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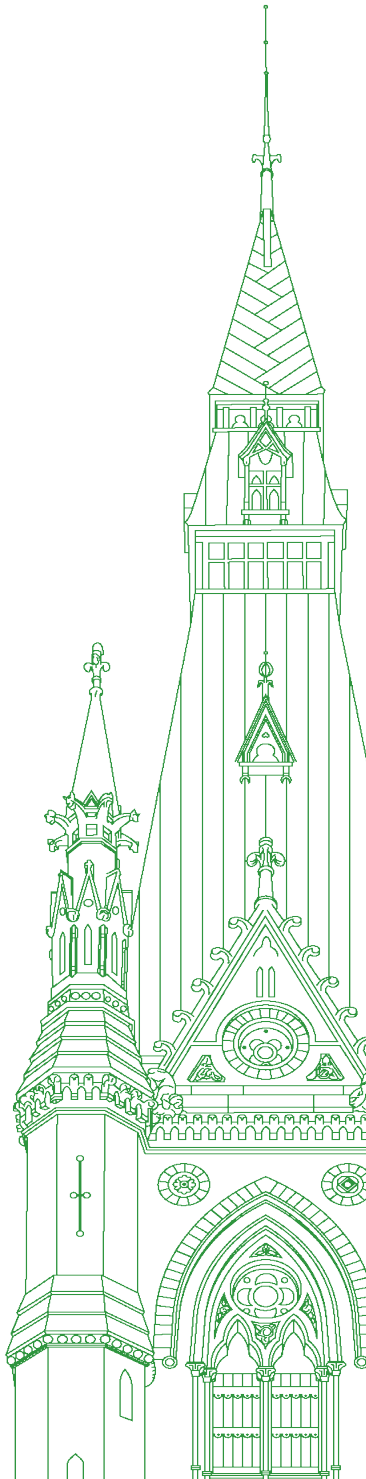

Chair: Mr. Ron McKinnon

Standing Committee on Health

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● (1405)

[*English*]

The Chair (Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.)): I now call this meeting to order. I welcome everyone to meeting number 14 of the House of Commons Standing Committee on Health. Pursuant to the orders of reference of March 24, April 11 and April 20, 2020, the committee is meeting for the purpose of receiving evidence concerning matters related to the government's response to the COVID-19 pandemic.

Today's meeting is taking place by video conference, and the proceedings will be made available via the House of Commons website. As at the last meeting, the website will always show the person speaking rather than the entirety of the committee.

I will go through a bit of housekeeping in order to facilitate the work of our interpreters and ensure an orderly meeting.

I will outline a few rules. Certainly, interpretation in this video conference will work very much as in a regular committee meeting. You have the choice at the bottom of your screen of either floor, French or English. The bottom of the screen applies if you are using a personal computer; if you are on an iPad, it's slightly different.

Before speaking, please wait until I recognize you by name. When you are ready to speak, you can either click on the microphone icon to activate your mike, or you can hold down the space bar while you are speaking. When you release the bar, your mike will mute itself just like a walkie-talkie.

As a reminder, all comments by members and witnesses should be addressed through the chair. Should members need to request the floor outside their designated time for questions, they should activate their mike and state that they have a point of order.

If a member wishes to intervene on a point of order that has been raised by another member, they should use the “raise hand” function. This will signal to the chair your interest to speak. In order to do so, you should click on “participants” at the bottom of the screen if you have a PC. When the list pops up, you will see next to your name that you can click “raise hand”.

When speaking, speak slowly and clearly. When you're not speaking, your mike should be on mute.

The use of headsets is strongly encouraged. If you have a microphone on your headset that hangs down, please make sure it is not rubbing on your shirt during your questioning time.

Should any technical challenges arise, such as in relation to the interpretation, or if you are accidentally disconnected, please advise the chair or clerk immediately and the technical team will work to resolve the problem. Please note that we might need to suspend during these times as we need to ensure that all members are able to participate fully.

Before we get started, could everyone click on their screen, in the top right-hand corner, and ensure they are on gallery view? With this view, you should be able to see all the participants in a grid arrangement. It will ensure that all video participants can see one another.

During this meeting we will follow the same rules that usually apply to opening statements and questioning of witnesses during our regular meetings. Each witness will have 10 minutes for an opening statement, followed by the usual rounds of questions from members.

I would now like to welcome our witnesses.

From the Department of Indigenous Services, we have Ms. Valerie Gideon, senior assistant deputy minister of the first nations and Inuit health branch; Dr. Tom Wong, chief medical officer and director general of the office of population and public health; and Chad Westmacott, director general of the community infrastructure branch.

From the Inuit Tapiriit Kanatami, we have Natan Obed, president; and Aluki Kotierk, who is a member of the board and president of Nunavut Tunngavik Inc.

From the National Association of Friendship Centres, we have Christopher Sheppard-Buote, president; and Jocelyn Formsma, executive director.

Finally, from the Southern Chiefs' Organization Inc., we have Grand Chief Jerry Daniels.

Welcome, everyone. We will now commence with statements from the panel.

We'll start with the Department of Indigenous Services.

Ms. Gideon, please go ahead.

Ms. Valerie Gideon (Senior Assistant Deputy Minister, First Nations and Inuit Health Branch, Department of Indigenous Services): Thank you very much, Mr. Chair.

I would like to thank you all for inviting me to appear before this committee on the issue of COVID-19. I want to begin by acknowledging that I am on the traditional territory of the Algonquin people, and I am here today, along with my colleagues, to discuss the unique strengths and challenges faced by first nations, Inuit and Métis in preparing for and responding to COVID-19.

First nations, Inuit and Métis know their communities and their community members. They know what will work and what will not work. The effectiveness of the government's response to COVID-19 among indigenous peoples relies on our ability to listen and provide support, tools, resources and reliable and timely information communicated in a culturally informed way.

The challenges faced today by indigenous peoples are related to poor social determinants of health and higher rates of respiratory and chronic disease. These challenges are well documented in countless detailed studies, including the Royal Commission on Aboriginal Peoples, the Truth and Reconciliation Commission, and the missing and murdered indigenous women and girls inquiry. These challenges are highly relevant to the COVID-19 planning and response required.

Lessons learned from H1N1 demonstrate the importance of connecting health to the social determinants of health in pandemic planning. The establishment of Indigenous Services Canada has strengthened the government's ability to focus its efforts, aligning the public health response with supports in social programs, critical infrastructure and broader emergency management. Investing in pandemic planning capacity and readiness across communities was also an important lesson learned.

With budget 2019 resources of $79.9 million over five years, Indigenous Services Canada proactively invested in first nations' capacity at the regional, tribal council and community levels in health emergency preparedness. The department also established a public health emergency network made up of regional medical officers and regional coordinators, including in emergency management, environmental public health and communicable disease emergency coordinators, to advise and support first nations across provinces.

While this capacity provided an important foundation, the need for communities and the department to adapt broad pandemic plans to the unique context of COVID-19 requires additional support and resources. It is also equally important to recognize the need to expand the support to first nations in the territories, Inuit, Métis, self-governing nations, indigenous individuals living away from their communities and indigenous communities within urban centres.

This is why the Government of Canada invested $305 million in the distinctions-based indigenous community support fund. These funds are provided to communities while maximizing their flexibility to respond to the immediate needs of their members. They include an urban and regional indigenous organization envelope of $15 million. Some of the needs being addressed through the community support fund are food subsidies for households; supports to control non-essential travel in communities; surge capacity costs for staff, critical equipment and supplies; and mental health supports.

In addition to the indigenous community support fund, the department is working with other federal colleagues to ensure that first nations, Inuit and Métis individuals can access the broader COVID-19 economic response plan benefits available to workers, families and businesses. Ten million dollars will be provided to Indigenous Services Canada's existing network of 46 emergency shelters, located on reserve and in Yukon, to support indigenous women and children fleeing violence. Approximately 329 first nations communities have been served by Indigenous Services Canada's funded emergency shelters.

● (1410)

On April 18, the Government of Canada announced up to $306.8 million in funding to help small and medium-sized indigenous businesses and to support aboriginal financial institutions that offer financing to these businesses. These measures will help 6,000 indigenous-owned businesses get through these difficult times and play a key role in the country's economic recovery.

Economic prosperity is an important determinant of health, particularly when you consider the younger age distribution among indigenous peoples.

In terms of my department's specific public health measures, I wish to highlight some of the core elements and activities of the response to date. While the exposure and number of confirmed cases among first nations and Inuit to date have been relatively limited, 0.01% of the total first nations on-reserve population compared to 0.09% for the rest of the population, vigilance is essential as the numbers are gradually increasing.

Communications and protocols have been critical, with multiple visual and social media channels being utilized and a heavy emphasis on adapting national public health guidance to target community priorities, including physical distancing, limits to non-essential travel, personal protective equipment, home and community care, long-term care and nursing homes on reserve, non-insured health benefits medical transportation, self-screening of health providers and visitors, access to testing and funerals.

As an example, we are supporting indigenous communities to implement adapted culturally relevant public health measures to promote physical distancing on the land. Translation of materials in indigenous languages will also continue.

At a national level, weekly briefings are taking place with the Assembly of First Nations chiefs committee on health, the Inuit public health task group and representatives of the Métis Nation. We are working closely with indigenous, federal, provincial and territorial partners through the public health working group on remote and isolated communities to ensure that the unique needs of these communities are met and that adequate preparedness, supplies and response levels are in place.

Weekly "touch bases" have also taken place with the National Association of Friendship Centres and the First Nations Health Managers Association. The department is also keeping apprised members of the indigenous women's well-being advisory committee, co-chaired by the National Aboriginal Council of Midwives and Pauktuutit.

At a regional level, our regional officials have either daily or multiple weekly calls with indigenous partners and work on a daily basis with provincial and territorial colleagues. As you know, health care is a shared jurisdiction, which raises the significance of coordination and collaboration among first nations, Inuit or Métis-led services with those of Indigenous Services Canada, other federal departments, provincial or territorial governments and their public health authorities.

During this pandemic, clarity of roles and responsibilities can remain a challenge, but thankfully, regional offices have spent recent years strengthening trilateral partnership tables. Relationships are well established and a strong asset in this COVID-19 response.

Indigenous Services Canada plays a more direct role for primary health care in 79 remote first nations communities and for public health among first nations on reserve across provinces, with the exception of British Columbia where the department acts as a funding and governance partner with the B.C. First Nations Health Authority.

Specifically, the department has mobilized its national health emergency network and regional command centres to actively support communities in updating testing and activating their pandemic or their all-hazards emergency plans. It has assessed more than 550 requests to the department stockpile for personal protective equipment and hand sanitizer, within 24 hours, intended for first nations health care workers. It has set up emergency contracts for surge nursing and paramedic capacity available to first nations health and long-term care facilities across provinces and identified additional physicians for the Society of Rural Physicians of Canada. It has worked with the Public Health Agency of Canada on the availability of swab tests, where these cannot be provided by provinces, and point-of-care testing in and/or near indigenous communities when those become available.

● (1415)

With fewer commercial flights and travel restrictions in place, the department has secured stable means to transport health professionals and needed supplies to remote first nations communities. Finally, we have directly purchased or funded alternative infrastructure for medical purposes or for accommodation. With a focus on remote communities, retooling existing space in schools, band offices or hotels is the preferred and fastest option. However, where this has been deemed impossible, 41 mobile medical units and 17 multi-purpose mobile trailers have been secured so far.

[*Translation*]

I understand the committee has been provided a copy of a dashboard we developed to provide to the committee some key information as it relates to COVID-19 and indigenous communities.

Indigenous Services Canada is also ensuring that additional supports are available through the emergency management assistance program, income assistance, non-insured health benefits, Jordan's principle, the Inuit child first initiative, and first nations child and family services.

When Indigenous Services Canada is made aware of COVID-19 tested positive cases, we work in collaboration with key partners to ensure appropriate health care is available for affected individuals; to implement immediate measures to reduce further community spread including contact tracing; and to identify any additional support that may be required. The health and safety of community members is a top priority, as is the need to respect the privacy of those who are sick with COVID-19.

With flood and fire season approaching, I want to assure you that the department is working closely with first nation communities to prevent any additional challenges that seasonal flooding and other natural disaster emergency situations may present in the midst of responding to the COVID-19 pandemic.

We are working to ensure that emergency seasonal evacuations continue to happen within the context of COVID-19. Confirmed and presumptive cases of COVID-19 will be assessed and treated using appropriate public health and primary care measures. Infection prevention and control measures are put into place to ensure that community members who are being evacuated are protected from being exposed to COVID-19.

