authorities. So for those of you who spend any time in Ottawa, who may live here during the week, you know that ottawa.ca provides a huge amount of information to residents of Ottawa on where they can find the clinics and other information on the vaccine and on H1N1. And because they are linked to Ontario Public Health and the Ontario Ministry of Health is linked to us through our network, all the information Canadians are getting from reliable public health sources is consistent and coherent.

You may question that there are a lot of other voices out there. That's right. And increasingly, when we hear and see vaccine myths or....

● (1700)

[*Translation*]

There is misinformation out there, which really does nothing to help Canadians make informed decisions. We are being aggressive in countering those sources of information, and we are trying to direct those who have questions to our Web site, FightFlu.ca. I just wanted to share those statistics with you. I know they may just be numbers that do not mean much to you, but as I tell you every week, I would be happy to update them in order to keep you informed of our activities.

[*English*]

The Chair: Thank you so much.

We're having bells at 5:15, so at 5:14 I'm going to suspend just to make sure we get out.

With the indulgence of the committee, I'm going to ask that instead of going to seven-minute rounds we go to five-minute rounds, starting with Dr. Duncan.

Ms. Kirsty Duncan (Etobicoke North, Lib.): Thank you, Madam Chair.

Thank you to the officials.

We know how hard you're working to get the message out about the vaccine. I think there are some challenges. Can I put a few on the table?

On what date will the non-adjuvanted vaccine be made available to pregnant women? Is the Australian vaccine the same as the Canadian vaccine? What data indicates that the adjuvanted vaccine is as safe as the non-adjuvanted vaccine for pregnant women? The reason I'm asking is that I have a friend who is 21 weeks pregnant. She has worked in pandemic preparedness. She knows the field. She's talked to 10 obstetricians and six nephrologists. She has questions and she's just over at.... I think people need some reassurance. What is the possible impact of the adjuvanted vaccine on mother and fetus?

I think there are questions for immunocompromised people—those who are taking chemotherapy, those who are HIV positive. Should they be getting the vaccine, and if so, which one?

What about people who have autoimmune conditions? I mean, if the adjuvant helps the body develop a stronger immune response by increasing the inflammatory response...how might the adjuvant boost? Is it local? Is it systemic?

● (1705)

The Chair: Dr. Duncan, could we stop there?

Ms. Kirsty Duncan: Can I ask one more?

The Chair: No. If we have time, yes, but I want the answers.

Ms. Kirsty Duncan: Okay.

The Chair: Go ahead, Dr. Grondin.

Dr. Danielle Grondin: *Oui, avec plaisir. Merci beaucoup.*

There are several questions, but I think I can group them in about three groups.

On the question on immunocompromised people—people who are taking steroids and all these things, patients with HIV or whatever—in fact, they are the ones who should be immunized. The reason is, first, that the vaccine is safe. It is an inactivated virus. It is dead, basically, so it cannot cause infection. It cannot give you the flu.

The thing is that between the adjuvanted and the non-adjuvanted vaccine, the adjuvanted vaccine is even better for the person who is immunocompromised and who has any health condition of that sort, because the adjuvanted vaccine, the studies have shown, is more efficient in creating immunities than the non-adjuvanted. We know that the problem for the immunocompromised and, let's say, young children, for example, is that they have an immune system that is suboptimal. To give them the best chance to boost the immune system, the adjuvanted vaccine is better.

Ms. Kirsty Duncan: What about for autoimmune people?

Dr. Danielle Grondin: I'm sorry, autoimmunity is the same. All the groups of autoimmune diseases—that would be lupus, a form of arthritis, with steroids, long-term steroids, HIV, any of them, kidney transplants—all these people, in fact, are at very high risk, if they're infected, of being severely ill, of going to the ICU, and even of dying, because they are among those who have had deaths. So should they vaccinate with the vaccine? Yes, yes, yes, yes. The adjuvant is the best, and that's the reason Canada has the adjuvant. They will have even better protection.

Ms. Kirsty Duncan: How about for pregnant moms?

Dr. Danielle Grondin: The second group is pregnant women. The thing is that there was already some information released last week by us, as well as by the Society of Obstetricians and Gynaecologists. We have been working very closely with them and also with the provinces and territories on some guidelines.

Based on the recommendations from WHO, the World Health Organization, pregnant women need to be vaccinated. The two vaccines are recommended for pregnant women, according to WHO. But during the summer, in August, what happened was that WHO recommended to its member states that they offer an option to pregnant women. If possible, offer non-adjuvanted vaccine, the reason being that the data available on women who have had the adjuvanted vaccine is not as complete. But that was an option, stressing that both can be given to pregnant women. In fact, several countries that only have adjuvanted vaccine are giving the adjuvanted vaccine to pregnant women.

Right now, the recommendation for your lady friend who is 20 weeks pregnant is that she should be immunized. The information is there and has been very consistent.

Ms. Kirsty Duncan: But they've been struggling—

The Chair: Monsieur Malo.

Ms. Kirsty Duncan: Can I know the date, Madam Chair? That was the question.

The Chair: Monsieur Malo, you're next.

[*Translation*]

Mr. Luc Malo: Thank you very much, Madam Chair.

Do you want to finish what you were saying? I will ask my questions afterwards.

[*English*]

Dr. Danielle Grondin: To complete the answer to Madam Duncan's question, from what I'm seeing, the information is there. A woman at 20 weeks pregnancy could easily be offered the adjuvanted vaccine.

