House of Commons
CANADA

Standing Committee on Health

HESA • NUMBER 031 • 2nd SESSION • 40th PARLIAMENT

EVIDENCE

Friday, August 28, 2009

Chair

Mrs. Joy Smith

Standing Committee on Health

Friday, August 28, 2009

● (1310)

[*English*]

The Chair (Mrs. Joy Smith (Kildonan—St. Paul, CPC)): I call the committee to order.

I welcome all my colleagues today on this very important occasion. Once again we meet on the H1N1 issue. It's very important to all of us here in Canada.

I would like to welcome all the guests who are joining us today. Thank you for taking the time to be here.

I especially want to welcome Minister Leona Aglukkaq. It's so nice to see you.

We will start right away. We have from 1:15 to 2:30.

I understand you're going to give a 15-minute briefing to everybody, Minister, and then we'll have questions and answers. Please begin.

Hon. Leona Aglukkaq (Minister of Health): Good afternoon, everyone.

Madam Chair, members of the committee, it's once again my pleasure to be here to talk about our response to the H1N1 flu virus, in particular our efforts to support and assist on-reserve first nations communities.

With me today are Dr. David Butler-Jones, our chief public health officer, and Shelagh Jane Woods, director general of primary health care and public health for Health Canada's First Nations and Inuit Health Branch.

I would also like to introduce Dr. Paul Gully, who has joined Health Canada as a special medical adviser. He will help coordinate the provisions of emergency health services in first nations communities affected by the H1N1 virus. Dr. Gully is joining us following his assignment at the World Health Organization as the deputy UN system influenza coordinator. He has also worked with Health Canada and the Public Health Agency of Canada in the past.

During our time together, I'll turn to them for information in answering your questions as fully as possible.

In my remarks today, I want to talk about how we've been managing the H1N1 virus for almost five months. In particular, I will delve into why focusing on first nations communities is important in preparing for the fall, how we're collaborating with the provinces and first nations leaders in helping communities get prepared, and what we're planning to do going forward to strengthen our response and raise awareness in protecting the health of our communities.

Understanding the virus, how it's spread, and who is most vulnerable to it has been our priority. We immediately saw the need to implement our national pandemic influenza plan. Since then, we have followed the guidelines of the plan, and it has served us well. For that reason, we must stay the course and see it through as we prepare for a possible increase in the spread of the disease in the fall.

Communicating with Canadians has been and will continue to be an essential part of the plan. Collaborating with provinces, territories, first nations, Inuit, and health agencies across the country has enabled a clear and consistent approach to the disease nationwide. Health Canada is committed to working with stakeholders and domestic and international partners to help further our understanding and our methods of preventing and treating the H1N1 virus.

Next week, the Public Health Agency of Canada will host a conference that will be the first of its kind in Canada. Public health officials, intensive care specialists, and medical experts from Canada and other countries will meet in Winnipeg to discuss the best methods for treating and managing the severe cases of H1N1. We hope to develop new guidelines for treating and managing severe cases and new guidelines dealing with the impact they will have on hospitals.

Development of a vaccine is going according to plan. Clinical trials should start in October, if not earlier. As you know, we will make more than 50 million doses of the vaccine available so that every Canadian who needs and wants it can be immunized. Vaccination is key to managing the disease. I hardly need remind you that prevention of the disease is our primary goal.

I would like to turn my attention now to the work we've been doing with first nations. It is important to note that there are different health care delivery models for different aboriginal Canadians. I am focusing today on on-reserve first nations because the provision of health services is a shared responsibility between federal and provincial governments. Territorial and provincial governments have primary responsibility for health care for Inuit, but the Inuit remain a priority of Health Canada as well. In fact, I met with 25 mayors in Nunavut on Wednesday.

There are demographic and social factors that make on-reserve first nations and northern and remote communities a priority as we prepare for the fall. While Inuit are also a priority for Health Canada and are supported by Health Canada's regional offices, I will focus on first nations today.

Our research has shown that some segments of society appear to be at greater risk of developing complications if they contract the virus. We know, for example, that younger people age 16 to 25, pregnant women, and individuals with underlying health conditions, such as diabetes, fall into this category.

Many of you already know that 50% of the people on reserve are younger than 25. In fact, the median age of the first nations population as well as Inuit is 25, as compared with 40 in the rest of Canada. In addition, the birth rate on reserves is three times higher than in the rest of the country, which means there are more pregnant women per capita in first nations communities.

● (1315)

Finally, there are higher rates of chronic disease within first nations communities.

All told, a higher percentage of the first nations population is at greater risk of developing a more serious case of H1N1 than in the rest of the population. On top of this, we know well that social conditions, including overcrowding and communities having limited access to water for handwashing, pose challenges in minimizing the spread and impact of any virus.

For all these reasons, we're putting greater priority on preparing for a possible stronger wave in the fall by ensuring that care is well coordinated for communities when they need it, that needed supplies are both available and accessible, and that communities are well prepared and well informed.

When it comes to providing care to first nations communities, ensuring effective collaboration between levels of government is paramount. When someone from a remote first nations community needs to be transferred to a provincial hospital, Health Canada provides for the emergency medical transportation. This means that on-reserve first nations with severe H1N1 symptoms receive hospital care through their provincial health systems.

When there are many players involved, we need to make sure that our roles are clearly defined and our tasks well executed. I would like to mention that H1N1 preparations for first nations communities will be on the agenda for discussions with my provincial and territorial counterparts at our meeting on September 17.

Health Canada officials from our regional offices have been strengthening working relationships with provincial counterparts. In Manitoba, for example, First Nations and Inuit Health attend regular tripartite meetings with the province and Manitoba first nations. These networks have proven to be effective, particularly at the height of the outbreak in Manitoba earlier this year.

In British Columbia, first nations are well positioned to deal with an H1N1 outbreak through their collaborations with the tripartite H1N1 partners group. Other members include Health Canada, provincial health officials, including the office of provincial health offices, and the British Columbia aboriginal health physicians adviser. Similar activities have taken place across the country.

In addition to our communication with provinces, our officials have also been working directly with first nations leaders, as they always do. In July, officials from the health portfolio were on hand to both provide presentations and answer some questions before the Assembly of First Nations annual general meeting, held in Calgary. On a regular basis, Health Canada's regional offices distribute information bulletins and hold teleconferences with first nations community leaders. On top of this, we also provide financial and technical support to communities for preparing their pandemic plans.

I should note that since his election in July, I've had a chance to speak with AFN National Chief Atleo, and H1N1 was central to our discussions. I should also add that I had a meeting with him again this morning. I'll also be meeting with British Columbia chiefs in the next two days.

We do have a national plan, the Canadian pandemic influenza plan, but we need pandemic plans at all levels in all sectors. In other words, a one-size-fits-all approach does not work for a country like ours. For first nations, the Canadian pandemic influenza plan includes annex B, which defines the roles and responsibilities of all partners in pandemic planning for on-reserve first nations, including federal and provincial governments and first nations communities themselves.

We also have plans that meet the needs of individual first nations communities, plans inspired by the principles of national and provincial plans but developed by community leaders. The community plans map out in greater detail how a particular community will respond in case of an outbreak. To date, more than 90% of the first nations communities in Canada have completed and tested their plans.

Health Canada officials in each region have been contacting and visiting communities in recent weeks to determine if any additional plans are needed. We know that many first nations have not only completed but also tested their community pandemic plans. I was in Saskatchewan last week and noted that practically every first nations community in that province had tested its plan. Those communities and many others across Canada have put a lot of effort into their preparations.

We are also committed to ensuring that first nations nursing stations are equipped with all the supplies they will need to treat patients affected by H1N1 virus. We have distributed antivirals in advance to nursing stations in remote communities and regional medical storage facilities so that they can be accessed quickly.

● (1320)

Of course, during a pandemic our most important resource is our hard-working front-line medical worker. If the H1N1 virus reaches its potential, there will be an unprecedented demand for nurses. Because Health Canada depends on nurses to provide the bulk of its services in remote communities, we need to be ready to respond to the communities where the need is greatest.

Earlier this summer, in response to the elevated situation in northern Manitoba, we reallocated our nursing staff among nursing stations to meet the urgent need. We will be ready to take similar approaches this fall.

In preparing for the fall, we're providing additional training to workers to respond to emerging needs. For example, we're making sure that the nearly 400 home care nurses on reserves are trained to administer vaccines. As you are already aware, we are also collaborating with other jurisdictions to provide supplies, training, and guidance to first nations communities.

All of these preparations should convey the fact that our top priority is to gear up for the possible stronger second wave of H1N1 during the upcoming flu season. This is the kind of outbreak that members of our health portfolio have been preparing for since SARS in 2003.

During those years of preparation, it became clear that public awareness and education would be a key component of our strategy. That's why we're now in the midst of placing public service announcements in aboriginal print publications. It's also why we've been providing information to band councils, chiefs, and Inuit organizations. It's why we're planning to run community radio ads with calls to action translated into 26 aboriginal languages and dialects, along with TV ads on aboriginal networks and community stations.

In addition, we're providing information specifically geared to first nations on fightflu.ca, and we've been launching a social media campaign to ensure that our reach is as broad and deep as possible. As our ad campaign reads, knowledge is your best defence.

Through our communications effort, we're seeking to ensure that first nations community residents have all the information they need. I look forward to continue working with the community leaders, many of whom are here today, on how to best support and strengthen preparedness for the fall. We know that we have to remain vigilant.

I look forward to receiving your questions this afternoon. Thank you very much.

The Chair: Thank you, Minister Aglukkaq. Thank you once again for coming here today and for being so available.

We'll now go into our first round, with seven minutes per person. That's seven minutes for the questions and for the answers.

We'll start with Dr. Bennett.

Hon. Carolyn Bennett (St. Paul's, Lib.): Thank you for agreeing to come.

Minister, are you aware of whether Canada's pandemic plan is available in Inuktitut?

Hon. Leona Aglukkaq: As far as I know, it has been translated into Inuktitut, yes.

Hon. Carolyn Bennett: Because yesterday the representative from ITK was saying during our conference call that it wasn't available in.... Also, we've heard that the Dene nations are concerned that in annex B it's not available in those languages. I would suggest that if ITK doesn't know it's available, it just speaks to a breakdown of communication.

Minister, have you been to any of the first nations communities?

● (1325)

Hon. Leona Aglukkaq: I have.

Hon. Carolyn Bennett: Where?

Hon. Leona Aglukkaq: In Nunavut—

Hon. Carolyn Bennett: No, first nations, like in terms of.... Have you been to a first nations community?

Hon. Leona Aglukkaq: Let me start off with the ITK issue.

In regard to Inuit health care delivery, the Nunavut territorial government as well as that of the Northwest Territories deliver health care, and not ITK.

Second, I've been to all the provinces and territories. I have met with the chiefs in Saskatchewan and Manitoba. On Sunday I'm meeting with all the chiefs in British Columbia. In Nunavut I met with all the mayors. So those are the communities I have been to.

This morning we had discussions with Chief Atleo. He and I will be organizing trips to various parts of the country to visit first nations communities.

Hon. Carolyn Bennett: Minister, you were in Saskatoon for the CMA meeting, I believe. So I'm taking this to believe that you have not made one special trip to see a first nations community since you've been minister.

Hon. Leona Aglukkaq: I've indicated that I've met with every chief...that I've been to in the provinces. I have not made a specific trip to a first nations community. If you want to call Nunavut communities first nations aboriginal communities, I'm from there. I've been to every community in Nunavut, as an example.

In terms of visiting first nations communities across the country, as I said earlier, I will be making plans with the new chief to visit various first nations communities across this country.

Thank you.