We are learning and adapting quickly as the COVID-19 pandemic evolves. Currently, we are focused on enhancing our response efforts in key areas. We are partnering with indigenous organizations to ramp up and tailor communications to their needs, including youth, urban-based and northern populations.

We are working collaboratively with first nations on ensuring access to mental health resources, including virtual counselling, crisis lines surge capacity and strategies to cope with alcohol, opioid and methamphetamine addictions.

● (1420)

[*English*]

The Chair: Ms. Gideon, could you please wrap it up? You're at 13 minutes.

[*Translation*]

Ms. Valerie Gideon: Okay.

Lastly, recognizing the large number of indigenous individuals residing in urban centres, we will continue to do outreach and collaborate with indigenous organizations, provinces and territories to offer extra support.

I want to assure you that we are taking this matter very seriously to ensure that no indigenous person or community is left behind.

I would be pleased to take your questions.

[*English*]

The Chair: Thank you, Ms. Gideon.

Next on my list is ITK. However, Mr. Obed is having trouble connecting. We will therefore go to our next group and get back to ITK shortly.

The next group is the National Association of Friendship Centres.

You have 10 minutes, please.

Ms. Jocelyn Formsma (Executive Director, National Association of Friendship Centres): Good afternoon, everyone. I am going to do the first five minutes and then I'm going to hand it off to our president, Mr. Sheppard-Buote.

My name is Jocelyn Formsma. I am the executive director of the National Association of Friendship Centres, NAFC. I am originally from northern Ontario. My family is from Moose Cree first nation, and I grew up in the surrounding area in my territory.

Friendship centres have been on the front lines of the COVID-19 response since the first day. I will give some examples of what they have been doing. They have been responding to increased service demands, delivering food to families, young people and elders. They have been responding to calls for assistance and support, and we've found that there are additional calls around sexual assault and family violence. They have also been providing mental health and cultural supports for urban indigenous community members. They have been asked to lead task forces or have just started them on their own, responding to the needs in urban settings. They have been asked by mainstream agencies to help deliver supports. They've been emptying their food stores, cooking food for community members and picking up and delivering food and traditional medicines.

We've even had an example of a friendship centre that went to a family home to deliver food, and they found out that the family's stove had broken down. They purchased a stove and arranged for it to be delivered to the home. In another instance, we found that they were delivering food to a family and that the father was very ill. They convinced him to go to the hospital so that he could seek medical attention. He thought that, whatever he was dealing with, he was safer at home than going to the hospital to deal with that medical issue. Although it wasn't COVID-related specifically, there are so many things that friendship centres have been doing to step up in this space.

The NAFC represents 107 local friendship centres and provincial and territorial associations, operating in every province and territory in Canada except Prince Edward Island. The services offered are as diverse as the communities in which they are located. They key point is that they are all culturally informed and culturally appropriate.

The NAFC received word from Indigenous Services yesterday that we will be receiving $3.75 million from the indigenous community fund, and that was representative of 100 different organizations, including the NAFC, six provincial and territorial associations and 93 local friendship centres. We certainly appreciate the support, but we know that these funds will not last long, and we welcome the opportunity to work with the government to seek additional supports for friendship centres.

Friendship centres are experts in urban indigenous service delivery. Since the 1950s, we've been working in a wide variety of our communities from Inuvik to Montreal to Labrador, Vancouver Island and everywhere in between.

Indigenous people, as we know, are diverse. A diversity of approaches and partners are needed to respond appropriately to this COVID-19 pandemic. We know that friendship centres are already providing services, food, supplies and staffing. We need support for creating safer spaces now and in the future. We need support for equipment and information technology, software, hardware and protective equipment for our staff, volunteers and community members.

The distinctions-based approach has affected urban indigenous pandemic responses. In echoing the words from the MMIWG inquiry report, we believe and would advocate that distinctions ought to be defined with an intersectional lens, not just including first nations, Métis and Inuit, but also considering the residence of indigenous people, the province or territory that they're in, whether they're remote or northern residents, their physical and mental abilities and their sex, gender identity and sexual orientation. We believe that, by including an intersectional lens to distinctions, we will be better positioned to provide wider and greater supports for urban indigenous community members.

I will provide the committee with a bit of context. In the early weeks, we found that jurisdictional wrangling had an effect on our ability to respond. As a national association, we immediately went to Indigenous Services and received word that the provinces and territories would have been expected to step in within the urban spaces for indigenous people, but when our provincial and territorial associations went to the provinces and territories for support, they were saying that we should be going to the federal government for financial support. This led to a lot of running around for friendship centres and nobody taking full responsibility.

● (1425)

We know that first nations, Métis and Inuit are a priority group for testing. They're a community of concern for the virus. We want to ensure that urban indigenous voices are considered and that our communities are considered in whatever approaches are taken to respond to this pandemic.

I'll hand it off to President Sheppard-Buote to wrap up our comments.

Mr. Christopher Sheppard-Buote (President, National Association of Friendship Centres): I'm going to take a bit of a different frame. What I am really concerned about, more than the timing and everything else, is that the Government of Canada continues to frame urban indigenous communities as somehow different or separate from our relatives who continue to live in their respective historical or current territories.

Since the 1950s, friendship centres have been the direct result of indigenous self-determination, designed to be a support foundation for indigenous people in cities, who for many reasons, ended up there. Friendship centres provided a safe haven that was fabricated from indigenous ways of knowing, outside and beyond historical government-determined boundaries. Current data shows that indigenous people will continue to move to urban centres and the numbers will continue to increase in urban centres. Systems, programs, pandemic planning and public policy are still crafted from a perspective that does not appropriately reflect where indigenous people live.

This can be most easily seen during this current health crisis. The majority of the support fund did not require a request for proposal process, whereas urban people were required to create a proposal. In most instances, it required our national association to intervene in the work they were doing on the ground, to ask questions to make sure we were getting the appropriate data to complete an application to get support for our organizations on the ground.

While friendship centres historically have been designed as wraparound civil society organizations, we have been fighting this notion that across the spectrum of program design within federal systems, there is very little space for urban people. This current situation is highlighting and compounding other problematic realities.

When you look at historically ineligible items to support your community, such as food security, in a time when food security is one of the biggest barriers in our communities, and our organizations know it's not typically an eligible expense, it takes a lot of written confirmation before they will be comfortable spending those resources. They have a huge fear of being told that what they're doing is ineligible.

I'll finish with this. It may seem unusual to a lot of people right now that you go to work every day fighting to keep people alive, but this is a normal occurrence in our organizations all the time. COVID-19 and keeping people alive is not strange territory for us. When you have urban people who are borderline invisible and not quite distinct enough, it takes an incredible amount of work, energy and response to make sure they have the best health outcomes every day. So it's very normal for our organizations not to even consider closing and to keep working, because this is their everyday life.

As we move forward, my hope is that policy responses to a health crisis like we're in right now represent the reality for urban people and for indigenous people in this country. Out of $305 million, $15 million is set aside for where the majority of us live.

Thank you.

● (1430)

The Chair: We'll go now to the Southern Chiefs' Organization, with Grand Chief Jerry Daniels.

Grand Chief, please go ahead for 10 minutes.

Grand Chief Jerry Daniels (Southern Chiefs' Organization Inc.): Thank you.

I would like to start by acknowledging that although we may not be together in the same place for this meeting, we are all on Turtle Island. Indigenous peoples have been on this land since the first sunrise.

I want to take a moment to acknowledge our elders, who are the keepers of our knowledge and culture and who are at increased risk during this health pandemic. I want to acknowledge all the people who are working hard on the front lines and behind the scenes to keep indigenous nations and Canada safe from COVID-19.

I would like to acknowledge the leaders and community members on the ground who are putting themselves at risk to ensure operations are maintained and families are taken care of. Whether it is running errands for others, delivering supplies such as groceries, water or medicine, or standing for hours at the road checks to help flatten the curve, I want to say *chi-meegwetch*, thank you from the bottom of my heart for doing that work and being the backbone of this country right now.

I thank the committee for the work you are doing and for inviting me to speak today about Canada’s response to the COVID-19 pandemic. I will speak about how the pandemic is impacting indigenous Anishinabe and Dakota people in what is now southern Manitoba.

I hope that this meeting will be fruitful and further inform the way forward. In my presentation I am going to focus on four key determinants of first nations health, how they are impacted by the COVID-19 pandemic and what is needed to effectively support our communities. At the heart of the determinants of health are inequities in the health system, inequities with federal funding, and ongoing inequities the communities are facing that make our elders and our youth so vulnerable.

I begin by focusing on health inequities that first nations people face in Canada. When it comes to accessing health care services and professionals, indigenous peoples are the most marginalized in the country, with the poorest health outcomes. As just one example, a joint study released last year by the First Nations Health and Social Secretariat of Manitoba and the Manitoba Centre for Health Policy demonstrated that decades of poor health outcomes have resulted in a gap in life expectancy between status first nations and all other Manitobans that now sits at 11 years. Shockingly, this 11-year gap is growing.

This lack of access to health care was allowed to develop over decades and many administrations. First nations reserves are often remote and far from major cities in which there is better access to health care. It is important to remember that displacement of Anishinabe and Dakota nations made way for those cities, such as Winnipeg and Brandon, with large health hubs and resources. I am concerned about our fly-in communities such as Poplar River, Pauingassi and Little Grand Rapids, which are particularly vulnerable in this pandemic. When the rest of the country comes to a halt or adjusts its production, transportation and distribution schedules, the impact hits our remote communities hard. They rely on supplies and health professionals from outside of their communities. For first nations living off reserve, we need only think of the death of Brian Sinclair to know that racism and stereotypes can be deadly in our cities as well.

As we continually check in with our communities, we hear their concerns. I can tell you that as of yesterday, Little Grand Rapids is experiencing a shortage of liquid baby formula at their Northern store. We ask that the systemic inequalities be addressed once and for all, with increased access to health care on reserve, with special consideration for remote communities.

Sadly, the inequities continue with the response to COVID-19. While we applaud the initial steps of this government with the indigenous community support fund, and are encouraged by the aid announced over the weekend for indigenous businesses suffering COVID-19 losses, there is a monumental financial shortfall that will cause hardship. This past Friday, CBC's *Power & Politics* host Rosemary Barton estimated that an unprecedented $113 billion has been allocated to help Canada thus far with the pandemic. Only $621 million is earmarked for indigenous communities. The 2016 Canadian census reported that indigenous people account for 4.9% of the national population, yet indigenous people are receiving just over half of 1% of the relief funds allocated by Ottawa. This is clearly disproportionate, and first nations are still left to manage in poverty.

While the argument may be that first nations are eligible for some of the billions in aid available to regular Canadians, for example, the increase in GST rebates or child tax credit, that will not be close to the extent that would close the gap between $621 million and the $113 billion. We ask that the funding for the indigenous community support fund be increased to equitably reflect the first nations population and realities, realities created by many consecutive Canadian governments. We ask that any proposal processes move quickly to the approval stage due to the state of emergency we find ourselves in.

Another area of concern is off-reserve members of our communities. Approximately half of first nations populations now live off reserve and in urban centres, yet we are not funded to care of our off-reserve members.

● (1435)

Chiefs are receiving calls every single day asking for help. With just $15 million of the indigenous community support fund allocated for urban indigenous peoples and divided among first nations, Inuit and Métis organizations across the country, it is simply not enough.

We ask that the funding for off-reserve services be increased to appropriately reflect population dynamics in urban centres.

I will now take a moment to highlight other inequalities that impact first nations, specifically food security and infrastructure deficits.

When it comes to food security, indigenous peoples have been in precarious and vulnerable situations since the disruption of our agricultural and hunting economies. Because so many of our families are already experiencing food scarcity, this crisis has made this situation so much worse.

We rely on strong partnerships, like the one with the Breakfast Club of Canada. Our 34 communities applied to the COVID-19 emergency fund, with a low barrier application and fast response. A big *meegwetch* to the Breakfast Club of Canada for their strong support.

As first nations, we have always hunted, fished and trapped to survive and feed our families. In this time of crisis, with restricted movement to the surrounding cities and municipalities, we are trying to return to traditional food sources and harvesting to increase our food security.

We ask for financial help to support the implementing of community food security projects.

The COVID-19 pandemic has reinforced that there is a lack of housing and a poor quality of existing infrastructure on reserve.

Where do you isolate in a community when there are chronic housing shortages and more than a dozen people in one home? There is a lack of on-reserve facilities and resources for community members struggling with addictions.

While we applaud the $50-million allocation for women's shelters and sexual assault centres, which includes up to $10 million for facilities on reserve and in indigenous communities, more is needed. There are only 46 shelters funded by Indigenous Services Canada across the entire country.

We ask for more investment in first nations' infrastructure for housing facilities and shelters.

Lastly, I would like to speak about the well-being of our elders and our youth.