● (1710)

Ms. Kirsty Duncan: Can I respond to that?

The Chair: No, I'm sorry, we need to give him a chance.

[*Translation*]

Mr. Luc Malo: If I may, I would like to talk about travel advice. In the spring, certain countries would not allow passengers arriving from targeted countries, including Canada, to travel within their borders.

Are those international travel restrictions currently lifted? Could countries prevent certain travellers from entering if they have not been vaccinated against H1N1, for example?

Dr. Danielle Grondin: I can answer that.

First, let's talk about the travel restrictions that were put in place at the beginning of the outbreak, when the first cases were diagnosed, in Mexico, the US and Canada, for example. At the time, transmission of the virus was associated with people travelling. It became very clear, however, that once the virus had entered our country, transmission was more community-based. Travel no longer mattered; it was no longer even a factor because we were spreading the virus amongst ourselves. Travel restrictions were therefore lifted, as there is no longer any reason for them. This is a pandemic, which means that the virus has now spread to every country in the world. Travel restrictions became irrelevant some time ago.

Mr. Luc Malo: Okay.

Dr. Danielle Grondin: As for your second question, can certain countries restrict entry to people if they have not been vaccinated? Yes, we are aware of that happening. We received information from the Department of Foreign Affairs to the effect that Saudi Arabia, for example, is going to require people entering the country to provide proof of vaccination. Certain countries are making such requests. It is a possibility. But we will not do that in Canada.

Mr. Luc Malo: You have recommended that crew members avoid using gloves, masks, face masks and eye protection in most situations. Why is that?

Dr. Danielle Grondin: Simply because that is not really the best way to protect oneself. It would be more effective for the infected person to wear a mask. Having the passenger wear the mask would be more acceptable, for instance. To our mind, walking around the aircraft in a mask is not very effective.

Mr. Luc Malo: When you say gloves, do you really mean medical gloves and masks?

Dr. Danielle Grondin: Yes, I am talking about masks like the ones we see in hospitals.

Mr. Luc Malo: Thank you for clarifying that.

My next question is for Ms. Chatigny. Today, I received one of those emails you send out to everyone in your address book. The purpose of the email was to restate the facts in response to messages sent out by other groups telling people not to worry about the flu. It just gave the simple facts, as you said earlier. It did not say whether the flu shot was a good idea or not, but it just described the symptoms, steps you should follow and measures to take if you have symptoms.

Does your communication plan include a similar mass email? Do you see that as a way to counter all the other messages going around the Internet?

Ms. Elaine Chatigny: No, we do not plan to use mass emails, as you say. After testing out different ideas on a group of Canadians, we decided to prepare an information sheet that is being distributed to 10 million households across Canada. It provides the exact same kind of information. People told us they wanted something tangible that they could put on their bedside table or on the fridge. I showed you a copy last week. You have to keep in mind that not everyone is on the Internet, not everyone would have access to that kind of information on the Internet. We decided that the best tactic was to have something tangible that people could look at again and again.

[*English*]

The Chair: Thank you, Ms. Chatigny.

I'm sorry. Are you finished?

[*Translation*]

Ms. Elaine Chatigny: Are you talking about blogs, or was it sent out?

● (1715)

Mr. Luc Malo: A mass email that goes out to everyone in your address book.

Ms. Elaine Chatigny: Many people are now visiting the FightFlu.ca and CombattezLaGrippe.ca sites through Facebook and Twitter. We are using social media to direct people to credible sources of information such as FightFlu.ca.

[*English*]

The Chair: Ms. Hughes, I'm sorry, but I think you have time for only one question.

Mrs. Carol Hughes: That's okay. I'll talk quickly.

On October 13 an interim order was issued by the Minister of Health at the request of the Public Health Agency. An interim order is usually issued under section 30.1 of the Food and Drugs Act in rare situations where the minister believes immediate action is required to deal with a significant direct or indirect risk to human health, public safety, or the environment.

If you believe the H1N1 vaccine is safe and clinical studies back that up, why was an interim order made for the vaccine? Doesn't it imply that there are outstanding issues regarding safety and efficiency?

On surveillance, I'm wondering who is coordinating this, because there are different parts of it. What part of the operation are we at right now, and when do we anticipate it to be at the end?

The Chair: If you can answer one of those, that would be great.

Dr. Danielle Grondin: On the first question, Health Canada would be more appropriate to answer. I will refer that to one of my colleagues next time.

The second question was on surveillance. I think you are referring to the new pamphlet you received. Various health authorities are sentinels. The sentinels in the field are the health professionals, nurses, doctors, and people working with the public who will observe some of the secondary effects associated with immunization and report back. So it's a bottom-up process.

There are various systems. For example, IMPACT is for children. The Canadian Paediatric Society is contracted to monitor the pediatric hospitals, and so on. They are located in most of the pediatric hospitals and intensive care units. They report to their local provinces or territories and us.

Mrs. Carol Hughes: Who is actually coordinating it?

Dr. Danielle Grondin: It's all linked to PHAC. For the public health components we have a huge system—database, staff, and so on—to compile that regularly. For H1N1 we will be producing a regular report about the secondary effects, and so on.

The Chair: Dr. Grondin, I want to thank you so much for coming today.

I want to remind everybody that we have the subcommittee on neurological disorders, after votes, here in this room.

The meeting is adjourned.

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