Hon. Carolyn Bennett: I have concerns about what is being communicated to you in briefings, and indeed the way the organization and revising and testing of the planning is being done on conference calls. You actually have to be in the community to understand whether or not they are feeling confident about what they will do this fall.

As you know, we have been to a number of communities, and this figure, that 90% of the communities have completed their plan, is not our experience. So I want to know whether people are on a conference call saying "Yes, we've completed our plan" when they aren't really sure what that means and what they need to do. I want to know from the communities that we've been to, that seem extraordinarily well prepared and that we'll hear from today, from Garden River, to some of the others that seemed very insecure about what will happen this fall....

How are you measuring and testing their capacity to revise or test their plan?

Hon. Leona Aglukkaq: I'll start off the response in terms of the planning going forward for the fall.

I said in my opening comments that my officials have been teleconferencing as well as visiting communities, and I will have my staff elaborate on the work they're doing with the community in developing and preparing for the fall.

Ms. Shelagh Jane Woods (Director General, Primary Health and Public Health Directorate, First Nations and Inuit Health Branch, Department of Health): What we have is regional staff who in fact are going to all of the communities. As you know, Dr. Bennett, a lot of this work has been going on since really just after SARS. Really, within about a year and a half of SARS we had started to organize information sessions with communities to talk to them about the importance of pandemic planning, and we then got into the actual pandemic planning some time after that.

You're quite right, some of the initial work has been done by conference calls. We've used e-mail and whatever means are available to get to the communities. Of late, and particularly since H1N1 emerged, but before it emerged in any of the first nation communities, the regional offices put a more intensive effort into going to the communities. Our pandemic coordinators have been to virtually all of the communities by now, and they know which communities have a plan. In fact, not only do 90% of them have a plan, but 70% of those have been table-top tested.

So we're quite confident. We do take the word of the community organizers who tell us that they've completed the plans. We've provided templates and we've provided examples. We do trust that they know when they have a plan.

● (1330)

Hon. Carolyn Bennett: I understand that in Quebec they have been prepared to twin a community that is feeling prepared with one that's not feeling so prepared. Is there any plan to offer that or to pay for the communities that feel pretty ready to go and help in other communities?

Ms. Shelagh Jane Woods: Where the regions are identifying additional needs, they're working to make sure there's a plan in place so that every community has completed its plan at or near the end of September. So they're using a variety of mechanisms.

Hon. Carolyn Bennett: Do you have any access to extra resources? The minister, in her opening remarks, said that you reallocated nursing staff amongst.... Certainly when we were in Manitoba they weren't thrilled that you were stealing nurses from one community to give to another. Is there any capacity to have extra nurses, extra resources? Are you training pharmacists? What's happening? Where's the money?

Ms. Shelagh Jane Woods: That's a numbers question.

Hon. Leona Aglukkaq: Let me start off.

Since 2006, when we put the plan in place, a huge number of investments have been made to the implementation of the pandemic plan. I think it was about $1 billion for that, and $2.3 million has been provided to strengthen public health capacity, $1.5 million has been provided for training and education at the community level to respond to the pandemic plan, and $1.6 million has been provided to date to support the community-level emergency plan. As well, this week I also announced an additional $2.7 million in the area of research.

In terms of how we were responding in Manitoba when the greatest needs were in pockets, health care professionals from other communities were put into that community for assistance.

The challenge we have from province to province is that, as you know, the licensing and credential recognition of nurses is a provincial jurisdiction. So in a pandemic it becomes a huge challenge for us to move staff from one province to another province when we have to go through the process of reviewing their credentials each time to be able to practise in that province. That applies to physicians as well. So within Manitoba, when we were responding to the pockets—

Hon. Carolyn Bennett: But there's a memorandum of agreement on that, Minister.

The Chair: Thank you.

We'll now go to Monsieur Malo.

[*Translation*]

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

Thank you, Minister. Dr. Butler-Jones, thank you for being with us this afternoon.

In a document that identifies the responsibilities associated with pandemic planning and response for on-reserve First Nations communities, it says that the provinces will basically be working with on-reserve First Nations communities with a view to coordinating management of the flu pandemic in these communities.

Having taken the pulse of Aboriginal communities in Quebec, it seems that what the Public Health Branch in Quebec has done is satisfactory and that the communities are, for all intents and purposes, ready to respond in the event of a new outbreak of the H1N1 virus.

Are you able to confirm that? Also, the communities are concerned about their peers living in Manitoba. I imagine that is because, last spring, infection rates in Manitoban communities were among the highest in the country, and very substantially so, given the percentage of the population these communities represent.

I imagine you have done some studies. So, are you able to tell me why communities in Manitoba are more affected? Also, is there reason to be more concerned for these communities?

● (1335)

[*English*]

The Chair: Madam Minister?

Or who would like to take that, Ms. Woods?

Ms. Shelagh Jane Woods: Yes, I can start.

Again, there were a number of questions.

[*Translation*]

I will begin in French, although I find it difficult.

I am pleased to hear that we agree the First Nations communities are ready. I also believe that to be the case.

[*English*]

I would say that in the province of Quebec about 96% of the communities completed their plans some weeks ago. So I'm not surprised you heard that.

Of course we are concerned about Manitoba, where the rate of completion was considerably lower—and we are putting a lot of effort there. We are concerned wherever we see pandemic plans not being completed. And of course there was the added factor of the outbreaks in Manitoba, so we are taking that very, very seriously.

[*Translation*]

I forgot the rest of your question.

Dr. David Butler-Jones (Chief Public Health Officer, Public Health Agency of Canada): When the pandemic began, the different communities, both Aboriginal and non-Aboriginal, were not at the same level in terms of their preparation. These communities had plans, but there were differences with respect to the evaluation and implementation of those plans.

Manitoba is facing an additional challenge, because that is where the pandemic first appeared. It's a little like when SARS first appeared in Toronto. Other communities benefited from the fact that there was a realization the pandemic had begun.

Mr. Luc Malo: Minister, in your presentation a little earlier, you basically identified three risk factors: being between the age of 16 and 25, pregnancy or underlying chronic disease. You seemed to be saying that the reason why Aboriginal communities are more affected than others is that there are greater numbers of individuals in those communities with those sociological or physiological characteristics. Therefore, there are more cases in Aboriginal communities for those very reasons.

Is that actually true? Has the Public Health Agency of Canada done any studies showing that there is a higher incidence in Aboriginal communities as a result of these factors, or are there other realities that could also be considered risk factors?

[*English*]

Hon. Leona Aglukkaq: I'll respond first to the question and then I'll pass it on to Dr. Butler-Jones.

I have said all along that the chief medical officers across the country have been looking at all of the cases we have seen in Canada, particularly the severe cases, which in some cases have resulted in death, to study and examine the underlying conditions those individuals may have had that resulted in death, and they are looking at the population, and so on. Next week, on Wednesday, the chief medical officers are gathering to further examine what other factors there may be and who is more affected.

But what I have outlined today is what we have seen, particularly in the higher-risk and serious cases—with pregnant women, as an example—and the younger population being hit by H1N1 across the country, aboriginal or not. This is the kind of information being collected that will help shape the guidelines we will be prepared to implement in the fall, as well as the sequencing of how the vaccine will be implemented.

Perhaps, Dr. Butler-Jones, you may want to elaborate a bit more on that.

[*Translation*]

Dr. David Butler-Jones: Well, it is not totally clear. I should say, however, that there are many challenges facing Aboriginal Canadians.

The fact is that 30 people died in hospital, in intensive care. The health status of 60% of them predisposed them to severe illness. In the general population, that percentage is only 4% or 5%, but that is not a complete explanation. We will continue to study this in order to get at the reasons. There will be a meeting next week with experts from different fields to help us gain a better understanding.

● (1340)

[*English*]

The Chair: Thank you, Dr. Butler-Jones.

We'll now go to Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis (Winnipeg North, NDP): Thank you, Madam Chairperson.

Thanks, Madam Minister, Dr. Butler-Jones, Shelagh Jane Woods, and Dr. Gully. I appreciate your being here.

This is a week after our first meeting, and the reason we all felt it would be important to hear from you at this meeting, as well as from representatives of first nations and Inuit communities, is that we had the sense that of all the areas of a possible pandemic, we were least prepared in terms of aboriginal issues.

Today you presented a fairly rosy picture, Madam Minister, suggesting that we're in great shape as we head into the fall, when we might be faced with a pandemic. But that flies in the face of everything we're hearing from first nations communities. We will hear from them again later today. They seem to feel that in fact we aren't as prepared as you're suggesting. They have big questions. There are very grave concerns about the adequacy of supplies, resources, staff, and communications.

So we're here to try to figure out what's missing and how we can fix the problems, because I don't think anybody here today would dare suggest we're as prepared as we should be at this point, near the end of August, facing a possible outbreak in September.

My first question is this. In Manitoba the first nations communities, under Grand Chief Evans, came together and requested funding for flu kits. The Province of Manitoba has agreed to provide some money for those flu kits. First nations communities have had to resort to doing fundraisers to raise money for flu kits. I was at the fundraiser last Friday night, which was well attended and raised a great deal of money, where Chief Evans indicated that this was a very important contribution to communities in Manitoba.

So my question to you is, Madam Minister, are you prepared to put some money on the table to support the provision of flu kits for every first nation and Inuit community in this country?

Hon. Leona Aglukkaq: I'll start off with the response to that issue of flu kits.

My officials have been in discussion with Manitoba's chief medical officer, I believe, to find out what is actually in the kit. I wasn't aware of what this kit actually entailed. That's the first issue.

I understand Manitoba has made a commitment to purchase a kit, but I'm not sure what is in it, nor have I been notified. I think Dr. Butler-Jones has had meetings since then to discuss what may be in the kit.

Dr. David Butler-Jones: Yes, and I think Dr. Kettner is also appearing before the committee later and he can speak to it directly.

But in essence, as you've heard me say before, it doesn't matter which family it is; there are some basic things that each family in this country should have, not just for a pandemic flu but for other flu-like illnesses at any time, and those are Tylenol for symptoms and a thermometer to know if someone actually has a fever or not. Obviously every household should have soap and water—and potentially a hand sanitizer to supplement that if you don't have easy access to water and soap—and information—

Ms. Judy Wasylycia-Leis: Could I interrupt you there, Dr. Butler-Jones?

If those items are part of the flu kit—because in fact many communities don't have those basics—is this government prepared to financially support the purchase of those flu kits, period? Yes or no?

● (1345)

Dr. David Butler-Jones: I think in terms of the flu kits, however the family finds the funds to cover this, this is not an expensive item. The other challenges are not, from a public health standpoint—

Ms. Judy Wasylycia-Leis: But you are talking about conditions on first nations communities that are under federal jurisdiction, where we know we're dealing with very serious economic and social problems. There isn't the same access to these products you've just outlined. There isn't a phone to pick up and call 911, and there isn't necessarily a way to move in and out of communities easily. So do you not see some responsibility to help provide for those flu kits?

It's not just the flu kits, but there's the question of resources in terms of extra nurses for nursing stations. You didn't yet answer the question that my colleague Carolyn Bennett raised. Are you prepared to support the rather enthusiastic outpouring in Manitoba and other places by nurses who are willing to go north? Are you moving them into first nations communities, and what is the plan to address the unique circumstances of first nations communities while you get more research?

I think the conference next week is great, but first nations communities know what they're dealing with, and they're asking for help right now. We're hoping to hear today what you're prepared to do to address that gap in services and support them in their cry for help.

Hon. Leona Aglukkaq: To start off the response, as an aboriginal person I have a very good understanding of what's in a community. I come from an aboriginal community of 1,000 people. It's an isolated community. I know very well what the limitations are of services. Not every community has a hospital. It requires partnership, and you know that.