From conversations with our chiefs and members, we know that many are concerned about the safety of our elders from the virus that disproportionately kills older people.

Elders are sacred in our communities. Not only are they much loved members of our families, but they carry our culture and knowledge, languages, our histories and traditions.

If the disease hits our communities and the personal care homes like it has in other provinces, it would deal a heavy blow to the intergenerational knowledge systems of our people. We need our elders close and cared for. We need more homes on reserves because our elders are not always treated well in personal care homes off reserve. We have just two personal care homes for elders in all of our 34 communities.

I want to acknowledge and thank the hard work and dedication of the Manitoba first nations personal care home network, our leaders of the on-reserve care homes in Manitoba.

Our communities are also worried about our youth, especially those in post-secondary education. The economic fallout poses a real risk, with no summer job prospects this year and no child care to support single parents. Attending post-secondary programs this fall may not be possible.

Indigenous youth have some of the highest rates of suicide and self-harm in the country, and are overrepresented in the child welfare system. Mental health supports and resources to keep youth engaged during this time of isolation are critical.

We ask for a measurable increase in mental health supports and a new commitment to address addictions on reserve.

We ask for an investment of four additional personal care homes that can serve Anishinabe and Dakota elders in our communities.

I have spoken of the current health inequalities and of the inequitable response to COVID-19. I have spoken of the food security and infrastructure challenges exacerbated by the pandemic.

As I conclude, I want to leave you with a new vision of health transformation.

First nations do not want to inherit a broken health system, but to create a wellness model with our governance and our values, a new and groundbreaking health system for all southern first nations communities that will begin to close the gaps.

We are days away from signing a memorandum of understanding with Canada to make this happen. I should not die a decade before you because I am an Anishinabe man, and my son should not die a decade before your child because he is an Anishinabe.

Let's work towards the Truth and Reconciliation Commission of Canada's call to action 19 and identify and close the gaps in health care outcomes. Reconciliation can mean letting go of the structures and the faulty dynamics that have plagued our relationship for generations.

Statistics and reports document the legacy of systemic neglect and negligence in the health care system for first nations, but together we can build a new future founded on true partnership as the treaties intended.

Chi-meegwetch.

● (1440)

The Chair: Thank you, Chief.

I see that Mr. Obed has been able to join us. I'm sorry for the connectivity issues.

We go now to Inuit Tapiriit Kanatami and Mr. Obed.

Mr. Natan Obed (President, Inuit Tapiriit Kanatami): *Nakurmiik*. Thank you. I'm glad that I was able to get on the call.

Inuit Tapiriit Kanatami is the national organization representing 65,000 Inuit in Canada, the majority of whom live in Inuit Nunangat, our homeland, and that encompasses 51 communities over possibly a third of Canada's land mass. All but two of those communities are fly-in, fly-out communities exclusively during the winter months and only a handful of those communities are serviced by marine ferry during the summer.

ITK is governed by the elected leaders of the Inuvialuit Regional Corporation, Nunavut Tunngavik, Makivik Corporation and Nunatsiavut Government. These four representational organizations and governments are Inuit rights holders under section 35 of the Constitution, having negotiated comprehensive Inuit-Crown land claim agreements between 1975 and 2005.

It is therefore appropriate that the Crown engaged Inuit rights holders in the COVID-19 response. ITK has helped facilitate regional engagement with the Government of Canada throughout this process through our national governance structures. There's a very large gap between Inuit and non-Inuit Canadians on key measures of importance to health such as housing, income, food security and access to medical care.

A few key examples in relation to COVID-19 are that 52% of Inuit in Inuit Nunangat live in overcrowded homes whereas only 9% of non-indigenous people in Inuit Nunangat do. The median income level for Inuit in Inuit Nunangat is $23,000 whereas the median income for non-indigenous people in our homeland is $92,000, which is about four times greater. In many of our communities, individuals are often multiple flights and days away from emergency or intensive care, as we have health centres instead of hospitals in the majority of our communities.

COVID-19 poses a particularly high risk to the health and well-being of Inuit living in Inuit Nunangat and also in urban centres. It's crucial to understand the unique and considerable vulnerabilities that create these negative outcomes in both illness and disruption in service in Inuit communities. We have been working with the federal government throughout the last six to eight weeks in regards to an Inuit-specific distinctions-based response.

There are three considerations that I'd like to discuss today. The first is in relation to public health measures to prevent the circulation of COVID-19 in our communities, and it starts with testing. We struggled with the limited availability of testing and the long turnaround times. This has also been our experience in our TB epidemic. There are significant negative consequences in not having immediate results or results within a short period of time.

The quick identification of the presence of COVID-19 in our communities would then be key to our response, as it is in any community in the country. There were daily flights prior to the restrictions that have been put in place in our regions due to COVID-19, but now there aren't regular flights. People might get tested but there might not be a flight for a number of days and then that test also waits in a queue once it gets to a southern centre for processing.

The rate of active cases and the data that we use to respond to this crisis depend on rapid access testing. We commend the federal government for moving quickly to acquire point-of-care and near-care tests and also prioritizing remote communities for the placement of these tests. We understand that Inuit communities are a key consideration in this national response, and that the federal government understands that there is an urgent need for these point-of-care and near-care tests.

Also, with respect to Inuit-specific public health guidance, we've done really well so far to minimize COVID-19 and its entry into Inuit Nunangat communities. Two regions, Nunavut and Nunatsiavut, have not registered a confirmed case yet, and there are just a handful of cases in Nunavik and a couple in Inuvialuit region.

● (1445)

We need to ensure that we are working as closely as we possibly can with provinces, territories, our public health and data systems, and the federal government all the way through. We have an Inuit public health task group that facilitates this work.

We commend all parties, from the Public Health Agency of Canada to Health Canada to Indigenous Services Canada, and the provinces and territories in which Inuit live as they try to work through a number of challenges that are grey areas of governance. Sometimes there are processes that don't require Inuit participation through legislation, but we are living in a time of reconciliation, and the more information and open communication there is between Inuit rights holders and public governments, the better, in relation to this crisis. We see that through the shared health promotion strategies that we want to invest in and help deliver for our communities.

Inuit communities are known to have high rates of risk factors for poor outcomes in relation to COVID-19 based on things like our smoking rate, poor nutrition, poverty and the active cases of tuberculosis in our communities. The support for programs that contribute to a reduction in smoking rates and improve food security and nutrition is key to protecting Inuit from COVID-19. The ongoing shared ambition between Inuit and the Government of Canada to eliminate tuberculosis by 2030 also comes into play when we're dealing with COVID-19. There are many different synergies in the types of responses, especially in consideration of things like housing.

We'll continue to work with the federal government to provide funding to Inuit representation organizations that allows them to implement strategies to improve food security, enhance hygiene and promote physical distancing in Inuit communities, including on the land programs, elder support and increased access to water service and cleaning supplies.

The second point is in relation to health systems. It is a necessity that our health systems continue to function with COVID-19. We need to ensure that the connections remain strong between Inuit communities and the service agreements that jurisdictions have with southern care facilities in relation to COVID-19. We would work directly with the federal government for any immediate point-of-care considerations for COVID-19 responses if there were many cases in our communities. We have talked with the federal government about possibly employing federal resources and military or navy resources in relation to a response. Hopefully we can continue to have those strong connections between the care provided to us in the south and that provided in regional centres in Inuit Nunangat and in other communities in the COVID-19 response.

We're also concerned about the shortage of drugs, supplies and staff. There are many different HR considerations, especially considering that many of our communities are staffed by only one or two nurses at a time and that there is a huge push for resources in the health care response in the south. That consideration is top of mind. There are also things like drugs for tuberculosis, such as the BCG vaccine, and worldwide shortages in relation to that. There are a number of different considerations there that we continue to work with the federal government on in relation to the COVID-19 response.

The third point is in relation to air transportation. ITK has made it clear that we see air transportation as an essential service. There are no other ways to get to our communities at this time of year, and the way our health care system and all essential services flow in and out of our communities depends upon our air carriers. In other parts of the year we will have major considerations for sea-lift resupply and cargo traffic, but at this time it cannot be overstated how important air links are. Federal support for those air links across Inuit Nunangat should remain intact.

● (1450)

The last thing we want is for any of our existing airlines to not be able to continue to operate. That would place a massive and considerable risk on those populations in our communities over and above the already difficult challenges that we face.

We'll continue to work with the Inuit Public Health Task Group and the Government of Canada, but any of the work we do, whether it's with you in this committee or anywhere else, will be focused on an evidence-based globally informed and Inuit-specific response.

We look forward to working with you under those terms to ensure that Inuit are not adversely affected even more than we already are in relation to the COVID-19 response.

The Chair: Thank you.

We will start our rounds of questions at this point.

First, Chief Daniels, I just want to point out that when you were speaking we were picking up a fair bit of noise on your mike, so when you're answering, try to hold your mike away from your body, if you can.

Also, if anybody needs to leave to get a coffee, leave your video on because if you turn it off, your picture gets moved all over the screen and it's hard to keep track of where you are.

With that, I'd like to thank everyone for their statements and the excellent information.

We'll start with Mr. Vidal for our first round of questions.

Mr. Vidal, you have six minutes.

● (1455)

Mr. Gary Vidal (Desnethé—Missinippi—Churchill River, CPC): Thank you, Mr. Chair.

I want to thank all of the witnesses for taking the time and making the effort to be with us today. It is appreciated.

My first question is for the National Association of Friendship Centres. I'll let the two of you decide who wants to answer.

As has been referenced a couple of times, $305 million was announced for the indigenous community support fund. Out of that $305 million, $15 million was allocated to urban indigenous organizations like yours. It was through an application-based process. My understanding, from a statistical basis, is that over 60% of indigenous people in Canada live in urban centres and that this funding represents about 5% of the funding for indigenous organizations.

You spoke to it a bit in your presentation, but perhaps you could elaborate on how maybe the underfunding of urban indigenous organizations during this pandemic puts indigenous people in urban centres at greater risk.

Ms. Jocelyn Formsma: Maybe I'll start on that and then ask President Sheppard-Buote to jump in.

It's been a challenge, because we don't want to be seen as throwing anybody under the bus. That's why, in my criticisms of the distinction-based, we're saying that there has to be a consideration for remoteness, for those who live in the north, for women and for a number of different intersections in terms of what makes up an indigenous person. We're trying to add a voice with regard to the urban. We say “urban”, but we have friendship centres in Inuvik and Happy Valley–Goose Bay. They're not the typical big, urban spaces. They are just off reserve, and typically not in Inuit Nunangat. Sometimes they are in Métis homelands but not part of Métis settlements. It could be in communities of over a thousand or five thousand, or in major metropolitan areas.

I think the piece we're trying to get across is the service component. As friendship centres, we look at people in terms of what they need and in terms of service delivery. Who they are in terms of how they identify is important to us, but we're also considering the factors that they need. We're trying to respond from a service point of view. We don't dictate who we get calls from. People who are living in urban spaces, if they need support and they know that there's an indigenous organization that might have a better understanding of who they are, will call that organization. They will call regardless of whether they're first nations, Métis or Inuit. They're there, they need something, and they need an organization that understands who they are.

We're finding that friendship centres have now been getting an increase in calls. The friendship centres in B.C. are not just at capacity; they're at overcapacity in terms of the services they're providing. The financial resources from any level of government have not materialized yet. As I said, we got notice yesterday that we will be getting funds from the indigenous community support fund in the amount of $3,750,000 across 100 different organizations. As the NAFC, we chose to write a proposal on behalf of all of our member friendship centres, because we did not want to have the burden put on the local friendship centres, who are in it every single day. I've had executive directors say that they've been sleeping overnight in the homeless shelter because of their lack of staffing. We've had people say that they had a 25% increase in requests at their food bank and ran out of food in an hour, or that they haven't been able to get access to some of the personal equipment. We've been getting stories from across Canada on just the service needs...and going from place to place to place, knocking on doors, trying to get some kind of financial support and some kind of financial recognition that we're there, we're doing the work every single day, and it has not materialized.

It has materialized in some of the local centres in some of the larger areas—for example, with the Vancouver Foundation and local foundations, where they've been able to get supports from some local centres—but until the federal funds start flowing from the federal government to us to the friendship centres.... The provinces have announced, to a certain extent, some indigenous funding. We don't know yet if that will go to friendship centres. Ontario seems to be the only province that has actually committed funds that friendship centres will be able to access. However, the work has been happening for the last six weeks. For six weeks the friendship centres have been doing this work without that financial support. I don't want to say that distinctions don't matter, but when you're in need and you're calling somebody for help, you want that help to show up. We've been doing our best.

I hope that answered your question. I was just trying to express the need that's there, the work we've been doing for the last six weeks and the support we're trying to get.