I said in my opening comments that in severe cases, individuals are transferred to hospitals in provincial jurisdictions, as they would be in Nunavut to Yellowknife, Edmonton, Manitoba, or Ontario. I understand that environment because I was born and raised in that environment, and I continue to live in an aboriginal community. So that's one piece.

The second part is that our priority remains focused on ensuring that the nursing stations are adequately equipped with the supplies they need to respond to the pandemic in the fall. At the same time, we'll be implementing the immunization program in the fall, which is key to prevention. That's the goal we have, to get that out by October-November, and clinical trials are happening now.

As it relates to the question on these kits, I think it's also important to note that it is our responsibility, my responsibility as well as yours, to purchase hand soaps. Is that a federal responsibility?

These are questions I need to ask—

The Chair: Thank you, Minister.

Hon. Leona Aglukkaq: One of the things I should also clarify—

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

Ms. Judy Wasylycia-Leis: So you're not prepared to support the purchase of flu kits?

The Chair: Excuse me, your time is up, Ms. Wasylycia-Leis.

We'll now go to Dr. Carrie.

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

I want to thank the minister. It's good to have you back to make yourself available to the committee. I would like to thank the officials as well.

Minister, I know you have a toddler. I wanted to ask a question. I'm a parent with three small kids. I have a seven-year-old, a 14-year-old, and a 15-year-old.

I know, Dr. Butler-Jones, you've been working hard on the preparedness part of the plan.

It's September. The kids are going back to school, and a lot of kids are going back to day care. I was wondering, when their kids are going back to school, what does the average parent need to know about what's going to be happening in the schools?

Dr. David Butler-Jones: There are the general guidelines out there, but the basic information that parents need to deal with—and it's good common sense, but we don't always apply it—is that if you have a sick child, it's not the time to send them to infect other children. Having our kids understand about handwashing, how to cough, making sure that we keep contact surfaces clean as much as we can, knowing that the day care or the school are also reinforcing those, those are all important, and also knowing, whether it's a child or an adult, that if you're becoming severely ill, particularly with something like influenza, if you have shortness of breath, if you have chest pain, that is not something to wait and see about. On the other hand, if you have milder symptoms, there are things such as Tylenol, comfort, lots of fluids, etc.

These are all things that are not mysterious but need to be constantly reinforced. Certainly we do know that the virus spreads in schools, it spreads in communities, etc., but we also know that where kids are educated, supported, and observed, they're more likely to get the appropriate care they need.

● (1350)

Mr. Colin Carrie: Thank you very much, Dr. Butler-Jones.

The minister said in her speech that knowledge is our best defence, and we've heard from the last meeting the importance of communication for Canadians, public awareness education. You just mentioned some really good things that parents should know. What actions have been taken by the federal government, in collaboration with their partners, to provide information to the public?

Dr. David Butler-Jones: As many of the members would have seen, there has been advertising, there has been information at airports, there has been advertising in the newspapers, etc. There are regular media briefings that have been well picked up by the media in terms of educating the public. There will be an escalating campaign as we move into the fall, appropriate to what we're seeing. We will add to that, when we come closer to immunization time, in terms of what the immunization procedures are, etc.

This is not just a federal activity. The provinces and territories have been doing this. I was recently in Nunavut, and I was very impressed, actually, with the collaboration between the federal government, the territorial government, and the local municipal councils there. Everywhere you went, there was information, both visual and in the official languages of Nunavut, about good hygiene but also what to do if you're ill, a whole range of things, and people were very aware. They had obviously taken that effort very seriously.

Mr. Colin Carrie: What about front-line workers? Before I was in politics, I was in the health care field for over 15 years. When SARS broke out in Ontario, I was actually quarantined.

Have you been providing guidance to the front-line workers? There is a concern out there, so I'm wondering what the Government of Canada has done to provide guidance to the front-line workers who are going to be right there treating this outbreak if it indeed does occur.

Dr. David Butler-Jones: The guidelines were part of the original plan and have been recently revised. We will continue to engage with the professional associations, experts, and others, and the guidelines will continue to be revised as we understand what's happening or if things change. So that's an important part of it. But it's also important to recognize that these are guidelines, and it's impossible, whether for a municipality, a band council, or a hospital, to get all the detail. That's where plans at every level really are important, because how you deal with it in a small rural hospital in Saskatchewan won't necessarily be the same way you'll deal with these things in downtown Toronto. So it really is important about applying these guidelines.

But the guidelines are there, they outline the important principles, etc., and then the local experts—public health, medical experts, and others—can apply them.

Mr. Colin Carrie: I think everyone on the committee is aware that this is an international issue. I know we've had some experience from Australia, which apparently has gone through its flu season. Could you elaborate on the role that Canada has played internationally and the communications we are having internationally? What are we learning at this stage?

Hon. Leona Aglukkaq: I'll start off with that and I'll pass it on to Dr. Butler-Jones.

Right at the very beginning of the pandemic plan we were working very closely with Mexico as well as the United States. In Mexico we provided assistance to the lab, which is why we were able to learn of H1N1 early on and start planning for it. In working with the United States as well as Mexico, we've been collaborating in a number of areas—the areas of research, information sharing—as we prepare for the fall.

In Geneva the three countries presented to the international community in terms of how Canada implemented its pandemic plan, how we developed it, and the implementation and pieces of it. The three countries were seen very much as leaders in pandemic planning as well as in responding to the pandemic plan, and our models have been shared with the international community to assist other countries that may need it, through PAHO for example, to assist the Caribbean communities to develop their plans. It really is in Canada's interest to ensure that these other countries are prepared to respond. Because we're dealing with a situation that does not see borders, it's an international issue. It was in our interest to ensure that we participated in that kind of planning.

We continue to do that to date, building capacity, training in Mexico. We've had discussions early on with the United States on border issues—for example, on whether we should restrict travel. That discussion needs to continue as we deal with the fall.

In terms of the officials, there are ongoing discussions with WHO. Dr. Gully has joined us from WHO, which will be very helpful to our implementation come the fall, as well. I'm very thankful he took on his role to assist us in that.

I'll ask Dr. Butler-Jones to elaborate on the work they do on a regular basis with the international community.

● (1355)

Dr. David Butler-Jones: Just to supplement this briefly, as the minister alluded to, Canada was the first country to actually have a national pandemic plan, which many other countries then adapted for their use. As well there's been our work internationally in supporting other countries, both in training and in the development of their plans, etc.

The work that the government has done with GlaxoSmithKline, in partnership with the developing capacity in Canada, now actually has created additional capacity for the world in terms of a vaccine. Dr. Gully actually used to be my deputy chief medical officer, and then we sent him to the WHO to support WHO's efforts in pandemic planning. Now that the effort is well under way, they've sent him back, so we've taken advantage of that.

We could take a long time to talk about how we're involved in different countries. I think the minister has expressed some of the range very well.

The Chair: Thank you so much, Dr. Butler-Jones.

We're now going to go into our second round of five minutes, questions and answers. Dr. Duncan and Dr. Bennett are going to share times. I believe Dr. Bennett is going to start.

Hon. Carolyn Bennett: I'm just going to start by saying that I was remiss in not welcoming back Dr. Gully. We are thrilled that you're here to help on this hugely important file, particularly with first nations and Inuit. Thank you very much.

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

Thank you, officials, and I second that.

I'm really struggling. I'm struggling because I hear we want to stay the course, and in saying that, I think we've moved slowly on some issues. The reason I say this is that in the spring, when there was real trouble in Manitoba, we would have liked, Madam Minister, to see you go to those communities. I would have liked to see some attempt at slowing down the spread of the virus. We knew from Mexico that some communities were more at risk. We know about it in first nations communities, as was outlined today, but in the spring we knew, for those same reasons, that they were at risk.

I would like to know how long the average length of hospital stay was in first nations communities, if they went down to Winnipeg, and how long they were on respirators compared to people in the rest of Canada. That is my first question.

I will ask the second question as well. I would really like to see a spreadsheet by province showing the first nations and Inuit communities, how many have a plan, some idea of the extent of that plan, and who has seen it. Is it at the start, the middle, or is it finished? If they have a plan, has it been tested? Have they ordered supplies?

We have been to communities where they didn't even know that you could order supplies. They haven't started their plans. If they do have supplies, it's not good enough to get a box of supplies with no labels.

The Chair: Dr. Duncan, it's a five-minute round. Could the minister answer those questions?

Ms. Kirsty Duncan: Absolutely.

The Chair: Minister Aglukkaq.

Hon. Leona Aglukkaq: There are a lot of questions in that.

There were some attempts to slow down H1N1 early on. As you know, we discovered H1N1 in April, four or five months ago. As we were dealing with H1N1 we were learning about H1N1, about who it was hitting. The international community was dealing with the same issues—what it is, how it's spread, why it's affecting. All of this information gathering has helped us to respond in terms of how to slow it down, such as washing your hands or coughing into your arm. Those are the things that we had communicated as well.

● (1400)

Ms. Kirsty Duncan: May I interrupt, please, Minister?

We know from the WH report that where containment was tried, it did slow down the spread of the virus. I can provide the date of that report. We've made no attempt here in Canada. While that would have been difficult in Canada in the big cities, in widespread communities there was a possibility.

The Chair: We're running out of time, so could we let the minister please finish the questions?

Dr. Butler-Jones, would you like to answer?

Dr. David Butler-Jones: Yes, just quickly.

We know that early treatment clearly works. On the question of going beyond that, again, there are very mixed views on that. We're actually doing some potential research to better understand that and other uses of antivirals, for example. Clearly the distancing, etc., the kinds of things we've talked about in Canada, we do believe will work.

It's interesting; when it comes to things like banning mass gatherings, closing schools, etc., we have an actual experiment between Argentina and Chile. Argentina undertook it and Chile did not, and it made very little difference in terms of the outcome and numbers of people affected. So as we move through this, we're finding out more and more what actually is practical, what is reasonable, and what works. We're trying to apply that as we go along.

Part of the reason for the ongoing consultations and the broad involvement of expertise from both the science side and others...and next week's meeting will focus on the most severe cases: who is it, why is it, and what can we do to actually reduce that impact?

Ms. Kirsty Duncan: Thank you, Dr. Butler-Jones.

May I ask a question? Since this committee is supposed to have oversight over H1N1, are we welcome to attend next week's meeting?

Dr. David Butler-Jones: It's not a large group, but if a couple of members from the committee would like to attend, I'm sure we can facilitate that.

This is a much more formal thing, but as we did during the early part of the outbreak, I'm quite happy to host information sessions on a regular basis, sharing everything we know at any point, not just with the critics but with any member of the committee or other parliamentarians, should they wish.

The Chair: Thank you very much, Dr. Butler-Jones.

We'll now go to Mrs. Davidson....

Yes, Mr. Proulx.

Mr. Marcel Proulx (Hull—Aylmer, Lib.): On a point of order, Mrs. Chair, I'm just wondering why it is we are having this meeting in this crowded room. I pity the poor media people. I've been looking at them, and they're having to use their knees instead of tables to do their work.

Why are we not in room 237-C?

The Chair: It wasn't available. I tried to get a bigger room. This is the room that was available.

Mr. Marcel Proulx: I've just checked, and room 237-C is available.

The Chair: Well, that's what I was told.

Mr. Marcel Proulx: It's very unfortunate. The media people are working in conditions that are unacceptable.

I'm wondering if you're trying to cut them off from reality here.

The Chair: You know what? We have decided today....

You're new to the committee, and I thank you for coming today, but we're really trying to deal with the issue of H1N1. I asked the clerk to get the biggest room we could. Since you would like to hear it from somebody else, I will ask the clerk to give you the advice that I just told you.

Mr. Marcel Proulx: Thank you.

[*Translation*]

Mr. Jean-François Lafleur (Procedural Clerk): I will basically be giving you the same answer. The Library of Parliament's shop is using one of the two rooms and work was planned for the second room, when we checked. As a result, there was only one room left where we could hold a televised committee meeting, and that room was this one.

Mr. Marcel Proulx: That is extremely unfortunate.

Thank you, Madam Chair.

[*English*]

The Chair: Mrs. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you, Madam Chair.

Thanks very much, Minister, for coming back and speaking with us again on this very important issue. I know that the whole committee, as well as all Canadians, are certainly concerned about it. I'm glad to see that we are progressing as quickly as we are and as successfully as we are.

One of the things that I was really pleased to hear you say in your opening remarks, Minister, was your step-by-step rationale for going through what's happening to address the issue of the H1N1. You talked about understanding how it spreads, who are the most vulnerable, recognizing those things, and making sure there is a plan in place and recognizing what that plan is: communicating to the public, collaborating with the territories and provinces, and the international aspect of the whole thing. I think all of those things are very good, and I think they are what is going to make this H1N1 issue manageable for this country.

I certainly don't have experience in pandemic planning, but as a municipal mayor for many years, I've had many courses on emergency planning and the role of the different levels of government. I think it's critical that we are able to collaborate and that everybody understands what their role is, because this isn't a federal problem, this is a problem at every level of government. Whether it is the municipal, provincial, or federal level, I think it's something wherein everybody has to understand what their role is and they have to clearly be able to implement their role. So I think it's good that we're talking today and we're talking in particular on first nations issues and the issues as they may apply specifically to those areas.

One thing you talked about was communication with the public. Although I didn't jot it down, I thought I heard you say in your remarks that you were doing some first nations publications. If I did, could you elaborate on that and tell me a little bit more about how that's happening, and how they're being distributed, who it goes to, and how the people in the first nations areas can access those publications?

● (1405)

Hon. Leona Aglukkaq: Thank you for that.

I'll start off and then I'll pass it on to my officials.

First of all, in terms of communications since April, early on there was daily communication with the Canadian population in terms of what we were learning about H1N1. The information I had is what I had shared with Canadians on a daily basis as we were dealing with H1N1 from April on. As we learned more about it, that changed to a weekly national media release to get that type of information out.

What was key in getting the information to communities was understanding what H1N1 was. How is it spread? How can you prevent it? That information was essential in terms of developing our communication strategy as we went forward to prevent the spread of it. As we're dealing with the fall, the information that we're going to gather in Winnipeg this week in terms of studying the cases that we have seen in this country, the more severe cases, the deaths, and what some of the underlying conditions were, that will further shape how we communicate to Canadians in the fall about who should be vaccinated and, if you're in one of these risk groups, to encourage you to get the vaccination. That information is essential for the fall, in addition to the prevention piece.

The other piece is to get vaccinated. That is key in managing this process in the fall. That will play into this, and we'll be communicating it to communities through the radio stations, through APTN, as an example, and aboriginal papers.

The other thing I said to my staff is that it has to be in the aboriginal languages. We have to get the information out in a language people can read. In Nunavut it's Inuktitut Inuinnaqtun, in the Northwest Territories it's Inuvialuktun, and there are the first nations communities as well. That will be key as we go forward in the fall in developing and managing the pandemic.

Perhaps you want to elaborate in terms of which organizations receive the information on that.

Ms. Shelagh Jane Woods: I'll give you the perspective from the officials' point of view. The preoccupation of our regional offices is always to make sure that our nursing stations and the staff at the stations, whether these are run by Health Canada or first nations, have the most up-to-date information from the provinces, because we operate as though we're under provincial jurisdiction. Of course, nurses and doctors are licensed in the jurisdiction where they're working. So we make sure we're passing along or facilitating the flow of all of the guidelines and those kinds of things from provincial authorities that are absolutely critical for the medical staff to have.

In addition, at the very beginning we did a large mail-out from headquarters to first nations communities to help build awareness so they knew what was going on. Of course, we work very, very closely with the Public Health Agency in all of these endeavours. We know how important these are. And of course, we've also made first nations aware of the website, fightflu.ca, for those who can gain access.

Our regional offices take this very seriously. Their perspective, which we share, is that you cannot over-communicate, so it's much better to bombard people with legible, understandable materials than to risk missing somebody. So that's the approach we've taken.

● (1410)

The Chair: Thank you.

Now we'll go to Monsieur Dufour.

[*Translation*]

Mr. Nicolas Dufour (Repentigny, BQ): Thank you very much, Madam Chair. I would like to thank our witnesses, as well as the Minister, for being with us today.

In terms of the relationship between First Nations and the H1N1 virus, I believe the problem goes much deeper than that. Right at the outset, you indicated that there is an issue in terms of the social groups that were most affected. We are talking about people between the age of 16 and 25—the Aboriginal population is younger, on average, than the rest of the Canadian population—pregnant women and people with chronic diseases.

You mentioned something several times that caught my attention: access to water and basic sanitation in First Nations communities. Some communities—for instance, some north of the Abitibi region, in Quebec—live in third world conditions. They have an issue with access to drinking water. So, it is all well and good to engage in extensive awareness campaigns to try and prevent problems, but there is a serious lack of facilities in these communities. They do not have the basic things that would allow them to adequately protect themselves against H1N1 flu. It's fine to tell them what they have to do in terms of prevention and how to prepare themselves, but if they don't have access to those basic things, it will not amount to much.

I would like to know whether the federal government intends to do something in that area.

[*English*]

Hon. Leona Aglukkaq: I'll start off.

In terms of the drinking water, the Department of Indian and Northern Affairs has provided water to some first nations communities, and we can elaborate a bit more on that. But there are some functions that fall within another ministry, whether they be housing or roads or water. So I will have my staff respond on how we are working with Indian and Northern Affairs Canada in responding to those challenges in remote communities.

Dr. David Butler-Jones: Shelagh, go ahead.

Ms. Shelagh Jane Woods: Well, not to wear you down with all of the bureaucratic details, we are working very, very closely with the Department of Indian and Northern Affairs. We have identified some of the water issues to them and are providing our best public health advice. They make a distinction between access to drinking water and access to water; you can wash your hands in boiled water, if you have to, and that kind of thing.

They're critically aware of it. They have a plan with us to make sure that all communities will have access to the water they need before the flu season starts.

[*Translation*]

Mr. Nicolas Dufour: Dr. Butler-Jones, would you like to comment?

Dr. David Butler-Jones: We know that some communities are facing major challenges. However, the government has invested in housing construction, which is a long-term solution.

As Ms. Woods was saying, access to water in the communities falls within the purview of the Department of Indian and Northern Affairs. That is another factor in the context of this pandemic. The long-term solutions are a major challenge for everyone.

Mr. Nicolas Dufour: Madam Chair—

Ms. Shelagh Jane Woods: Could I just add something?

The Department of Indian and Northern Affairs uses cisterns, or mini cisterns, when the situation is urgent. That is a significant part of our plan.

● (1415)

Mr. Nicolas Dufour: Do I still have a few seconds?

[*English*]

The Chair: I'm sorry, you only have 30 seconds left. If you can do that in 30 seconds, Monsieur Dufour, go ahead.

[*Translation*]

Mr. Nicolas Dufour: Will there be enough nurses to deal with the pandemic, if it comes to be?

[*English*]

Ms. Shelagh Jane Woods: It's a very difficult question to answer. We will do our best.

If I understood your question well on whether we will have enough nurses, we will do everything we can. We talked about the urgent need sometimes to reallocate. We are also trying to identify and work with as many partners as possible to see if we can even use retired nurses in limited circumstances, and any help we can get, as long as we are respectful of nursing qualifications.

The Chair: Thank you, Ms. Woods.

We'll now go to Ms. McLeod.

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

Thank you for coming today.

First of all, I think we were really lucky to have had SARS and to have created the plan, which is being implemented. Of course, there's always room.... And we're fortunate to have a little bit of time to be looking at our plan and making sure things are in order.

I have a few thoughts and questions, but I think we are underestimating what's already been done. For example, in my local newspaper there were articles every day this week saying that the school board was prepared, that the university was prepared, etc. My background is in health care, and we have worked with our aboriginal communities over the last three or four years in creating pandemic plans. So we have some details, but I think we are really making great, great strides.

I have a couple of more technical questions, whether for Ms. Woods or the minister.

You alluded to transferred bands and a number of different models. Of course, some bands are completely transferred. We look in British Columbia, where within our regional health authority we have a very, very strong connection between all of our aboriginal communities and our public health system. So it would be interesting to hear if there is any difference in how Health Canada deals with the different bands, depending on the relationship. It would be nice to understand a bit more in terms of whether it depends on the on-reserve structure.

Ms. Shelagh Jane Woods: Sure, I'd be happy to try to answer that one.

We make no distinction in the case of an emergency. So when we ordered pandemic supplies, it wasn't as if we ordered pandemic supplies only for the communities where the nursing stations were operated by Health Canada. There is no distinction when it comes to that level. An emergency is an emergency, and everyone has to be well supplied. We work very closely with the transferred communities.

I think one of the things I failed to mention this afternoon is how important it is to make sure the first nations and the provinces are working together. You referenced B.C., but I know of lots of cases in all of the regions. I know Dr. Kettner is here, and we've done a lot of work with Dr. Kettner and Manitoba Health and Healthy Living with the first nations to make sure we're all in the same circle.

So the short answer—and I've never given a short answer in my life—is no, we don't treat them differently.

Mrs. Cathy McLeod: So it would actually be an interesting experiment at the end to see, in the provinces that had a more direct relationship, how the planning went. But that's for later.

I'm a nurse by background. We're talking about capacity of nurses and we talked about training home care nurses. In terms of giving a vaccine, are there not other people we can train to be immunizing, with nurses in charge of clinics?

Ms. Shelagh Jane Woods: Well, home care nurses are nurses. We're just making—

Mrs. Cathy McLeod: No, others.

Ms. Shelagh Jane Woods: Oh, others. Yes, certainly. We're combing every inventory to try to find other people, but also to find other people who can support the nurses, so that they can take some of the workload away from the nurses. Also, on the vaccine side, if you're particularly interested in the vaccination, at headquarters we're trying to form a couple of special teams from the medical personnel who happen to work with us, so that they would be able to go out to communities and help to blitz immunization clinics.

Mrs. Cathy McLeod: Obviously you use the expertise of the nurses, but many, many people can technically give a needle. So I think we have ways to build capacity.

● (1420)

Dr. David Butler-Jones: Certainly when you look across the country, each jurisdiction is a little bit different. For example, in Ontario I used to use licensed practical nurses, under the supervision of RNs and PHNs, to deliver the routine vaccine programs, and they can be mobilized.

I just got a letter from the Canadian Veterinary Medical Association. They give immunizations all the time, to a different species from us, but again, they have the skill, and with the right information, as Shelagh Jane is referencing, we have other supports there. We actually have a lot of experience with large mass clinics in different settings and having the supports there, so that the nurses can focus on what they need to do, answering questions, getting the immunizations done. There are nursing students, medical students, a whole range of people who are being looked at, and as I've heard, pharmacists included. All the jurisdictions are actually working together on how we can maximize our ability to immunize quickly, no matter where people are in the country—and clearly, isolated northern communities and others that are going to be a very high priority in terms of getting that done.

The Chair: Thank you, Dr. Butler-Jones.

We'll now go to Monsieur Proulx.

[*Translation*]

Mr. Marcel Proulx: Thank you, Madam Chair. Thank you, Minister, and thank you to all our witnesses for being with us this afternoon.

The Chair was correct when she said I have just joined this Committee, but that does not mean I am not concerned.

Minister, you said that more than 90% of First Nations communities have completed their pandemic plan. You also said that for Quebec, that percentage was 96%. Could you table that report with the Committee, Minister?