I will say one last thing. We've been hearing from a lot of first nations about the supports for their off-reserve, and we've been trying to meet those needs. A lot of our friendship centres do have good relationships with their local first nations. I think one of the best problems we will have is that our people will have not just enough, but too much; you know, I don't think it's going to be a problem.

● (1500)

I think that the more supports we can get out, the more supports we can make available for people and the more options they have to meet their needs, will only serve the people on the ground. I think we should be doing the best we can to make sure that we coordinate our efforts and resources, plan and work together, and ensure that there are no gaps and that we're not leaving anybody behind.

Thank you for that. I'll hand it off to President Sheppard-Buote.

Mr. Christopher Sheppard-Buote: Thank you.

To echo what Grand Chief Jerry Daniels said, it isn't enough money, period.

You start with a deficit from the very beginning, and from our perspective, to see that envelope of money and to know that we are now competing for $15 million across the country, knowing that there are 100 organizations to try to get resources to on the ground....

To me, the fact that there was a structure that was that underfunded and competitive was very disrespectful. You are asking people to say, “You're kind of indigenous, not indigenous enough to be trusted to be given resources to support people, so we're just going to make you dig really hard to get the data and report on it so that you can help people on the ground.”

The fact that this design even existed in some way, shape or form tells me that there's a huge problem with how this response has gone for everyone in the indigenous space, especially when it's so obvious that you have a section of individuals who are treated so differently.

We don't know when that money is actually going to reach organizations. There are multiple non-indigenous, not-for-profit agencies and national organizations that did not have to apply for their allocations either because they're providing essential services or because they're providing something that's needed. I think, even when you look at it within that scope, there's a clear issue with how this has been developed and framed. Why is that?

Mr. Gary Vidal: Thank you, Chris.

The Chair: Thank you, Mr. Vidal.

We go now to Mr. Kelloway.

Mr. Kelloway, you have six minutes, please.

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Thanks so much, Mr. Chair.

Hello colleagues, and thank you to the witnesses for coming today.

Before I begin with my questions, I'd like to acknowledge that I'm speaking to you from Mi'kma'ki, the ancestral unceded territory of the Mi'kmaq people.

My first question—and I have two—is an open-ended question to anyone on the panel who would like to answer it.

As we know, COVID-19 can affect anyone, anywhere. We all know that all too well. Emerging research shows us that there are risk factors that make certain communities in our country especially vulnerable to this coronavirus, as the disease emerges with such speed, such cruelty. Due to consequences of systemic racism, geographic inaccessibility and historical injustices, many indigenous communities find themselves especially vulnerable in this pandemic.

Can you speak to two measures that you believe the government is doing well and two in particular that we need to change immediately? That would be very helpful. That would be my first question, Mr. Chair, and that's open to anyone and everyone on the panel.

● (1505)

The Chair: Go ahead, whoever would like to answer.

Mr. Natan Obed: Perhaps I'll start.

We've found that there's been a lot of communication, but also at the same time a lot of confusion. The way the Government of Canada has worked with Inuit in allocating $45 million of the $305 million for the indigenous community support fund was in line with the Inuit Nunangat policy approach, and then the ITK board of directors allocated those funds within the board process, so each of the regions had a specific allocation. Now there are a number of interventions that have already happened.

On the other hand, there have been challenges with responsibilities and participation in conversations about health care systems, data, personal protective equipment, and a number of the essential considerations for the flow of health services in response to COVID-19. It would have been great, and it still will be, and the thing we look forward to is participating in those conversations even if we as Inuit don't always deliver those [*Inaudible—Editor*] to our communities.

Perhaps President Kotierk could talk specifically about what Nunavut has done in relation to the implementation of COVID-19 funds.

The Chair: Go ahead, if you wish.

Ms. Aluki Kotierk (Member of the Board and President of Nunavut Tunngavik Inc., Inuit Tapiriit Kanatami): Thank you for the opportunity.

In terms of the resources that were allocated through the federal government, in Nunavut we were very quick to determine how we would allocate those funds across the vast territory. As you know, Nunavut makes up one-fifth of the geography of Canada. The Nunavut Tunngavik Inc. board members have been having daily calls to determine how best to allocate that money, and much of that money has already been allocated to provide financial support to elders so they can purchase food items, as well as cleaning supplies.

We have provided a substantial amount of resources to municipalities so they can ensure that there is water and sewer delivery on a daily basis. Particularly when there's the public messaging about washing hands, we think it's crucially important in overcrowded housing situations in Nunavut, which is very common and we know in this day and age we need at least 3,000 houses just to meet the current housing needs across our territory. The common mentality is to conserve water usage, and we don't want that in a time when we're having a global pandemic.

The other area we've put some resources into is to address food insecurity. In Nunavut, it's astounding that already seven out of 10 children go to bed hungry each night, and instead of their getting better, we know the statistics recently released have indicated that it is now actually eight out of 10 children that go to bed hungry each night. We know with the experience we have had with infectious diseases such as tuberculosis, both overcrowded housing circumstances and food insecurity have a big impact on how one is able to fight off infectious diseases.

While the approach we've been taking is very much focused on meeting the basic needs that, in our view, should be met even before we find ourselves in a global pandemic, the opportunity for us in this global pandemic has been that we've been able to have very open communication and decision-making amongst Inuit organizations and all government levels, including the territorial public government here in Nunavut, as well as the federal government.

Our position at Nunavut Tunngavik Inc. is that the federal government should invoke the Emergencies Act in Nunavut, because in our view, although we don't have a confirmed COVID-19 case yet, we know that our capacity financially and in terms of human resources is not what it needs to be in our territorial public government, and that has been crucial, even before COVID-19.

We need to look at, and the very terrifying public healthy crisis we are all under right now is an opportunity to highlight, the great needs that so many Canadians live under. This is an opportunity for you as members of Parliament to take a better look at the social inequities that Canadians face. Of course, I am advocating for Nunavummiut to say, please take a look at the social inequities faced by Nunavut Inuit.

● (1510)

Mr. Mike Kelloway: Thank you very much.

The Chair: Thank you, Mr. Kelloway.

Is there anyone else who would like to respond to Mr. Kelloway's question? Otherwise, we'll go to our next questioner.

Mr. Christopher Sheppard-Buote: One of my biggest concerns, or things that are not being done well right now, is the framing and preparation of the disaggregated data that should be collected to really see what this looks like and what the outcome was for indigenous people across this country.

Not every region collects really good disaggregated indigenous health data, and it will be really important for us to know what the outcome was for our people across this country in every jurisdiction. I know that health is a provincial piece, but I think that for the Public Health Agency and Health Canada it will be very important to make sure that data is disaggregated so you can tell that story after the fact.

Mr. Mike Kelloway: That's a great point in terms of the data, the evaluations and the assessments. I appreciate that feedback greatly. Thank you.

The Chair: Thank you, Mike.

Grand Chief, I see you leaning forward. Does that mean you wish to respond as well?

Grand Chief Jerry Daniels: Yes. Just on the health transformation piece, I think that was even prior to COVID-19. I think that's a good thing that the government has done. We've been trying to move as quickly as we can, pursuing the B.C. First Nations Health Authority model where you have first nations being a lot more hands-on and more involved in the strategy and the planning for the communities as well.

Mr. Mike Kelloway: I will just say this very quickly, because I know I'm over my time. Grand Chief, I'd like to, at some point, talk to you about your efforts with respect to securing doctors from Cuba, how you're getting along and how the government can help.

Thank you.

The Chair: Thank you, everyone.

[*Translation*]

Mr. Thériault, you have six minutes.

Mr. Luc Thériault (Montcalm, BQ): Thank you, Mr. Chair.

In the course of the testimony heard by the Standing Committee on Health, one constant emerges regarding the ability to counter the pandemic and limit the contagion of the virus and its virulent effects.

All living environments that were fragile before the pandemic are environments where it is difficult to contain the virulence of the contagion. That's what worries me, especially when I hear witnesses talk about the lack of resources.

In Quebec, 55% of indigenous individuals live in urban areas. That's rather worrisome.

During this first round of questions, I will have some quick questions for the representatives from Indigenous Services Canada. I would ask that the answers be as brief as the questions.

In order to properly counter a pandemic, it is important to have an accurate picture of the situation. I'd like to know whether the territory of Nunavik has adequate screening measures. I would also like to know whether Canada has sent rapid tests there. These tests are important for people who live in remote regions, especially since people with the virus have to be isolated. Before the pandemic, more than 20% of indigenous populations faced housing and overcrowding problems. Have rapid tests been sent there? Is there an adequate isolation plan?

Canada has sent Rangers to Nunavik, but I don't know if they've arrived there yet. I'd like to know their exact role and mission, and how they will be deployed.

In terms of health, the curve needs to be flattened so that the health care system can provide intensive care. Do the territories have everything they need in terms of human resources and equipment to save the lives of people who are virulently affected by COVID-19?

● (1515)

Ms. Valerie Gideon: I can answer some parts of the question, and then I'll give the floor to Dr. Wong to see if he has anything to add. Perhaps Mr. Obed might even have information to give with respect to Nunavik.

As you know, the Nunavik regional authority is part of the provincial system. We don't directly fund the health services of the regional authority, which is integrated into the Quebec system. However, the people in the authority do share information with us when necessary. Of course, if they need additional supplies or equipment, they can ask us. In fact, they have submitted a request to us for personal protective equipment. We were able to send them some based on the inventory we have in the department.

When the province of Quebec saw a significant increase in COVID-19 cases, they were concerned about not receiving equipment quickly. They made a request to us, and we were able to meet their needs. The reason I put this in context is that we aren't as integrated into their day-to-day operations as they are, because they are part of the provincial system.

I can tell you, however, that they have asked for the Rangers to be sent, mainly to help them with infrastructure logistics. That goes back to your point about the additional infrastructure needs. Often, the infrastructure exists, but it has to be adapted for different purposes. Facilities need to be disinfected, and it's necessary to ensure that the required supplies, furnishings and equipment are in place so that they can be used for other purposes, such as isolating community members or housing individuals delivering services who are mobilized to provide the additional capacity required to respond to the pandemic.

We are playing a more direct role in first nations communities. We have purchased many temporary structures that can be deployed quickly in the communities. Already 78 different infrastructures are being set up or are ready to be used in the communities to meet these additional needs, especially in small or more isolated communities.

With respect to critical care capacity, it is obviously related to the capacity of the hospital environment across the country. Only two hospitals in Manitoba are under the responsibility of our department, so we're working more closely with them.

We are working with provincial governments to ensure that they have plans to increase critical care capacity and that they can receive first nations patients living in isolated communities. We are working very closely with them to make sure they have plans to evacuate community members early enough, before they get very sick. We can't wait until they are in critical condition. They need to be close to the hospital environment or in the hospital environment as soon as they have complications related to COVID-19.

That's a partial answer.

Dr. Wong, do you have any additional information to provide with respect to Nunavik?

● (1520)

Mr. Luc Thériault: I'm sorry for interrupting. Could you speak to the situation in Nunavik, but also the situation in general, because overcrowding—

[*English*]

The Chair: Mr. Thériault, your time is over.

[*Translation*]

Mr. Luc Thériault: Okay.

[*English*]

The Chair: I'll let Dr. Wong respond to your question if he has something to add.

Dr. Tom Wong (Chief Medical Officer and Director General, Office of Population and Public Health, Department of Indigenous Services): Thank you.

[*Translation*]

In the area of public health, our priority in the Government of Canada is to make testing available in remote communities. This is very important to us.

Spartan Bioscience, which produces the rapid tests for Canada, doesn't yet have the test boxes because the plant is in the process of producing them. In about two or three weeks, the company will be able to produce enough tests for some locations. We are very pleased to know that in two or three weeks there will be devices available in remote locations.

[*English*]

The Chair: Thank you.

We go now to Ms. Ashton. Please go ahead. You have six minutes.

Ms. Niki Ashton (Churchill—Keewatinook Aski, NDP): Thank you very much, Mr. Chair.

Welcome to all of the witnesses here today.

First of all, I'd like to register a number of key concerns that my colleagues and I share with respect to what indigenous communities are going through. We are very concerned to hear about, including at today's meeting, the absolute lack of funding available to off-reserve indigenous peoples and the fact that there was a deadline connected to this funding. This is an area that needs to be dealt with urgently, recognizing how vulnerable indigenous urban communities are.

I do want to spend the next few moments asking questions of Grand Chief Daniels, as well as President Obed, but certainly would also like to bring the focus to urban indigenous communities at some point as well. Obviously, we're very limited in our time here and I, like many, hope that we can have a virtual Parliament so that we can raise these issues at all levels with the urgency they require.