[*English*]

Hon. Leona Aglukkaq: In terms of the pandemic plans, I believe they're all posted and publicly available. In terms of the percentage where we had tested, I believe it was 96%.

[*Translation*]

Mr. Marcel Proulx: I am not convinced that it is already posted on the Internet. In fact, Ms. Woods did not seem to be at all certain that it is. So, once again, Minister, I ask that you table them with the Committee.

I have three questions that I would like to ask of the Minister, one after the other. That way, we will not waste any time.

First of all, what is the status of the information-sharing process with the provinces? Also, what is the situation as regards follow-up of results?

Second, Quebec has made a commitment to provide compensation for injuries or consequences associated with the vaccine. Since the government is responsible for approving the vaccine, can I assume that the federal government will also be offering compensation when there are injuries in other provinces of Canada, and that it will reimburse the province of Quebec?

Third, I am concerned about your meeting next week. You talked about all the public health and other experts who will be in attendance, but you did not mention general practitioners. You said there were three groups that are particularly at risk. Individuals between the age of 16 and 25, pregnant women and people with a predisposition. I obviously do not belong to the first two groups, but I do belong to the third. I will be seeing my GP on September 8. Has he been informed? Have you given briefing sessions to family doctors, and not just to the experts, so that they know what to tell their patients?

[*English*]

The Chair: Thank you.

Madam Minister.

Hon. Leona Aglukkaq: The MOU on information sharing has been signed by 12 of the 13 jurisdictions. Quebec is in the process of moving through with its signature. The MOU on mutual aid has been signed by 12 of the 13 jurisdictions, and Quebec is still working on obtaining that sign-off.

In terms of the experts I spoke of earlier, that involves general practitioners, and we'll also be consulting a number of stakeholders on that in terms of developing the guidelines as we deal with the fall. Dr. Butler-Jones can elaborate a bit more on that. It also involves individuals from intensive care units, because that particular discussion from my department is to deal with the more severe cases, how to manage those. The results of that discussion will be shared with general practitioners across the country. The idea is to assist general practitioners and health care providers in managing the severe cases in the fall.

I'll pass it on to Dr. Butler-Jones to elaborate on that.

● (1425)

Dr. David Butler-Jones: Certainly, information sharing between us and other jurisdictions has not been a problem.

[*Translation*]

There is a network linking the various authorities with respect to programs, recommendations, and the like. As the Minister noted earlier, the protocols binding the various authorities are now in place.

Furthermore, physicians, family doctors, nurses and members of other professional organizations are working with us to prepare instructions that will be passed on to members.

[*English*]

Mr. Marcel Proulx: Madam Chair, I didn't hear an answer in regard to a compensation plan.

And on a point of clarification, I understand the PMO refuses to release the particular report on the action plans.

The Chair: Dr. Butler-Jones, on the answer about compensation, could we have that? This is the first time this has come up, so I'm not aware of it.

Dr. David Butler-Jones: In terms of a compensation plan, Quebec has a unique compensation plan among the provinces and territories, and it was implemented some years ago. No other jurisdiction has implemented that since. We have a different structure in Canada, so for whatever reasons, jurisdictions have not gone down that path.

In terms of a new vaccine and issues of indemnification, we're involved with the manufacturer on that, but it is not a compensation plan.

The Chair: Thank you.

Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: Thank you, Madam Chair.

I can't believe what I heard the minister say earlier in response to my question, that first nations people should simply go out and buy what they need in terms of flu supplies. We used to have an old expression about 30 years ago that said, what if day cares had all the money they needed to raise children, and the Senate had to hold a bake sale in order to pay for its offices and salaries? I find it absolutely appalling that first nations communities should have to hold a bake sale to raise money for flu supplies.

I appreciate, Madam Minister, that you are from an Inuit community and you've seen the conditions, but it sure doesn't seem to be applied in terms of what we're dealing with today. I've been to Iqaluit and Pond Inlet and Pangnirtung and Resolute Bay, and I know how much groceries cost and how hard it is to get those groceries. There isn't a Shoppers Drug Mart around the corner. There isn't a quick way out of a community.

It just seems to make sense that you look at some of the issues around the conditions on reserves—for which you have full responsibility—especially since under your government conditions have deteriorated, poverty has grown, and people have less and less access to the kinds of supplies you're talking about.

In fact also, as I understand it, some nursing stations don't even have the ability to give out Tylenol. We're talking about basic supplies that are needed in the event of a pandemic that could hit in less than a month from now. Yet you're still telling me that people should go out and buy the supplies.

[*Translation*]

I will repeat that in French. I have given this a lot of thought, because I took part in an event to raise money to fight the flu. No community or reserve should have to raise money, or depend on charity, to cover its flu-related expenses.

[*English*]

My questions are simply these. Are you going to stop putting this lens of a middle class suburban family on the situation, start looking at the real conditions, and start addressing the needs in first nations and Inuit communities? I want to know specifically, if this thing hits tomorrow, how many reserves, how many first nations and Inuit communities, will know who to call? Can they get to a place and get the supplies that we're now trying to provide for them? Can they pick up a phone and call emergency?

The Chair: Ms. Wasylycia-Leis, could we let—

Ms. Judy Wasylycia-Leis: How do they get access to the information they need to respond on behalf of their communities?

The Chair: Could we give the minister some time to answer a few of those questions?

Madam Minister.

Hon. Leona Aglukkaq: Thank you, Madam Chair.

First of all, under this government we've increased transfers to the provinces and territories for health care by 6% again this year, which the member voted against.

The other point is that we've also transferred an increased budget for the delivery of health care to first nations communities, which was in the budget and which the member, again, voted against.

In terms of the question related to the remote communities, I know full well what it's like to live in a remote community, and there are some inaccuracies in the picture you paint. In terms of the stores, there are supplies in the stores in remote communities, Tylenol and so on.

That being said, I want to commend the communities—first nations communities, as well as the mayors in most communities—who have gone out of their way to communicate with their residents on H1N1. It takes a lot of work, dialogue, and partnering with communities to get that information out.

I also want to commend the communities that are fundraising to assist people who may not be able to afford to purchase hand soap. As individual citizens we purchase hand soap. Does the health care insurance program provide a bar of soap? That's a question we need to ask.

In terms of providing communities with the medical supplies needed to respond to H1N1, the nursing stations in every community are equipped to respond to H1N1. The question was about this kit. I have no idea what's in the kit. Even in terms of whether what's in the kit is effective, again, we can't respond because we don't know what's in the kit, nor were we consulted when that decision was being made.

Thank you.

● (1430)

Ms. Judy Wasylycia-Leis: Do I have time for one more question? No? Oh.

The Chair: Thank you so much, Madam Minister.

Could we call to order for just a minute? This has been going so well up until now.

Madam Minister, I want to thank you so much for coming today and answering the questions that are so important to all of us on this committee.

We're going to suspend for two minutes to ask the first panel to come in. This is the panel: the Assembly of First Nations; from the Government of Manitoba, Dr. Joel Kettner; the Assembly of Manitoba Chiefs; Inuit Tapiriit Kanatami; Manitoba Keewatinowi Okimakanak; and the Prince Albert Grand Council. So we'll suspend for two minutes.

● _____ (Pause) _____

●

● (1435)

The Chair: Please could we get started now. We do have a lot of business to go through today and a lot of wonderful opportunities to speak with our very learned witnesses.

I want to welcome our esteemed guests: Dr. Joel Kettner, welcome; Grand Chief Ron Evans, it's so nice to see you today; Glen Sanderson; Gail Turner; Elizabeth Ford; and of course, our very distinguished Grand Chief Sydney Garrioch.

Because we have a variety and quite a number of guests, I'm going to start with the Assembly of First Nations. Do we have the Assembly of First Nations here?

There are some witnesses missing. One group is missing.

A voice: Mr. Atleo is not here.

The Chair: Okay. I'm going to start with the Assembly of Manitoba Chiefs, Grand Chief Ron Evans. You have three to five minutes for a presentation.

We're going to have each of the presenters give a presentation of three to five minutes. When you see the light go on, you'll know that you're getting near your time. Then we'll go into the questions and answers.

Grand Chief Ron Evans, would you please begin?

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

Good afternoon. My name is Ron Evans. I'm the Grand Chief of the Assembly of Manitoba Chiefs. I would like to thank the standing committee for the invitation to be here to speak on this very critical issue that has had a significant impact on the first nations of Manitoba.

I'll like to introduce Glen Sanderson. He's the senior policy analyst at the assembly who is our lead on this H1N1 issue.

I've been asked to relay regrets from Chief David Harper, who was supposed to be here today. His mother had a heart attack. He had to be with his mother, of course, and he sends his regrets, so that you'd know.

The Chair: Grand Chief, of behalf of myself and the committee, would you please relay our hope that she'll get better very soon, and our understanding? We certainly look forward to seeing him sometime in the future. Thank you.

Grand Chief Ron Evans: I'll do that.

The H1N1 virus is a world health threat that is affecting Manitoba first nations disproportionately in comparison to the general public. This is due to poverty, lack of access to home medical supplies, lack of access to health care, the lack of information about H1N1, overcrowded housing, and a lack of access to running water. Overcrowded living conditions are breeding grounds for the rapid spread of an airborne virus.

A second wave of the H1N1 virus is poised to devastate our communities. The Manitoba first nations have completed training on an incident management system to enable us to respond in a coordinated manner to the H1N1 threat and to act as nerve centres for each first nation. They will respond to local emergencies and will prepare for the fall flu season in respect of pandemic planning.

As an educational campaign, we printed and distributed H1N1 posters to 17,000 first nations homes and businesses in Manitoba. On June 24, 2009, under the direction of the AMC executive council, I requested that all Manitoba first nations declare a state of emergency on the H1N1 pandemic. This was done to ensure the safety of all first nations citizens during this upcoming crisis and to hold governments responsible and accountable for taking the necessary measures to fulfill their fiduciary responsibility towards first nations.

There is abundant reason to be concerned about the H1N1 virus threat in Manitoba, where 62% of the first nations population are under the age of 25. We know that the average age of confirmed H1N1 is from 12 to 17, that the average age of death is 22, and that 52% of those hospitalized were under the age of 19. We also know that pregnant women are the highest at risk and are four times more likely to be hospitalized.

In the first wave, we were ill prepared to deal with the impacts of the influenza. Our nursing stations reached surge capacity almost immediately. Thirty-seven first nations communities have health centres that do not provide any primary care. The nearest primary care is, on average, an hour's drive away.

In the last four months we have encountered challenges and obstacles while putting an intervention plan in place. On training, for instance, INAC and FNIHB were non-responsive to requests to train managers to set up the incident command centres until media reported that MKO had gone ahead with the training without any help from the federal government. We are continually stonewalled by tight-fisted financial decisions that ignore crown fiduciary responsibilities for health care. FNIHB, for example, delivered instructions to use health dollars for pandemic operations when they were already earmarked for other essential services.

We are discouraged by how quickly governments stepped up to prop up the hog industry from revenue losses because of the words "swine flu", and then dragged their feet when we needed help. It takes extensive and necessary discussions and continual interventions at many different government levels to determine precisely who and what agency has the respective jurisdictional responsibility and, in some cases, the simple willingness to act in these important matters. As with all other jurisdictions in Canada and, for that matter, the world, we await the availability of a vaccine, but we are very concerned that the flu virus may well occur before the vaccine is widely available.

As a first line of defence, we have developed a medicine kit against H1N1, which the province and corporate partners are stepping up to pay for. We would like to think that the federal government would support such well-thought-out actions as opposed to raising both explicit and implicit criticisms and barriers. We have come to the conclusion that our best preparations may fall short of what is required, particularly because of our unique situation where many of our communities are remote and very poorly equipped.