First, to Grand Chief Daniels, thank you for your powerful presentation. You've talked about huge inequalities that first nations in your region struggle with on a daily basis. I'm wondering if you could talk a bit about announcements or calls that you've already made around the need for Cuban doctors. Why is it that SCO first nations are making that call?

I'm also wondering if you could talk a bit about the need for federal infrastructure funding in communities, whether that's for repurposing spaces right now to create temporary housing; whether it's building a ventilation centre like Berens River has proposed for its area and the surrounding communities; or whether it's some communities, including further north, that have talked about the need for military hospitals. Should there be direct federal funding for infrastructure at this time?

Finally, can you speak to the need for personal protective equipment not just for health care staff, but also for front-line staff who work for first nations?

Could you reflect on some of those key messages? Thank you, Grand Chief.

● (1525)

Grand Chief Jerry Daniels: Thank you, Ms. Ashton.

I would just like to state, on the question around the Cuban doctors, that we took a tour to Cuba and asked to have a contingent or a brigade come here to Manitoba. Part of the reasoning behind that was that we had seen a crisis coming. We had already been working to have this happen prior to the pandemic getting to the point where it is. We wanted to see the kind of impact that it could have, because what we've seen in our communities is a lack of services on the ground. We haven't had long-term people in the community. We have rotating nurses coming into some of our isolated communities. We wanted to have long-term, consistent service being provided.

What we saw was the World Health Organization giving a great deal of notoriety to the Cuban health system. We wanted to see if the return on investment would be significant and we wanted to see what kind of return on investment we would get if we were to put it side by side with what we're seeing with the current health outcomes and the current strategy. That was kind of the reasoning. There aren't a great deal of resources, and we understand that, so if we can get better health outcomes through this process then perhaps that's something that we should consider expanding. That was kind of the point with Cuba, and we're continuing, obviously, to try to have doctors come into our communities to help with the health transformation side of things. We could, maybe, have some of our people trained at their international health institute over there. We toured the facility. That was our point there, to get a better return on investment. If we could see that as a reality and a measured investment that could work, then we would like to go there.

Second, in many of our communities, rather than having people go into the urban centres and purchase goods, they actually buy in bulk. Some of the communities are disinfecting the merchandise that comes into the community and then packaging it into care packages. They break open the shipments and break them down into smaller packages. At that point, they didn't have PPE equipment. We wanted to have that in our communities for the people who were doing this, so that they could screen out any potential bacteria that might have been coming into the community. There are examples of that in many of our communities, including Wayway and others—in quite a few actually. That's what they've been doing in the communities, bulk buying.

Many of the communities have also been doing that in the urban centres, in Winnipeg. Many of the tribal councils have been involved in that. That's kind of what we're looking at, how best to utilize the limited resources we have while protecting our people. That's what many of our people, those people who are receiving the food and other stuff and protective equipment, have been doing. We've been hoping to support them more. I know there were about two or three weeks when there was nothing there for them. There was a bit of risk happening. Thank god in Manitoba we've done a very good job of flattening the curve, and hopefully we will continue to see zero new infections.

Ms. Niki Ashton: Thank you, Grand Chief.

Quickly, to President Obed, I'm wondering what you could share with this committee about what you need to see in your territory from the federal government to support elders, anybody who's over 60 years old, those who, we know, are especially vulnerable to COVID-19.

● (1530)

Mr. Natan Obed: *Nakurmiik*. Thank you, Niki.

I think, just from a structural standpoint, an Inuit Nunangat policy approach should be employed any time the federal government is considering specific interventions for our communities. That means not leaving behind Nunatsiavut and Nunavik in a northern policy approach because that's really the way in which a lot of these interventions are structured—north of 60, south of 60. We are a very considerable part of this country, and our policy space should be contiguous from all Inuit regions and then also the urban components as well.

Then you get into the specific considerations for our most vulnerable. We have Inuit in long-term care facilities in the south because of a lack of care facilities in Inuit Nunangat. We have a large number of urban Inuit in the south who require very specific considerations and sometimes fall through the cracks. Luckily, we have our land claim organizations that are specifically considering the needs of elders at this point in time. There have been either direct payments or vouchers that have been given to them so that they can have food, but when it comes to the functioning of the health system, the near-term care and the ability to act quickly in response is going to save lives. Even if we don't have the numbers today, that specific consideration of getting point-of-care testing to our most vulnerable and then being able to treat Inuit where they live, rather than shipping Inuit south, is also going to save lives.

The Chair: Thank you, Ms. Ashton.

That concludes round one. We will now start round two. I'm going to be a little more ruthless in our timing going forward.

Please go ahead, Mr. Kitchen, for five minutes, please.

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

Yes, you'll always be ruthless when I come on.

Thank you, everybody, for being here. I appreciate that and the opportunity for you to speak to us.

I noticed that as of yesterday 53 first nation people and 13 Inuit have tested positive for COVID-19. I hope and I pray that we will not see any more of those. The one thing that we haven't been told is how many have recovered, and I'd love to see that information to know how many of those actually have recovered.

My first question is for Ms. Gideon. On your website, you state that the ISC maintains a stockpile of personal protective equipment—PPE—and hand sanitizers in the event of a health emergency in first nation on-reserve communities. Can you tell us how many masks, gowns and gloves are in that stockpile? If you can't, can you provide that for us today? Can you provide that information to the committee?

Ms. Valerie Gideon: Thank you very much.

I don't know if Dr. Wong has the numbers handy in front of him. Otherwise, we can certainly share that information with you subsequently.

Dr. Wong.

Dr. Tom Wong: Just to give you an idea, currently we have over a million gowns and close to a million gloves in our stockpile and, at this moment, more than 300,000 N95 masks. Those are just some examples. In addition to that, every time Canada receives a new shipment, part of that goes to the Public Health Agency—the national stockpile—and to Indigenous Services in order to offer PPE to first nations on reserve. We have access to that stockpile as well.

Mr. Robert Kitchen: Thank you. I appreciate that.

How much of that stockpile is being distributed to our first nations?

Dr. Tom Wong: Since January, just to give you a magnitude of scale, approximately 160,000 gowns have been distributed, and just under 500,000 gloves have been distributed. Close to 200,000 surgical masks have been distributed. As for N95 masks, which are used for aerosol-generating procedures, close to 90,000 of those N95 masks have been distributed.

● (1535)

Mr. Robert Kitchen: I appreciate that. Thank you very much.

Are there any first nations that are still waiting for a supply of PPE?

Dr. Tom Wong: Every day we get requests. As of yesterday, 570 shipments from the warehouse have been made in response to requests. On an average day, depending on the number of requests coming in, approximately 20 to 30 requests are waiting to be processed. We operate seven days a week. Some days it's smaller and some days it's bigger. It depends on the number of requests coming in.

Mr. Robert Kitchen: Thank you very much, Doctor. I appreciate that.

As we know, after the H1N1 pandemic in 2009, many of our first nations in Canada, such as, in my riding, Carry the Kettle Nakoda First Nation, the Cowessess First Nation and the White Bear First Nations, have taken positive steps in setting up monitoring stations at their entrances. I know this is going on across the country. In fact, I've been led to believe that about 376 communities have done that. It's important for them to develop this emergency response plan and protocol in the event of a future pandemic.

Grand Chief, what are your thoughts with respect to creating a coordinated emergency response plan for all first nations across Canada, while continuing to respect your individual jurisdictions?

Grand Chief Jerry Daniels: I think theoretically it works. Practically, I'm not sure how that works. I think when you start getting into the different regions there are problems with coordination. Communication is always a big factor in those kinds of scenarios. In any national strategy there are always going to be regional demographic differences. How do you communicate effectively between the national level and the regional level, which may have a better understanding of what's required and better communication?

What we've found is that if you have it more regionalized.... I know the larger strategy is important, but you can have large strategies that are in the region. I think that's what you have to build off of. That's the best way forward. You can't connect at the same level from a national perspective. You can't connect locally as much as a more regional body would.

That's what we've done. We've been connecting very closely with the communities. We have people in the communities who work with our organization. What we've found is that we're better received, our communication lines are better and we continue to get a great deal of confidence from the community in our organization. We think it should be the same thing with any health strategy.

Mr. Robert Kitchen: Thank you very much, Grand Chief.

The Chair: We'll go now to Dr. Powlowski.

Dr. Powlowski, you have five minutes, please.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I'm the member of Parliament for Thunder Bay—Rainy River. I'm happy to acknowledge the traditional territory of Fort William First Nation. Chief Collins, I hope you're watching.

I think some of you may know that Thunder Bay has the largest urban indigenous community, proportionally speaking. My questions will go to the friendship centres.

We know that the expected lifespan of people from indigenous communities is significantly shorter than that of people from non-indigenous communities, and there are concerns about having the resources to deal with urban indigenous populations. One of the concerns of people in my riding, and of someone who worked with youth at risk in the indigenous community, is that because we are trying to use social distancing we are unable to bring together at-risk youth for counselling. This is a real concern. As he rightly pointed out, these are youth who probably have a far higher risk of dying because of suicide or violence than because of COVID-19, and now we're asking them to pay the price for protecting the elders in all of our communities.

What can we do to ensure that we continue to provide services for that kind of at-risk population? What can we do together? I know that one of the big things you're going to say is money. Our party realized that $15 million isn't enough and that it's just a start. Besides money, what can the friendship centres and the government do to address the risks to that vulnerable population?

● (1540)

Mr. Christopher Sheppard-Buote: Thank you. My favourite questions are about indigenous young people. On my screen in front of me, there are at least three of us who were members of our national youth council.

In terms of one thing that Canada can do, right now in this country there is no program specific to indigenous youth to support their identity or their culture or to create leaders. There is nothing. The fastest-growing demographic in this country does not have a specific program for it.

Canada's literal future economy is based on a population that has the least amount of support of any demographic, yet we ask what we can do for a population that has the highest rates of suicide, the highest rates of self-harm, the lowest educational attainment and the highest rates of incarceration. It's a fact that you have no program that is specifically designed for indigenous young people.

Other than that, I don't know what else to say.

Ms. Jocelyn Formsma: Perhaps I could add quickly what we've been hearing from the friendship centres. There are a few things.

A lot of the friendship centres are trying to provide supports for youth who are in foster care or who are youth in care, because sometimes the friendship centre is the connection to their culture and their community in the urban spaces. We've heard that some friendship centres are doing the best they can to provide special outreach to those young people.

We are also calling for some technology—software, hardware, tablets, laptops and cellphones —so the friendship centre staff can move to a virtual service provision instead of working out of an office and still be able to connect. They also want to be able to donate or to lend these devices to community members so they can stay in touch, not just to young people so they can keep in touch with their counsellor at the friendship centre, but also to other vulnerable members of the community, such as indigenous seniors, whose mental health is also being affected. They are unable to connect as well.

A lot of friendship centres have transitioned their programming to be capable of virtual access. They have been doing a lot of youth-specific outreach to keep young people connected with each other and have been trying to find new ways to connect.

I will add there the connectivity issue, the issue of ensuring that the Internet is widely available, especially in the rural and remote northern communities, so that they can tune in to some of the programming and have access to content that is being developed to help them stay connected.

Also, it's not just having the Internet available, but being able to pay for that Internet at home so that we don't have young people who have to walk or drive out to parking lots and huddle under a blanket so they can do their homework or connect to what's happening and have access to all these virtually provided services.

Mr. Marcus Powlowski: Ms. Formsma, you did mention—

The Chair: Marcus, I believe your time is up.

I think Grand Chief Daniels has a response. Did I misunderstand?

Grand Chief Jerry Daniels: We can comment.

It's important that mentorship is a cornerstone of helping our young people pass on the values and the teachings of our people. I obviously benefited a great deal from many of my elders, many of my elder cousins and people within the friendship centre movement who helped mentor me.

When we think about young people, it really is about a mentorship, supporting one another, and in this case, a national strategy. It was one of the reasons, when I was first elected Grand Chief, that we created a youth council here. We gave the youth a vote. We work very hard to try to mentor our young people. We go out of our way. We had drum practice here.

A lot of that was interrupted by the COVID-19 pandemic. We were out on the road taking action, such as running and raising money for diabetes. There were all kinds of actions we were taking. That's an important part of creating better outcomes and a better quality of life for our young people. It's by creating as much opportunity as we possibly can.

● (1545)

The Chair: Thank you.

We go now to Ms. Jansen.

Ms. Jansen, go ahead for five minutes please.

Mrs. Tamara Jansen (Cloverdale—Langley City, CPC): First I want to say thank you very much to all the witnesses. It's been very eye-opening. I very much appreciate all of your testimony.