● (1440)

We are absolutely amazed that the Government of Canada, even though it has a well-developed plan called "Annex B" for dealing with the unique situation as it relates to first nation communities, has not chosen to implement that plan. That particular lack of action is, in our view, totally unconscionable. My overarching concern in the matter of the H1N1 pandemic is that we are not ultimately addressing the very conditions that make first nations populations high risk.

As an economic factor, it is widely recognized that the maintenance of good health is more affordable over both the short and long term than dealing with chronic illness. Therefore, why is it that first nations continue to face the substandard community realities that have long been identified and well documented? Why are we not dealing with the physical conditions that simply continue to worsen, further increasing the risks of this particular pandemic, not to mention the already-present high risk factors of illnesses such as diabetes and obesity? What better opportunity is there to finally address the pervasive issue of living conditions on first nations communities than by addressing such a serious health issue?

It is entirely clear to me that the cost of dealing with these identified conditions of risk in a proactive manner would be an excellent investment in the present and future health of first nations. This investment would also address once and for all the treaty responsibilities of the Government of Canada with respect to the very unequal living conditions of first nations and ensure equality of access and resources over the long term.

Ekosani. Meegwetch. Masi-cho. Wopida. Thank you. *Merci beaucoup.*

● (1445)

The Chair: Thank you so much, Grand Chief.

We have with us National Chief Shawn Atleo. Welcome. We're very honoured to have you here.

Would you be so kind as to give your presentation now?

I would ask that all witnesses please stay within the five minutes, because we're very anxious to ask you some questions and get your feedback.

Thank you, Chief.

Chief Shawn Atleo (National Chief, Assembly of First Nations): Thank you, Madam Chair.

To members of the committee, thank you for the privilege of appearing here. I appreciate the vigorous focus on something so important. As has already been articulated here today, we're talking about the lives of people.

Grand Chief, I echo the sentiments; please pass them on to the chief. Our prayers are with the chief and his family.

I want to begin by recognizing, respecting, and supporting the grand chief's comments, in particular as he finished off, with an acknowledgment of the importance of the treaties. They were always about mutual recognition and respect, about living in harmony with one another. This issue, H1N1, is bringing light to, as the grand chief said, the opportunity for us to rethink how it is we view one another and work together.

In support of what the grand chief has said, perhaps I'll add some comments on the part of the Assembly of First Nations.

I very much see it as our role, the role of the office of national chief, to support the chiefs in their efforts and to recognize that they are the ones whose ancestors signed treaties. They're the ones who hold title and rights.

Grand Chief Garrioch, when I travelled up to see you in northern Manitoba, the first thing the chiefs talked about at the meeting you were hosting was H1N1. They were deeply concerned about the health and well-being of their families and their communities.

Really, this is a conversation about how we can bring sharp focus and attention to the health and well-being of our people in our communities and to make sure there is a timely response to the issue of H1N1, which, as we head into the fall, will be increasingly important. This is why I'm appreciative of the committee bringing us all here together.

I had expressed my concerns, reflecting much of what the grand chief has expressed to the minister, and asked that we do meet. I was pleased that we did have a fulsome discussion with the minister this morning. We were talking about a number of issues, principally around the recognition of jurisdiction of first nations to care for their people, much of what the grand chief has described.

We know there are other examples out there, including that of tripartite arrangements, where the various jurisdictions, first nations and other levels of government, have the opportunity to work together to respond to the issues, as opposed to just having unilateral decisions being taken or solutions being brought in.

I think the principal message that I want to share with the committee is the idea of jointly responding to these issues, the idea of joint policy analysis, jointly arriving at the data and the information, particularly as it pertains to recognizing first nations as a priority. I think if there's one strong message that I want to bring forward—this comes from the chiefs I just met with yesterday, and it's shared by chiefs across the country—it's that we firmly feel that while we are addressing issues of the scientific analysis, importantly, we need to look at this through the full lens here of the social indicators of health. That includes first nations issues like the ones I heard being talked about, water and other factors. This is going to require full partnership and recognition of the jurisdiction of first nations, that we have treaties.

We have some examples. In the B.C. tripartite situation, there was joint communication occurring. Perhaps these sorts of examples need to be contemplated as far as how we work together. Clearly the resources need to be there as well for this sort of work to occur.

The joint development of national guidelines is something that I want to table to the committee as being important and needed.

These are all points, by the way, that I also tabled with the minister. I suggested very strongly that first nations jurisdictions need to be recognized. The issue of the high rates of pregnancy, the particular vulnerability that the grand chief alluded to—these are elements that this country, this committee, needs to pay particular attention to. We're talking about the lives of individuals here, and extremely vulnerable people within our society and within our community. There's a need for full collaboration and transparency in this effort.

● (1450)

When I spoke to the grand chiefs when we were meeting, I heard disparities in information. Disparity in information about what is actually happening on the ground is not helpful. It raises fear, it raises anxiety, and it puts mistrust between people in the relationship. I believe our people require us to be demonstrating much better leadership than that. I believe we received the commitment from the minister to follow up and work much more closely, and this is something that grand chiefs need to talk further about as to exactly how we would execute that.

Last, the idea we tabled was that we have a national exercise of some kind rather quickly to make sure that we bring focus and attention to this. To conclude, what the grand chiefs said was that while absolutely this is a crisis—it's in front of all of us, and you heard the call for declaring a state of emergency—we need to turn this crisis into an opportunity to talk about what's not working in the system more broadly, to make sure that we talk about the link to the broader social determinants of health, which include water and the need for proper education and educational facilities, and most importantly, the recognition of first nation jurisdiction and of the sacred treaty relationship.

I'm very pleased that Dr. Barker is here today. We've asked the minister to make sure that the H1N1 first nation adviser who has been put in place work very closely with our Assembly of First Nations health adviser, and there has been a commitment to that process as well. So Dr. Barker is here also to offer any thoughts as this conversation ensues.

Thank you once again.

The Chair: Thank you very much, National Chief Atleo. It's an honour to have you here, and the grand chief as well, and all the representations from the aboriginal community.

This committee is here to listen and to ask you questions.

We're going to go on to the Prince Albert Grand Council, represented by Vice-Chief Don Deranger and Chief Bart Tannsie. Welcome.

As well, we have Mr. Sanderson. Welcome.

Who is going to be presenting?

Thank you, Vice-Chief Deranger.

Chief Don Deranger (Vice Chief, Prince Albert Grand Council): I have with me Chief Bart Tannsie, from the Hatchet Lake Denesuline First Nation. I guess I'll be speaking.

I want to say good afternoon to you, Madam Chair and members of the committee. I'm Don Deranger, vice-chief of the Prince Albert Grand Council.

I want to thank you for giving me the invitation to appear before you to address the concerns, preparedness, and response plans for first nations of the Prince Albert Grand Council on the H1N1. I just want to brief you a little bit about who we are.

The Prince Albert Grand Council consists of 12 first nations, representing approximately 35,000 members and 24 communities. The 12 first nations are divided into two and four sectors: the first sector, the one far north, the Athabasca Denesuline sector, the Swampy Cree, the Plains Cree and Dakota nations, and the Woodland Cree.

The Prince Albert Grand Council also occupies four treaty areas, Treaties 5, 6, 8 and 10. The land base of Prince Albert Grand Council area is approximately 100,000 square kilometres. This area is located in the greater part of central and northeastern Saskatchewan. The Prince Albert Grand Council is one of the largest tribal councils in western Canada, and we have isolated communities in our jurisdiction as well.

Since the arrival of the H1N1 flu virus, the Prince Alberta Grand Council and its communities have been busy dealing with the challenges associated with this. We have been quite fortunate thus far as we have had no fatal cases in our PAGC communities. With the flu season upon us and the medical experts predicting the next wave of the H1N1 to be this fall, we at the Prince Albert Grand Council are doing our best to prepare our communities with the best possible pandemic plans; however, to assist our communities and to ensure the plans developed are effective, there are a number of issues we need to reflect to ensure that our communities can sustain themselves during the outbreak of the H1N1. These issues include, one, the lack of additional financial support; two, nurse recruitment and retention; and three, the sustainability of programs and services.

The lack of financial resources. The population in each of the Prince Alberta Grand Council communities increases significantly on an annual basis without being reflected in the administration funds. Population and financial increments are lagging, which puts many of our communities at a disadvantage right from the start.

The meagre annual 3% increase does not even begin to address the health issues and the demands that our communities face each year. The Prince Albert Grand Council is expected to prepare for the H1N1 with these limited funds and carry out the day-to-day administrative programs and services, purchase expensive medical emergency supplies and stockpiles of essentials, retain health professionals, etc. Over the past six years, the Prince Albert Grand Council communities have been preparing, with the assistance of NITHA , the third-level service provider, pandemic plans that would assist communities in being prepared for the H1N1 flu outbreak. In that sense, we are fortunate; however, there is still the underlying fear of running our already financially exhausted budgets to a stage where financial recovery will be a burden long after the H1N1 virus has made its mark.

The federal government needs to acknowledge the fact that this issue is long-standing and needs to be addressed before we can expect our communities to have adequate and effective plans in our communities.

Nursing recruitment and retention. The Prince Albert Grand Council communities continue to struggle with the retention and recruitment of our nurses in our communities. Nurses working in first nations communities are not treated fairly when it comes to financial compensation. Nurses working for the provincial system receive substantial increases and incentives that draw them out of our communities because we cannot compete with the provincial pay scales. The federal government has not recognized the fact that we do not receive any additional resources to compensate nurses working our communities.

● (1455)

The lives of our members will be jeopardized because we will not have the medical professionals in our communities to assist when the H1N1 outbreak arrives in full force. The lack of nurses is a major issue that needs to be addressed because of how it affects how well we are prepared to take care of our people during the outbreak. It is a critical issue that needs to be acknowledged and can no longer be ignored. We need to address this issue before the outbreak is upon us.

An example of the nursing crisis we face in some of our communities is that there are service contracts being set up with emergency medical service providers. They contract nursing personnel from far and wide just to have the coverage in a community for the weekend. Nurses are becoming stressed out and end up going to work for the province because we cannot compete with the provincial nursing pay scale.

The final issue I want to bring forward is the sustainability of programs and services. The expectation that the Prince Albert Grand Council communities must continue to operate, develop, and plan for the H1N1 flu outbreak on the existing budgets and resources is no longer acceptable. Additional resources are needed to be able to sustain the existing programs and services in our communities. The Prince Albert Grand Council has developed its own contingency plan for where areas of critical response may be required and how we will respond to the communities that will experience cases of the H1N1. Due to provisions of additional second levels in nursing, training, education, and prevention, assistance in the development of pandemic plans has been extremely beneficial and rewarding in terms of keeping the spread at a very low rate. Pandemic planning in our communities has been ongoing for the past six years or more and continues to be a priority with the Prince Albert Grand Council.

In all, with the exception of the three areas identified, the Prince Albert Grand Council has taken a very keen interest in making sure that our communities are prepared for the H1N1 flu season. It is hoped that there will be positive response from the federal government to recognize our needs.

● (1500)

The Chair: Thank you so much, Vice Chief. I appreciate your comments.

Now we'll go to Sydney Garrioch, the Grand Chief of the Manitoba Keewatinowi Okimakanak.

Grand Chief Sydney Garrioch (Grand Chief, Manitoba Keewatinowi Okimakanak): Good afternoon.

On behalf of the 30 first nations and 62,000 citizens of northern Manitoba represented by MKO, I thank you for the opportunity to take part in your expert panel on H1N1 preparedness and response of aboriginal and Inuit communities to the H1N1 virus.