I was reading a newspaper article from CBC that said that some members of the military were being deployed to predominantly indigenous northern fly-in communities, and it said that they would be making clean drinking water available.

I was wondering, Ms. Gideon, whether it is that easy. Do we have to have COVID-19 to get clean drinking water to those communities?

Ms. Valerie Gideon: I apologize. I don't have any specific information about any requests for assistance relating to drinking water, but our department wouldn't necessarily see all of the requests for assistance. Those would be submitted through provincial or territorial governments.

I do apologize, but I do not have the specifics on that front.

Mrs. Tamara Jansen: Okay.

Ms. Valerie Gideon: I would say to you, though, that having surge water infrastructure and capacity are things that communities are submitting requests to our department for as part of the COVID-19—

Mrs. Tamara Jansen: Sorry, I have a really short time. My apologies.

I have a question for Jocelyn Formsma, and it is actually also in regard to water.

I have seen a photograph of 24 bottles of water for $100, and I hear that a bag of flour sells for $100 as well up there, and I'm just wondering if that is normal. Are those normal costs up there?

Can you speak to that, Ms. Formsma?

Ms. Jocelyn Formsma: Are you referring to costs in the territories?

Mrs. Tamara Jansen: Yes.

Ms. Jocelyn Formsma: I might not be the best person.

We're looking at friendship centres all across. Perhaps in the northern territories that might be the case, but the folks from ITK might be better able to speak to those matters.

Mrs. Tamara Jansen: I think overcrowding was another thing you mentioned. How is social distancing done in the homes that are overcrowded? Are you, Grand Chief, familiar with how that is able to be carried out?

Grand Chief Jerry Daniels: Yes, I can actually answer that.

In Berens River, actually, they've been working on creating a camp for isolation. That's what the council has been communicating to me.

Mrs. Tamara Jansen: Okay.

Grand Chief Jerry Daniels: On the topic of water infrastructure, we have had huge problems with the water infrastructure process, and I think there's a very big conflict happening within the regional office on this issue. We've had examples of infrastructure development that cost almost $2 million over what could have been utilized. Skownan has an example of this. Just down the road in Waterhen, they had a water treatment plant that was award-winning. It took water from the lake, while the one in Skownan took water from the ground, because it was a state-of-the-art membrane system. It cost $2 million more, and to this day it hasn't worked.

That's a clear example of where the regional office has failed when it comes to providing water for our communities.

Mrs. Tamara Jansen: I have a quick question, then, in regard to getting information out.

I know that Ms. Gideon talked a lot about getting information out in regard to COVID-19 and so forth, but it's my understanding that even the cost for data, as I think one of the previous witnesses mentioned, is hardly affordable.

How exactly do we get that information out to everybody with those kinds of costs?

Maybe Chief Daniels could also speak to that.

Ms. Valerie Gideon: I can say that we are funding communications activities. When first nations organizations have submitted requests, for instance, for communications campaigns or outreach, we have funded those.

Mrs. Tamara Jansen: Grand Chief, is that money getting out to the further-out areas?

Grand Chief Jerry Daniels: Could you ask the question again?

● (1550)

Mrs. Tamara Jansen: Is that money that she's talking about—for data and for making sure that people can actually access the online information—getting out to the rural and remote areas?

Grand Chief Jerry Daniels: I think that it is, to an extent. I know that many of the communities are online. There are calls every day here in the region. There is some back-and-forth happening.

Mrs. Tamara Jansen: Okay.

Ms. Formsma, I think you mentioned that there are many young people who are having a hard time getting that data, that online availability.

Ms. Jocelyn Formsma: We've been working to try to make sure that the information is getting out. NAFC is partnering with the Well Living House to ensure that urban-specific information is getting out. We've also been working with Indigenous Services and Dr. Valerie Gideon. We're about to embark on some urban-specific messaging and communications. We recognize that a lot of the information is specific to living on-reserve, so instead of just complaining about it, we've offered to work with the department to ensure that the communication is available. We want to make sure it's getting out as far as possible using our network. That's what we're doing.

Mrs. Tamara Jansen: Do they have boots on the ground in the—

The Chair: Thank you, Ms. Jansen.

We go now to Ms. Sidhu. Ms. Sidhu, you have five minutes, please.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you all for joining us today.

Even though I'm joining from my home, I would like to begin by acknowledging that the land I'm sitting on, where we gather, is the traditional territory of the Haudenosaunee and Anishinabeg.

My question is to Grand Chief Daniels. You mentioned the prevalence of diabetes. Up to 80% of indigenous youth will be diagnosed with diabetes in their lifetime. Could you go into detail on how, during this time, especially with this dire epidemic, and especially for people who are more vulnerable with heart disease and diabetes, we are handling those populations?

Grand Chief Jerry Daniels: I think that in the long term we need to focus on food security and creating community gardens, year-long gardens, in the community. We see examples of these in OCN, where all year they're producing their own vegetation, their own produce, and then they're providing that to the community. We need to see this expanded.

I think that the education system should shift towards these kinds of things. We really need to focus priorities around what young people really need. What are the tools that they need? What are the skills that they really need to learn? Skills on survival and food security, those kinds of things, should be of the highest importance.

When we think of the education system, when we think of employment and training, we have to think about those kinds of things, micro-strategies, micro-sustainability. That's the kind of thinking we need to be focused on. I would encourage all sectors of government to think that way when they're thinking of first nations. First nations can't be reliant on just these big aggregates all the time. There really needs to be a localized strategy. I think that's the best way forward.

Ms. Sonia Sidhu: At the last meeting, the Canadian Mental Health Association testified, and you mentioned the youth council and guidance from elders as well. How can the federal government better support mental health for the indigenous population? Can you elaborate on that?

I want to ask the National Association of Friendship Centres if they can elaborate on that too.

Grand Chief Jerry Daniels: We've asked for mental health to be expanded in the region. We have two facilities here in our region, and we're looking to expand them. A great deal of work needs to be done in this area.

I think the national suicide prevention strategy that was implemented way back in the day yielded a great deal of results. The friendship centres were involved in that, and so were a lot of other indigenous organizations. We want to see continued focus on our young people, providing support so that we're not involved in the kinds of numbers we're seeing right now.

We need to see a change in the number of people who are feeling like they're hopeless. That takes a combined strategy with a lot of different partners. A lot of it has to do with the institutions that govern, and in some of those interactions, indigenous people feel systemically discriminated against. It's in every institution we can possibly look at. There are examples we can point to.

You need to create the facilities. You need to make space for that. You need to have a strategy so that you also have facilities in the community and support positive livelihoods in the schools. It's all those areas.

Mentorship is key on this. People need to feel supported. Young people need to feel supported and feel loved. It's unfortunate that history has got us to this place, but I think there's an opportunity now for us to create that change.

● (1555)

Ms. Sonia Sidhu: The First Nations Health Authority in B.C. has the virtual doctor of the day program. Do you think that type of program is of benefit to remote communities? Can it be helpful to indigenous populations in areas that are too far away?

Ms. Jocelyn Formsma: I'm not clear on who that was directed to. I was going to respond on the mental health question, but I'll leave it to the chair.

Ms. Sonia Sidhu: Mr. Chair, do I have more time?

The Chair: Your time is up, but there is a little confusion over who will respond to that. Was that directed to Grand Chief Daniels?

Ms. Sonia Sidhu: Yes, or to the National Association of Friendship Centres. Perhaps they could give a short answer.

The Chair: Could you give a quick answer, please?

Ms. Jocelyn Formsma: Sure.

With regard to mental health, our national youth council has also identified that as a priority for youth across Canada. I would just say that for health care in general, but especially for mental health care, availability within urban spaces doesn't always mean access for indigenous people, because it's the culturally safe environments that really foster well-being within our communities.

When it comes to mental health, I think there's availability. As to whether it's accessible, or whether it's something that indigenous people, especially indigenous young people, feel safe accessing, is another question. I think if somebody is getting to the point where they can actually reach out and say that they need help, then when they make that call or when they do that outreach, there definitely needs to be somebody responding back with “Yes, I can help you” and not “Sorry, you need to call this number”, because if they get told that two or three times when they're in a state of mental crisis, it can be very discouraging for them.

I guess it's about making sure that if those services are available, then they're also accessible. If a young person says, “Hi, I'm a child of a sixties scoop survivor, and my grandfather went to residential school”, and the counsellor doesn't know what that person is talking about, then the young person is in the position of having to educate the person who is supposed to be helping them out of that crisis. It adds an additional burden.

I'll leave it at that for now on the mental health piece.

Ms. Sonia Sidhu: Thank you.

The Chair: Thank you.

[*Translation*]

We'll now go to Mr. Thériault.

Mr. Thériault, you have two and a half minutes.

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

Wherever COVID-19 is found around the world, three negative effects of confinement are beginning to emerge, and they are mental health, substance abuse, and family and domestic violence.

First, I will address the National Association of Friendship Centres, and perhaps also Grand Chief Jerry Daniels.

Can you tell us whether your associations and the organizations you are in contact with have also observed an increase in these negative effects since the beginning of the pandemic?

Since there is always a need for prevention, I would like to know what you need to do to adequately counter these kinds of negative effects, and the solutions you would recommend to do so.

● (1600)

[*English*]

Mr. Christopher Sheppard-Buote: Jocelyn can probably follow up more specifically with examples from the specific centres, but I think it's about understanding the isolation that already exists in urban spaces. As Jocelyn said, there's this idea that if you live in a city, it must be better because you have access to counsellors or services or programs, but in reality it is sometimes even more isolating, because you don't always have the same kinship bonds you would have in your own territory.

People are more than just a clinical response. They require an emotional response, a clinical response and sometimes just a social response or opportunity. If it's an urban person who may not have a phone, who may not have the Internet at home, who may live in a boarding house, for example, all those factors contribute to someone's isolation and the buildup of some of these other social issues, because there really isn't a strategy for dealing with some of these interpersonal stressors and if you don't have a virtual way to meet with a counsellor, you're alone. For a lot of these issues, that isolation makes it even worse.

Connections and connectivity need to exist in communities to make sure people are wrapped right into the services they need. In terms of eligibility for programs, there are federal programs in which technology is not an eligible expense. You have to start looking at how you support the most vulnerable, and it's the flexibility to get the tools people need to be as connected and supported as possible.

I'll go to Jocelyn because I know she has specific data about what we've seen since the start.

Ms. Jocelyn Formsma: I'll just add quickly—

The Chair: Ms. Formsma, if you could do it in about 15 seconds, we'd appreciate it.

Ms. Jocelyn Formsma: I'll be very short.

The only thing I want to add is that we are hearing that the workers and the volunteers at the friendship centres are also experiencing great mental health strain from feeling they're not doing enough and not meeting enough of the communities' needs. We've been trying to figure out how we support the front-line workers in dealing with their mental health in addition to community members' needs.

That's all I'll add. Thank you.

The Chair: Thank you.

Merci, Monsieur Thériault.

We go now to Ms. Ashton for two and a half minutes, please.

Ms. Niki Ashton: Thank you, Mr. Chair.

Building on what you've been saying, I was wondering, President Sheppard-Buote, if you could perhaps reiterate how insulting the lack of funding is for urban indigenous communities, as well as the imposition of a deadline on the grants that were being made available. Does this need to change now?

Mr. Christopher Sheppard-Buote: For what friendship centres have contributed to Canadian society and what they do every day, I want to start seeing that recognition and that trust instead of hearing about it.

We hear a lot that friendship centres do great work. They support people every day and they make millions of client contacts each year, with 3,600 employees, but we have seven days to prepare a national proposal to support our organizations on the ground when we have people chasing down commercial sanitation trucks to get enough supplies to keep their homeless shelter sanitized. Then we're told to write a proposal and to have our measurements and our data collection strategy in place. As someone who used to be an executive director of a friendship centre, I couldn't expect our organizations to do it, and I felt bad for other urban organizations that may not have had the capacity.

Ms. Niki Ashton: Thank you.

President Obed and Grand Chief Daniels, we heard about the urgent need for food security, and there was mention, Grand Chief Daniels, of the lack of access to baby formula in Little Grand Rapids. Should the federal government be stepping in to make sure that whether it's diapers, baby formula or healthy food, they are made available now to fly-in communities?

● (1605)

Mr. Natan Obed: Absolutely, and there have been announcements of a top-up to Nutrition North's expansion of specific items, but there's a larger issue of food insecurity and poverty that has to be addressed in the long term.

Also, on a day-to-day basis, we don't know where the COVID-19 response is going. We don't have a full understanding of all the effects of food insecurity on our vulnerable communities, so next month we may need something very different from what we need today. We need it to be front of mind that people are already hungry and that our response has not been enough systemically, so at this time we need even more.

Grand Chief Jerry Daniels: Food security needs to be addressed right away. There can't be any back-and-forth about how it's the province's jurisdiction. The federal government is responsible for indigenous peoples, period, so we need to make sure that those kinds of things are being provided for our communities and our community members.

The Chair: Thank you, Ms. Ashton.

That concludes our second round of questions. We will start our third round now with Mr. Jeneroux.

Mr. Jeneroux, please go ahead for five minutes.

Mr. Matt Jeneroux (Edmonton Riverbend, CPC): Thank you, Mr. Chair. It's good to see everybody again this week.

I'm going to split my time, if available, Mr. Chair, with MP Vidal.

The one question I want to get out there is on testing. If anyone is able to answer, that would be great. How available are tests on reserve? Where do people get the tests done? Are temporary hospitals being established in communities, or are they being considered?

Thanks.

Ms. Valerie Gideon: I will ask Dr. Wong to start on this question, and I may supplement if there's time.

Dr. Tom Wong: Thank you for the question.

Currently in our nursing stations in all first nations on reserve there are swabs, and nurses are available to take samples from the nose and send them off to the provincial laboratory system. As you know, in each province there are guidelines on the criteria for testing, and we follow the guidelines of the province where the particular reserve is located.

In addition, we acknowledge there's a lag time, both in transporting the swab to urban centres where the provincial labs are situated and also, as you have heard, in wait times, depending on the province. Some provinces have longer wait times and longer turnaround times for the results to actually get back.

One of the latest developments is the approval by the regulators here in Canada, by Health Canada, of two rapid point-of-care test kits. One is produced in the United States and the other is produced in Canada. Those two test kits have the potential of bringing the testing much closer to the community.

For the U.S. tests, unfortunately, because there is currently difficulty in getting some of the test equipment and test kits out of the United States, they are therefore slow coming into Canada. Those test kits and that equipment produced in the United States are being placed in hospital labs.

Currently the product produced here in Canada, which recently got approved, is not available other than for beta testing, for pilot testing by a provincial laboratory system and the National Microbiology Laboratory. When we asked the company, they said the reason is that they have to internally ramp up their production schedule in order to come up with the test machines as well as the test cartridges. They are hoping that in a couple of weeks' time they will be able to have some boxes of equipment and cartridges available for testing.

In the meantime, over the next week or two, all they have is a very small number of test kits and some test equipment for provincial laboratories and the national laboratory to actually validate the testing. At that point they will be able to ramp up the testing so the test kits can actually go all over Canada. However, even at that time they are expecting that in the beginning they will have only a small supply, and then the supply will increase over the course of the coming weeks and months.

● (1610)

Ms. Valerie Gideon: On the field hospital side, what we're doing now in remote and isolated communities is we have pre-positioned some mobile, temporary structures that can be deployed, flown into a community setting, which then can provide extra space for testing purposes or assessing individuals.

They're not intensive care units. The idea is that individuals would be able to be tested, assessed, and then, as needed, would be transported out of their community and brought closer to a hospital system to ensure that they're properly treated, as may be required.

Mr. Gary Vidal: Thank you. My question is for Ms. Gideon as well.

In the application process that's been much talked about today on the urban side, there's obviously been some concern expressed. Can you tell us who was at the table in making the decision on how to allocate that money and what criteria were used?

Ms. Valerie Gideon: We had representatives within the department with expertise in terms of social programs who led the coordination and the assessment of the proposals very quickly. Those recommendations were then brought to our deputy minister and will be brought to our minister. We expect decisions to be able to be finalized within days.

The Chair: Thank you, Mr. Vidal. Thank you, Mr. Jeneroux.

We go now to Mr. Van Bynen. Mr. Van Bynen, you have five minutes.

Mr. Tony Van Bynen (Newmarket—Aurora, Lib.): Thank you, Mr. Chair.

This question is for Dr. Wong and Ms. Gideon.

On April 10, there was a technical briefing with Minister Miller and you that brought out the fact that first nations and Inuit communities were susceptible to COVID-19 because of housing overcrowding, which can make it difficult for people to self-isolate. Since the briefing, have different communities found potential solutions for this issue so that individuals testing positive for COVID-19 can self-isolate safely? What roles does ISC play in this?

Ms. Valerie Gideon: I can speak to that. Communities have looked at various options. Some are renting hotel rooms that are nearby or in the community, and we are helping them to pay for that. Some of them have repurposed other facilities that they have in the community in order to create those spaces, and some have purchased—or we have purchased for them—ready-to-move trailers that offer individual spaces.

The World Health Organization has also issued guidelines for preparing such spaces, based on public health expertise, to ensure that they are safe and protect individuals who are within them. We are working community by community or, in some cases, with tribal councils, or assisting communities with respect to identifying what their space requirements are.

Mr. Tony Van Bynen: Thank you.

I'd heard that the department was looking into tents to be used as temporary shelters for health care provision, and I'm hoping that you can tell us if they are still being considered as an option. If so, in what capacity will they be used? If not, what were the deciding factors on that conclusion?

Ms. Valerie Gideon: These are mobile structures. I think they are very self-contained, and they would be used for medical assessments, testing and stabilization of patients. We have purchased a number of them directly, and we have also worked with a first nation partner in Saskatchewan to purchase some for pre-positioning in Saskatchewan and Alberta. We're pre-positioning some in Manitoba and Ontario as well. They can be flown in and deployed as required. Those are the purposes, and we've done that. We have about 47 so far that we've secured.

Mr. Tony Van Bynen: Thank you.

My next question goes out to the community leaders. In addition to the challenges posed by the current housing conditions in the indigenous communities, what other issues relating to preventing and stopping the spread of COVID-19 within these communities have been brought to your attention? What is currently being done to address those issues?

I'll start with the Grand Chief.

● (1615)

Grand Chief Jerry Daniels: Just to reiterate, every community is doing different things. Many of our communities have just shut down their border. I think that this has been a good strategy, in that if your community is isolated, maybe the community can still be a community and still have some community events if you can keep it out that way.

That's a good thing in terms of the mental health aspect. If we can isolate it from our communities, then maybe our communities can still function in the way that we did and not be ethnically isolated from each other. There's that aspect.

The other thing that I think needs to be done is that we need to have more involvement of the health care system when it comes to communicating the who, when and where about people who are being confirmed positive. That was the biggest concern for many of our communities: If we have a community member who is sick, we would like to know. We don't need to know who it is, but we would like to know if the person is from one of our communities. That's kind of been an ongoing thing.

Thankfully, we haven't gotten to that point, but how fast the spread happens is probably what we're most concerned about. Should that occur, we would like to know immediately, so that we can respond properly. If you're not isolating quickly enough, it's not going to work. It doesn't matter how many isolation areas you have; if it's not done fast enough, it's just not going to work. That, I guess, is their biggest concern.

Mr. Tony Van Bynen: I'd like to go back to an earlier statement you made: that you'd like to rebuild the health care system. Frankly, I'm glad to see that you're making a bold statement such as that, but more importantly, it is important for me to hear that you're doing something about it. Your initiative to go down to Cuba to find other solutions is really reassuring.

We've heard of all the money that's being made available. I'm not going to recite those numbers, but I've heard that it's not enough and I understand that. I've also heard that it's just the beginning. However, what concerns me is the discussion about how the decisions are made and how the distribution of funds doesn't appear to be equitable in some cases.

Is there a more equitable, more responsive or more efficient and accountable way that you'd recommend be considered in the distribution, or the funding, of any of the programs that relate to your community?

Grand Chief Jerry Daniels: It's as simple as the demographics themselves. We're 4% or 5% of the population, so 4% or 5% of the allocation should be for indigenous communities.

We're the closest to the ground, to the political representatives here in the region, and we respond very effectively to our communities. We've done our best to have their buy-in. What we're seeing is that buy-in. They have bought into having a Cuban model, Cuban doctors in our communities.

Let's see what type of impact that has. If we see an increase in health outcomes as a result, because we're taking preventative action rather than providing a solution after or providing a response later, we're going to get a better return on investment. I think that's what everybody wants. Everybody wants the best use of our resources, so let's look at examples that people are saying work around the world.

Mr. Tony Van Bynen: Thank you.

The Chair: Thank you, Mr. Van Bynen.

We will go now to Mr. Vidal.

Please go ahead. You have five minutes.

Mr. Gary Vidal: Thank you, Mr. Chair.

I want to follow up with Ms. Gideon a little on the question I started earlier.

I don't think you really identified what criteria was used. Could you maybe clarify the criteria that was used for that?

Also, there has been some talk about maybe saying that this $50 million is just the beginning. Would it be your expectation that the application process be used again for any future funding for urban indigenous people, and would the same criteria be used to distribute that?

Ms. Valerie Gideon: In terms of criteria, there were some parameters laid out in terms of the RFP itself, which essentially set the stage in terms of addressing unmet needs, areas where there were no other support systems available to organizations and specific needs that had emerged as a result of the COVID-19 situation.

There was absolutely an effort to be as inclusive as possible, understanding the number of organizations that had submitted requests, and to try to balance those needs both geographically and across the different service delivery areas. It included things such as mental health services, food security, equipment and supplies to continue to run essential services, staffing and coordination with [*Technical difficulty—Editor*], the core elements that were part of the application process.

I certainly can't speculate as to what classes would be used if [*Technical difficulty—Editor*] were made available. Those would be decisions [*Technical difficulty—Editor*] the number of [*Technical difficulty—Editor*] demonstrated a significant need.

● (1620)

Mr. Gary Vidal: Thank you.

In your presentation you talked about economic prosperity being an important determinant of health, particularly when you consider the younger age distribution among indigenous peoples. One of the things we've been talking about over the past couple of weeks is the idea that first nations business models, these models that are limited partnerships, have been excluded from the Canada emergency wage subsidy.

I raised that issue with your office back on April 7 and wrote a letter to Mr. Morneau last week. I know there was some funding announced on the weekend that is intended to help small and medium-sized indigenous businesses, but I can't seem to get any clarity from anybody that it will cover the hole that has been created by their not being eligible for the wage subsidy.

Can you identify why these limited partnerships were excluded from that? Is there some plan to make a change and include them in it?

Ms. Valerie Gideon: Unfortunately, I don't have that particular response, but I certainly can say, from the announcement this weekend, over 6,000 first nations, Inuit and Métis businesses will benefit from those resources through the aboriginal financial institutions with which they already have pre-existing relationships. However, I will follow up to ensure that a more detailed response to your specific question is provided.

Mr. Gary Vidal: Thank you. I appreciate that.

In my riding, I've been in close contact with the Prince Albert Grand Council vice-chief, and he's been doing some talking—like we've heard from other people today—about the shortage of groceries and baby supplies.

There have been some responses to that already, but nobody has asked you the direct question, Ms. Gideon, as to what Indigenous Services is going to do to address those shortages that we're starting to find in remote communities that, for example, are losing their winter roads and don't have access to supplies outside their communities. There are these remoteness issues. I'm curious about what preparedness actions your department is taking for those communities specifically.

Ms. Valerie Gideon: I'm just going to see if my colleague Chad, who has not had a chance to intervene from our regional operations side, would like to jump in on this question.

Mr. Chad Westmacott (Director General, Community Infrastructure Branch, Department of Indigenous Services): Sure. Thank you, Valerie.

I have just a few quick things on this one. First of all, in terms of the winter roads, there was every effort made, as there is every season, to make sure that the supplies needed for these remote communities got into the remote communities. In a lot of cases, if not all cases, the supplies that were needed got into the remote communities based on those winter roads. There is also the opportunity in some of those cases to use barges or air transportation to get additional supplies in.

You also raised the issue of shortages of groceries, etc. One of the things that are eligible under the indigenous community support fund is actually supplies: food, etc. That is one of the things that, if the chief and council so decide, the indigenous community support fund can be used for.

Mr. Gary Vidal: Thank you.

I'm going to get one last quick question in if I can, and I'll leave it open to anybody in the department.

What is the department's plan to assist first nations in increasing testing capacity and tracing after the curve is flattened, so that communities can begin to adapt to the next phase of this process?

Ms. Valerie Gideon: As indicated by my colleague Dr. Wong, we are already making testing available across nursing stations, health centres with treatment, any community that has primary health care capacity on site and wishes to have access to testing. We will support them with access to swabs, training or whatever it is that they would require in order to be able to do that, and that will continue.

Dr. Wong is working very closely with the Public Health Agency of Canada and the National Microbiology Lab to ensure that rapid testing or point-of-care testing, once it becomes more broadly available, can be pre-positioned, particularly in remote and isolated communities, but also across indigenous communities where they have the ability to support it.

● (1625)

Mr. Gary Vidal: Thank you.

The Chair: Thank you, Mr. Vidal.