I wish to point out an alarming trend that occurred within our region during the first wave of the current H1N1 pandemic. According to the Public Health Agency of Canada, on July 15 there were 151 first nations laboratory-confirmed cases nationwide, and 139 first nations laboratory-confirmed cases were from Manitoba. According to Manitoba Health, on the same date, 125 first nations laboratory-confirmed cases were from northern Manitoba, or the MKO region. As of August 6, 2009, there were 133 laboratory-confirmed cases from our region of northern Manitoba, and there were two recorded deaths, with one questionable death involving the loss of a child to a pregnant mother who was confirmed with H1N1. The severity of the H1N1 impact in the MKO region is illustrated by known statistics.

The alarming trend in our region is in fact a "cluster", as defined by the World Health Organization. This cluster should have alerted First Nations and Inuit Health Branch and Public Health Agency of Canada to the severity of our situation, and these organizations should have been prompted to respond according to the mandate of the National Office of Health Emergency Response Teams, whose goal is "to train and certify Health Emergency Response Teams across the country, and to ensure that they are ready to be deployed on a 24-hour basis to assist provincial, territorial or other local authorities"—our emphasis—"in providing emergency medical care during a major disaster."

We are concerned that our first nations are being left out of the scope of the emergency response protocol of the Public Health Agency of Canada, since there has been no reaction from them to date in the MKO region, other than in the Island Lake region in response to political pressure, despite a similarly high incidence of H1N1 in other communities.

Funding and human resource response levels to date provided by First Nations and Inuit Health on pandemic preparedness have proven wholly inadequate, with unrealistic expectations. Since 2007, MKO has received $375,000 for consultation and training with our first nations in pandemic preparedness. The three tribal councils represented within our organization received a total of $72,000 for pandemic preparedness. Our first nations have received nothing.

When one considers the vast geographic area to be covered in the provision of consultation and, most recently, planning assistance to our first nations, the human resources that can be dedicated under such limited funding regimes leaves the coordination, planning, and implementation of community pandemic response plans and related training out of our grasp. The MKO region covers two-thirds of the province of Manitoba, with 16 of our first nations accessible by air only. In short, the federal government has not prepared to respond to the current pandemic as it concerns our citizens.

It is inconceivable to complete the first-nation-specific community pandemic response plans with no new local funding available and sporadic regional funding for tribal councils and MKO and the unrealistic timeframe of two months, as First Nations and Inuit Health publicly stated on May 29, 2009. In comparison, the Burntwood Regional Health Authority, funded by the Province of Manitoba, received in excess of $60 million per annum and continues to develop its pandemic plan.

To further highlight First Nations and Inuit Health's lack of preparation, the Manitoba regional director general issued a letter on June 17, 2009, advising first nations that an arrangement may be negotiated to divert program resources, as an interim measure, to address influenza outbreaks. This is ridiculous, as it asks first nations to defer desperately needed programs to support presently unfunded pandemic planning. There is no long-term strategy at this time. MKO had to divert its funding from the aboriginal health transitions fund adaptation envelope to help communities respond, through education, awareness, planning support, research, media analysis, and policy development.

● (1505)

MKO employees have met with the regional health authorities—the Burntwood, Nor-Man, and Parkland authorities—to determine their response to first nations' pandemic planning and preparedness needs. To date, only the Churchill Regional Health Authority has produced and shared a pandemic response plan with MKO. Others have done internal planning, but generally have not involved first nations directly, except when political pressure is applied. MKO trained incident managers from each of our 30 first nations on June 22 to June 25.

There are no first nations community pandemic plans that have been tested. Only two first nations out of the 30 have completed their community pandemic plans.

Several of the incident managers who were trained have quit functioning due to the complexity and magnitude of the tasks involved, with all of them citing the fact that the role of incident manager is a voluntary position, as funding is not available for it from existing programs and services.

A dedicated human resource response is required, where all of the agencies involved collaborate with first nations on a community-by-community basis. This, together with a long-term funding commitment for local health emergency planning and preparedness, is needed immediately to ensure that pandemic plans are not only completed but are also thorough and comprehensive. Right now, communities are overwhelmed and don't have the support they need to at least feel prepared.

MKO has submitted a modest proposal to the Minister of Health, geared to the planning and preparation for health emergencies. Separate contingency funds should exist to be released to cover the implementation costs of actually responding to health emergencies. The proposal to the Minister of Health is only for the immediate needs to combat H1N1, apart from the long-term needs for adequate housing, safe drinking water, and access to quality health programs and services.

This expected funding will allow first nations to develop comprehensive community pandemic and health emergency plans. MKO and the tribal councils will be able to assist community pandemic planning coordinators with research and policy analysis, as well as education and awareness, in developing their plans and preparing their communities for implementation. MKO will also have the capacity to create regional plans and conduct policy research and analysis on regional, provincial, and national levels. We maintain at MKO that health is a treaty right.

Clearly, a new and more in-depth approach is required, one that brings together all levels of government in full partnership with first nations governments to ensure that the health and well-being of our citizens is maintained and enhanced through proper planning and investment in the determinants of health, and readiness to respond to any and all threats to the lives of first nations people.

MKO, on behalf of the 30 first nations and the 62,000 citizens we represent, is requesting that the Standing Committee on Health use its influence in Parliament to ensure that first nations receive adequate funding, necessary supplies, and essential services that should be available during an international crisis of this magnitude. Given our social and health conditions, MKO first nations require the necessary resources to adequately prepare and respond to this immediate threat, as well as future threats.

Thank you.

● (1510)

The Chair: Thank you, Grand Chief.

We will now go to the Inuit Tapiriit Kanatami. Gail Turner is the chair of the National Inuit Committee on Health, and Elizabeth Ford is the director.

Who would like to make the presentation?

Ms. Gail Turner (Chair, National Inuit Committee on Health, Inuit Tapiriit Kanatami): I will be speaking.

The Chair: Thank you, Ms. Turner. Please proceed.

Ms. Gail Turner: [*Witness speaks in Inuktitut*]

Good afternoon. I wish to thank the Standing Committee on Health for the opportunity to speak today representing Inuit Tapiriit Kanatami and the Canadian Inuit on the issues of H1N1 and its impact on us.

I am an Inuk public health nurse currently working as director of health services in Nunatsiavut, northern Labrador, and the current chair. I speak from a place of knowing.

Inuit Nunangat, our Arctic homeland, comprises 40% of Canada's land mass and 50% of its coastal shoreline. We number only 50,000 people living in 53 remote and isolated communities across the north. Most of our communities have no roads or hospitals, doctors or pharmacies. We live with significant issues of overcrowding, which creates an environment for disease spread and challenges the ability to reduce the risk to others. We have very poor general health and a much lower life expectancy than other Canadians.

We have a huge generational divide, with 35% of our population under the age of 15, compared with 18% for non-aboriginal Canadians. Young people and pregnant women, two of the high-risk groups identified for the current circulating H1N1 virus, are highly represented among Inuit. For the pregnant Inuit women, the risks are increased by having to travel in their last few weeks before delivery away from family and familiar health care providers to larger centres where they may be in communal accommodations.

Inuit fear H1N1, a fear generated not by media attention but rather by the very real history of the impacts of previous pandemics on Inuit. In Okak, northern Labrador, where I live, the Spanish flu wiped out nearly the whole community in a matter of days. Inuit are aware as well of their vulnerabilities created by geography, weather, and co-morbidities. Not for us the comfort of knowing that access to health care is nearby. As wonderful as the nurses are in the clinics in our communities, should we fall ill and our condition worsen, there must be a plane to the next level of care, and that is totally dependent on the weather.

The Canadian pandemic plan does not specifically address the unique issues pertinent to pandemic planning in Inuit regions as it does for first nations on reserve. In fact, it does not give the attention warranted to remote and isolated communities in Canada where guidelines created do not fit and use a language that is full of false assumptions and hints of colonial bureaucracy. In June the board of directors of Inuit Tapiriit Kanatami met in Nain, Labrador, and passed a resolution calling for an Inuit-specific appendix to the Canadian pandemic plan. They consider that given the high risks for contracting H1N1 and other viruses, having a pan-Inuit strategy would be an important step in the prevention and management of current and future pandemics.

The challenges for planning for Inuit are further complicated by jurisdictional issues, with land claims in two territories and two provinces and the lack of clarity around the role of Health Canada and the Public Health Agency of Canada. The relationships between federal, territorial, and provincial governments reflect the changing nature of politics and require a more concentrated focus on the people they serve. We have heard back from Dr. Butler-Jones a willingness to begin discussions of such a plan, and we are aware that this will not be until the pandemic is over.

In the interim, we are working on a trilateral work plan for H1N1. The plan must be written by us and not for us. Inuit must be engaged so that what is written is culturally relevant, and we can take our realities and include what we have learned from our journey with H1N1 and our pandemic planning efforts to date and create a meaningful document that can guide us in the future to the level of preparedness that we deserve.

● (1515)

Our human health resources are a great concern. We have communities where there is only one nurse, and his or her priority will have to be the provision of primary care. The logistics are daunting. With both staff and supplies having to be flown in, and the vaccine itself protected against the extreme temperatures that we face in the Arctic, by the time this vaccine is ready, we cannot be efficient. Immunizing a community of 250, given our resources, could take several days once you factor in the flight schedule and the weather.

Consideration must be given to support access to the vaccine for Canadian Inuit. We cannot change the social determinants in our immediate future. Right now, vaccine is our only defence against spread. We have no capacity for alternate care sites and will have to use home isolation.

The Chair: I'm going to have to interrupt you. We are running out of time. I've given you overtime now. Could you please wrap it up so we have time for questions and answers?

Ms. Gail Turner: Thank you.

I beg your indulgence, but I would like to continue just for one more minute, if I could, please.

The Chair: For 30 seconds, because you're way over.

Thank you.

Ms. Gail Turner: I'll move on to speak to some of the challenges, and then I'm into what we're calling on this committee.

I'm appalled, on a daily basis, at the lack of knowledge by bureaucracy at all levels in this country on who Inuit are and where and how we live.

In closing, Inuit Tapiriit Kanatami and the Inuit of Canada call upon the Standing Committee on Health to support the creation of an Inuit-specific annex to the Canadian pandemic plan, support the mass immunization of the remote communities as high priorities once the H1N1 vaccine is available, and begin the very serious work of addressing the social determinants of health that keep Inuit in Canada on the bottom of the health status scale.

Food security and access to health care must be improved. There are significant issues of social injustice that must be addressed. Canada must set target dates for the reduction of the number of persons living in a household until it resembles that of the average Canadian. The life expectancy of the Inuit should be rising, not falling, as it continues to do so.

At the end of the day, Canada will be judged on what efforts are made to improve health for all, and in particular for Inuit.

Nakurmiik.

The Chair: Thank you so much, Ms. Turner.

I'm going to ask all of you to please submit your presentations, and we'll see that each member of the committee gets a copy of each of your presentations.

Now, last but not least, we're going to hear from Dr. Kettner.

Dr. Kettner, perhaps you would be so kind as to make it brief, because we want to get into the questions. I have been generous with the presentation times because I thought it was so important to listen to this.

Thank you.

Dr. Joel Kettner (Chief Public Health Officer, Government of Manitoba): Thank you.

I'd like, first of all, to thank you for inviting me to attend this meeting on this important topic.

I'm going to say three things. One is that I want to be clear what my role is here. That's the first thing I want to briefly talk about. Second, I want to talk—very high level—about what we've learned in Manitoba from the first wave of the pandemic. And third, I'll talk about what I think are the key things going forward.

First of all, just so it's clear, I'm the chief public health officer of Manitoba. I'm here to speak to this very specific question that's on the agenda. I'll do that on my own behalf, as the provincial public health officer. I'm not here speaking on behalf of my deputy minister, minister, or government. And I'll do the best I can to speak truthfully and clearly with facts and opinions, as I'm asked.