We go now to Mr. Fisher for five minutes.

Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.): Thank you very much, Mr. Chair.

As usual, I want to thank you all for being here. Again, one of the benefits that we have in this health committee is hearing from experts like you.

I want to thank you and welcome you to the committee, so hello from my dining room table in Mi'kma'ki, where we're fortunate enough in our city to have an incredible friendship centre, the Mi'kmaw Native Friendship Centre over in Halifax. I believe it has expanded a little, bought some land in Dartmouth and plans to expand some of the services it provides.

Jocelyn, you talked about just a handful of the services that friendship centres across Canada provide. I've been somewhat fortunate to see some of this first-hand, and I want to thank you and all of the, I believe, 107 friendship centres and provincial-territorial associations from coast to coast to coast for what you provide.

During COVID-19, what have the friendship centres had to do to reorganize or change operations to continue to provide those services that you, Jocelyn, outlined in your opening remarks, and what does that do to capacity?

Now, I realize that a lot of people are staying home. A lot of the folks who come into friendship centres sometimes don't have homes. Maybe, Jocelyn—or perhaps, Christopher—you could fill me in on some of the ways that you've had to reorganize or change the way you normally do things. I'm also interested in what things look like now in perhaps a city like Halifax where we know there are COVID-19 cases, but we only know them by region, so we don't know if folks who are coming into the friendship centre are actually struggling with COVID-19 symptoms.

Ms. Jocelyn Formsma: Thank you. That's a lot.

This is what we've been hearing from the ground. Immediately, the staff of some of the friendship centres had to physically shut their doors, but a vast majority of the friendship centres stayed open in some respect. Even if their doors are physically closed, they are still receiving calls, still doing referrals, still doing outreach and still doing service delivery in some capacity. We know that even though people say their doors are closed, they are open. They are fully open. They have just changed the way they are providing those services.

There are some friendship centres that have social enterprises, so the businesses they are running are losing revenue. They've had to shut down kitchens. They had people who were visiting from different communities or were there for medical appointments and were in hostels, and they were asking, “What should we do with these people? Should we get them a flight home? We don't know what to do.” There was some of that.

There was a shift to virtual contact as much as possible, with people getting at least some communication out, largely via social media. Some friendship centres have housing units, so they were worried about their tenants. Some of them have very crowded conditions, even within those housing units. Some friendship centres have homeless shelters and offer services for those who are unsheltered. There I think the big concern was for those community members, especially because when you're publicly saying to self-isolate and someone literally has nowhere else to go and is living on the street, the friendship centres are saying we can't just close our doors, because that's unethical. It is unethical for us to close. I've heard that from some of our executive directors, so we have to figure out how to do this safely.

They are worried about their staff, about having gloves and masks to be able to provide those services safely to community members. Eighteen friendship centres have been approached to be testing sites. It was about a week and a half ago that we collected that information. I don't know if that's been transitioned yet. They are going to have to physically manoeuvre and manipulate their physical space to be able to allow that testing to be done safely. We don't know what the cost is.

Some of the friendship centres have set up access sites through their windows. You need access to email to apply for your CERB benefits, but if you don't have a computer and don't have access to the Internet, friendship centres in Manitoba, for example, have set up two computers so that you can apply for your benefits through the window.

Some friendship centres are people's mailing address, so how do you close when somebody is relying on you to be open so that they can access their mail? The capacity piece has been huge, because now we're getting to the point in week six where the staff is becoming exhausted. We're hearing our staff saying, “We're tired. We don't know when this is going to end. We don't know when we're going to get help. We're doing the best we can, but we don't feel like we're doing enough.” The capacity piece is really huge.

What we are trying to do with the national office is to collect the information as to what is happening now and relay it to anybody who will listen, but we already have our eye to the future to say that if friendship centres aren't able to fundraise for themselves and can't do their bingos and can't do their fundraising events and their social enterprises are shut down, they are not only losing revenue but they are also spending more to be able to get those services and supplies to community members. We don't want friendship centres to be in financial difficulty six months to a year down the line, so we already have our eye on how to make sure that we have friendship centres in six to 12 months. We're looking already at the recovery process that we need to support friendship centres and ensure they are not going under because they did everything they could possibly do to save people's lives.

This is just to give you a little sense of what we're hearing on the ground.

● (1630)

Mr. Darren Fisher: I suspect my time is probably just about up—

The Chair: Thank you.

Mr. Darren Fisher: —but I do want to take a quick second to thank you for all the things that you folks do at friendship centres. I look forward to seeing a bright, shiny one in Halifax and I hope to be part of that some day.

The Chair: Thank you, Mr. Fisher.

We will go now to Mr. Thériault.

[*Translation*]

Mr. Thériault, you have two and a half minutes.

Mr. Martin Champoux (Drummond, BQ): If I'm not mistaken, Mr. Chair, it's my turn to speak, unless there's a procedural error.

[*English*]

The Chair: Who just spoke?

[*Translation*]

Mr. Martin Champoux: Mr. Champoux.

The Chair: According to the information I have, it's Mr. Thériault's turn, but he can give you permission to take the floor.

Mr. Martin Champoux: Mr. Chair, Mr. Thériault has already agreed to this.

I would like to thank the witnesses for the very interesting insights they have brought to the situation.

The current crisis makes us aware of several shortcomings in society, including inequalities in access to an adequate Internet network. Many families across the country are currently experiencing problems related to telework or distance learning, among other things. This is also a glaring problem in a number of indigenous communities, if I understand correctly.

Ms. Gideon, would better Internet access in remote areas have enabled you to be better equipped to protect certain indigenous communities from the pandemic upstream? What difference would that have made?

Ms. Valerie Gideon: Telemedecine networks have already been operating for several years in northern Manitoba, Ontario and Alberta. Telemedecine plays a very important role in improving access to health care services. In fact, many communities are visited regularly by physicians, who now offer their services more frequently using telemedecine networks. Manitoba and British Columbia have just announced a virtual service that will be coordinated at the provincial level.

We are in the process of financing the increase in costs related to telemedecine networks, since their use will increase because of COVID-19. We fully support access to telemedecine networks, especially since they are necessary in the current circumstances.

Mr. Martin Champoux: Thank you.

My next question is for Mr. Obed or Grand Chief Jerry Daniels.

Are you confident that what is happening now will make us realize how urgent it is to resolve the problems and injustices that have been condemned for several years now with regard to the situation in several first nations communities in Canada?

Do you think the current situation is underscoring how urgent it is to resolve cases such as those in your communities?

● (1635)

[*English*]

Mr. Natan Obed: I'm sorry, but because of my trouble getting on I don't have access to translation like the rest of you, and I don't speak French. I apologize greatly for that.

The Chair: Mr. Obed, are you on a PC or an iPad?

Mr. Natan Obed: I'm on a PC.

The Chair: If you look at the bottom of your screen you'll see a little icon that says “interpretation”. If you click there you can choose English.

Mr. Natan Obed: I had tech staff help me to get on, but it wasn't in the formal way so I don't have access to that particular icon. I greatly apologize.

The Chair: M. Champoux, your time is up, but I will give you time for another quick answer because you weren't able to get an answer.

[*Translation*]

Mr. Martin Champoux: Does Grand Chief Daniels have access to translation? Can he answer my question in the short amount of time we have left?

[*English*]

Grand Chief Jerry Daniels: Yes. There are definitely some barriers there.

I think the best course of action going forward is the emergency preparedness planning that happens here in the region. The regional office has been involved in the emergency planning. There are two sides to this. There's the ISC side, and then there's the FNIHB side.

I know they've been brought together, but they're still independent of each other. I think the best process is to bring them together and then have first nations do the comprehensive community planning, the emergency preparedness planning, those kinds of things. We always have questions and problems when we assess what they mean by “emergency planning” or what they mean by “comprehensive community planning”.

Looking at all of the different variables that produce a community, that can produce opportunity and a good quality of life through those services, we would say there's a deficit, an intergenerational deficit, of underfunding, decades and decades of government administrations just not taking it seriously, not letting the communities or first nations lead this. That's always been the problem here.

What we've always pushed for is local control, a local strategy, and then working as a regional body. We're very close to the ground. We have 34 communities we work with from the the Anishinabe and Dakota nations, so we're adamant that when it comes to comprehensive community planning or when it comes to emergency preparedness, we be the ones involved in this and we be the ones who are structuring this because we have the most at stake here. We really care about our communities. It's hard to bring in an administrative body that is separate from the community and then task it to ensure the community is prepared.

Look at the variables being utilized and the different characteristics of the comprehensive community planning or the emergency preparedness. It wasn't enough. It failed. It's failing, and it's going to continue to fail until you transfer that responsibility directly to first nations governments.

[*Translation*]

Mr. Martin Champoux: Thank you very much.

The Chair: Thank you, Mr. Champoux.

[*English*]

We will now go to Ms. Ashton for two and a half minutes, please.

Ms. Niki Ashton: Thank you.

My question would be for the ISC officials.

There was reference to the urgent need for testing kits in the north, in Nunavut, and in communities across the country. I know Dr. Wong spoke to this briefly, but how quickly can communities, particularly fly-in communities but ultimately all first nations and Inuit communities that need them, get these testing kits that can both be used and analyzed in the community itself? How quickly can this be done?

Dr. Tom Wong: Thank you for the question.

At this moment, based on the information from the company, if everything goes well, we are expecting that by early May they will have a significant quantity of these rapid test kits produced in Canada and able to start being used in remote areas.

We work very closely with the Public Health Agency of Canada, the indigenous leaders, as well as the provincial lab system in order to try to prioritize the remote and isolated areas as the top priority, so that we prioritize the needs of remote and indigenous communities to get these test kits.

Of course, this equipment also needs training, because once it's set up, the staff there need to be trained, so we are working with the national lab, as well as with the provincial lab system and the territorial lab system, in order to make sure that the training does take place and that there's a quality assurance and a quality control system in place. We're looking at a couple of weeks. By early May, the company should be able to come up with boxes of that equipment and the test kits that will be rapidly moved to those locations.

● (1640)

Ms. Niki Ashton: Thank you.

To ISC officials, there have been calls in our region and across northern Canada to shut down work camps and mining sites because they put workers and first nations at risk. Many of us are alarmed to hear about the outbreaks coming from Fort McMurray. We're dealing with really serious situations across the country and our regions cannot handle a minimal spread, let alone a surge. Is ISC looking at the need for national leadership around shutdowns of work camps and mining that could put first nations and our regions at risk?

Ms. Valerie Gideon: Maybe I can start and then I'll see if Dr. Wong or Chad have anything further to add.

We have certainly offered public health expertise to help support planning and support these particular communities, as well, that are impacted or near to those operations to ensure that we can maximize their ability to protect the health and safety of their members through physical distancing measures and limitations of non-essential movement back and forth from the community.

Dr. Wong or Chad, I don't know if you have anything more to add.

Dr. Tom Wong: Regarding the infection control processes and measures as well as physical distancing inside the work environment, from a public health perspective, we would be supporting any community in order to maximize those measures. As for the shutdown of those facilities, it would be the decision of the provinces or territories, in collaboration with partners, on when to shut down or not shut down.

Chad.

Mr. Chad Westmacott: I don't have anything else to add on that. I think you guys covered that well.

Thank you.

The Chair: Thank you, Ms. Ashton.

Thank you, everybody. That wraps up our third round of questions.

I would like to thank all the members of the committee for their great questions.

To the panel witnesses, I would like to thank you for sharing with us your time and your informed and important expertise.

I would like to ask the committee members to stick around for a minute for a brief note about committee business. We have had a response back from Dr. Aylward regarding the WHO. In part, he says the following: “May I express again my regrets to the honourable chair and members of the committee that I was unable to accept the original invitation without this having gone through appropriate WHO channels. I particularly regret any inconvenience or frustration this may have caused. I trust that a way forward can be sorted as soon as possible so that the WHO might help the committee in its important work.”

This is an ongoing conversation. I have Dr. Aylward's number. I believe he's in Europe at the moment. I will be reaching out to him later today or early tomorrow. I will be happy to report back to the committee in our meeting of subcommittee members on Thursday.

That's all I have. Thank you.

Does anyone have any comments?

Mr. Matt Jeneroux: Mr. Chair, thanks for sharing that. I think the timeliness of it all is what we're curious about, and if there's any indication from him on whether or not he will make it May 1. Obviously, being away in a different country is something that needs considering, but again, the date was specifically May 1. I'll just be curious to see what he has to say about that.

● (1645)

The Chair: Absolutely. I think a conversation is in order. I shall try to reach him and make sure he understands what it is we're asking of him, and that he actually doesn't have to be here to do that.

Are there any more questions or comments? Seeing none, thank you to all.

The meeting is now adjourned.