Regarding our experience in the first wave, it looks as if it's probably mostly over with in Manitoba. The first point is that overall the pandemic was not as bad as some people feared it would be; however, some groups in Manitoba were more severely affected than others, not the least of which were our first nations people and other aboriginal people. I could give a lot of statistics and numbers, but I won't do that. I think those are pretty much known.

It's important to point out that from our analysis so far, even when accounting for many other of the known risk factors, it still appears that being a first nations person or an aboriginal person is a marker of risk for severe disease. Of course there are lots of reasons for why that's true, and I'd be happy to entertain that discussion if there are questions and if there's time.

Moving on to the third part, is the next wave going to be worse? Many experts think it may be. We have to plan for that possibility as well as for other possibilities. In Manitoba there are three issues we need to be aware of and plan for. The first is to prioritize aboriginal people for early use of the vaccine when it's available—presuming it's effective and safe—as well as early use of antivirals and early treatment for people, simply because we know they're at high risk by being aboriginal, regardless of what all those reasons might be.

The second is that we need to strengthen and improve our public health and primary programs and services for aboriginal people, wherever they live in Manitoba. They need better coordination and they need better integration. And that work needs to continue and improve more quickly than it has, through collaboration of aboriginal people, federal government agencies and organizations, and the provincial health department and its regional health authorities.

The last point, but not the least important, is that although we're battling influenza in this conversation, the long-term effective strategies and actions for public health to address the public health issues and health outcomes for aboriginal people require addressing the underlying social determinants and many other long-standing reasons for the poorer health outcomes that we've observed in people of aboriginal descent, not only from infectious diseases but for practically any health outcome that we measure.

● (1520)

The Chair: Thank you very much, Doctor.

With the indulgence of the committee, I'm going to ask, with your approval, that we go to our first round, a five-minute question and answer, because we do have another panel. I was very generous with the presentations. I thought we all should hear these very important presentations.

Do I have the agreement of the committee that we go into a five-minute round?

Some hon. members: Agreed.

The Chair: Thank you very much.

We will begin with Dr. Bennett.

Hon. Carolyn Bennett: Thanks very much, Madam Chair.

I thank all of you for your presentations. I do apologize.

I do think, Madam Chair, we could have started much earlier today. It would have been much better to have a longer time with this panel in particular. In the future, I hope we can do better for the people who have come all this way.

That being said, I think their presentations were pretty well self-explanatory—that this is a very dire situation.

First, I want to apologize to Ms. Turner that I didn't word my question to the minister properly. I can hear from you that you do not want the general pandemic plan translated into Inuktitut; you want a commitment from this government to work with you to make sure there is a separate Inuit annex.

I was wondering, with the indulgence of the committee, if we could have all-party consent to ask the minister to help with that right away, because I don't think the question was asked. You can sort out how we'll do that, but we want to help in whatever way we can to make that a priority.

The second question is for the national chief, and for anybody else here. Are you aware if the aboriginal leaders in Canada have been included in the federal-provincial-territorial health ministers meeting in September?

● (1525)

The Chair: Who would like to answer that?

Chief Shawn Atleo: I am not aware of an invitation. Not that I'm aware of.

Hon. Carolyn Bennett: Do you think it would be a good idea if you were included?

Chief Shawn Atleo: Absolutely. It would be absolutely necessary.

As you say, some of these things speak for themselves, the inter-jurisdictional nature in particular, and the grand chief made reference to the issues in Manitoba and Ontario with resource planning. In my earlier remarks, I made reference to the tripartite notions as being a way of making sure these issues do not fall through the cracks. So I think if this committee can bring some focus and attention to encouraging jurisdictional efforts to be undertaken, I think that would be incredibly important.

Hon. Carolyn Bennett: I guess one of the things that are very important to us as parliamentarians is when two witnesses say pretty well the opposite.

I would like Regional Chief Garrioch to explain how many of his communities have a pandemic plan that has been revised and brought up to date with this particular H1N1 outbreak and has been tested.

Grand Chief Sydney Garrioch: Only two communities in northern Manitoba can be classified as having completed plans, but none of these have been tested.

Hon. Carolyn Bennett: Again, I would ask, how do you report to First Nations and Inuit Health Branch on preparedness? Is that by e-mail? Is it by teleconference, where somebody says, do all of you have your plans? Is that what's happening? Or how is this working, that these numbers can be so different from Shelagh Jane Woods' numbers, that 90% of first nations communities across Canada have a plan?

The Chair: Who would like to answer that?

Grand Chief.

Grand Chief Ron Evans: Actually, I share with the other presenter, Ms. Turner, how appalled she is about the lack of knowledge the minister has, how the minister's office and those working under her authority fail to inform her of the state of first nations and aboriginal communities.

She asked about what's in the flu kits, but we have met with her regional office to share with her—and it has been in the media—what's in the kits, what they cost, and what they're for. To say to the communities that all they need is a bar of soap and everything is going to be fine is not acceptable. We're going to need more than that.

Hon. Carolyn Bennett: You're going to need water.

Grand Chief Ron Evans: In order for that to happen....

When I say there's lack of knowledge, many of our communities also have high unemployment rates and poor and overcrowded housing. It's not only overcrowded housing, but those houses are also in a state of disrepair, so it's going to become—

The Chair: Thank you, Grand Chief. I'm sorry, but I'm going to be really tough on time.

I'm going now to Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Thank you, Madam Chair.

As I was listening to all the presentations, I had the very definite impression that we are dealing here with a persistent and ongoing problem. Today we are talking about the H1N1 flu virus, because that is the greatest risk facing the communities this fall.

However, as Chief Evans was explaining, living conditions in your communities are such that they run the risk of being seriously affected by this disease, as well as others. There is reason to wonder today why action has not been taken to improve those living conditions over time. That would have meant that, in dealing with a possible H1N1 pandemic, the communities would have been better equipped at the grassroots level to deal with the situation.

A littler earlier, my colleague was asking officials what the current situation is with respect to access to water. At this time, it is expected that tanks will be delivered to certain communities that do not have access to water. That resolves one issue at a very specific moment in time, but it does not solve the long-term problem. And, it is a problem that can become critical when we are talking about a disease that is likely to affect the community.

Ms. Turner said that, in the short term, the only tool available to them to deal with the H1N1 virus is the vaccine. As for the other issues, unfortunately, it is too late to deal with them before the fall. Is it your sense that, right now, the real priority is to ensure that everyone has access to the vaccine?

● (1530)

[*English*]

The Chair: Who would like to answer that? We only have two minutes left.

Grand Chief Ron Evans.

Grand Chief Ron Evans: Yes, I would agree that we do need vaccines, but more importantly, we need to ensure that the plans can be tested. We don't have a plan that has been tested. We don't know what to do with transportation if there are no supplies and weather is poor. What happens if we need additional space because of the lack of infrastructure? What do we do if we need more nurses or more physicians? We have not tested any of these plans simply because we don't have the resources to do so.

The Chair: National Chief Atleo.

Chief Shawn Atleo: I think this is a really critical point. It's about not always looking just at treating the symptoms when the underlying causes are being avoided. It's that notion that wealthy is equal to healthy, more generally. And building on the grand chief's comments once again, it's also important to recognize that we would be having a similar conversation, I would expect—I would be looking to the experts to confirm—if we were talking about third world countries. Well, this is in Canada, and that's the reason I so strongly support all of the sentiments that have been expressed.

Also, Vice Chief Deranger talked about the PA grand council, which has been putting plans and efforts in place. What's required is to recognize that this is where good health planning can and should occur, to recognize the treaty jurisdiction, and to make sure those efforts are recognized and supported.

The Chair: Thank you very much, Monsieur Malo.

We'll now go to Ms. Wasylycia-Leis.

Ms. Judy Wasylycia-Leis: Thank you, Madam Chair.

Clearly, we're talking about some long-term issues as well as short-term band-aid solutions to a possible pandemic this fall.

Let me start with you, Dr. Kettner. You said you thought things were progressing in terms of preparations for the possible pandemic, but that the best way to prevent the spread of this H1N1 is good health. What do you suggest we do with that, as a committee, in terms of the big issues that you and others have raised here today?

Dr. Joel Kettner: If we're talking about the pandemic H1N1 influenza, just to be clear, there is a whole set of strategies and actions that are needed to reduce the morbidity and mortality that we may anticipate from the next wave of this. Good health, being as healthy as you can, having your chronic medical conditions well looked after, knowing about measures to reduce the spread of disease, all of these things are important. And it's useful to divide them into two categories.

One is reducing the probability of getting exposed to the virus, and that has to do with crowded housing, handwashing, knowing how to conduct yourself in social settings to reduce the risk of exposing others to the virus. So there's that whole category.

But it's a different question from the question of, if you do get the flu—and we have to expect that many of us, no matter where we live, are going to be exposed to the flu; it's a very difficult virus to contain—who's more likely to have severe disease and need intensive care and die? It's a really important question. That has more to do with chronic health conditions—we've talked about that already—it has to do with getting appropriate and timely care if you are in that very small percentage of people who go on to get pneumonia or severe complications. For those people who we think we can help with early use of antivirals when they first get even mild symptoms, if they have those risk conditions, it means having access to that. And it means, on both sides of the table, an educated, enlightened public who know when to access health services and a ready health system that's there to receive them and give them appropriate care.

I could speak more about what some of those dimensions are, but I wouldn't want to oversimplify the issue to be either one of prevention or one of treatment. It's really a combination of both.

● (1535)

Ms. Judy Wasylycia-Leis: Thank you. And I think that's what Gail Turner was saying as well, that it might be too late in terms of dealing with the long-term systemic issues for this possible pandemic, but we'd sure better use our heads and start planning in the future.

Ms. Gail Turner: Can I comment?

The Chair: Yes, please, Ms. Turner.

Ms. Gail Turner: I think it varies across Inuit regions as well. I live at the top of the province of Newfoundland and Labrador, and on a good day, without H1N1, we have no capacity. We have no hospital beds; we have one anesthetist, so additional ventilators won't really help us; and of course we always have the challenge of geography and weather. We don't know yet how we are going to immunize in our communities. Because we're an Inuit land claim within a province, we don't fall under the same umbrella of service of Health Canada as many other places do. They won't be looking to send us additional resources, and so we will have to work ourselves and try to ensure that it is delivered.

Ms. Judy Wasylycia-Leis: Could I ask National Chief Atleo a question?

First of all, congratulations on your election.

The AFN has recommended funding for a task force to implement annex B, investing, as we just talked about, in first nations communities. On a short-term basis, what do you think about the idea that is now implemented in Manitoba of having a special aboriginal expert coordinating on the pandemic? The person in Manitoba is Dr. Cathy Cook, who's well respected—I'm sure that Grand Chief Ron Evans will comment on this as well—and I'm wondering about that as a national issue and a possibility. Should we do that nationally or should we coordinate with what's happening in Manitoba and Cathy Cook?

Chief Shawn Atleo: Actually, because you're talking about Manitoba, I'd like to defer to Grand Chief Evans, and if there is a moment I'll have a quick comment after.

The Chair: Actually, we're running out of time right now, so I'd ask, Grand Chief, if you would mind commenting on that for Ms. Wasylycia-Leis.

Thank you, National Chief.

Grand Chief Ron Evans: First of all, I want to thank Manitoba for doing what they're doing in terms of working with our communities. But what is needed, in the absence of implementing and working towards the long-term solutions, is to provide the communities the resources to start training whoever will be needed, whether it's the nurses or whether it's the caregivers, and the resources for putting their plans in place for the additional space they're going to need. Preparing for the worst case, that's what we need to do. We have to test those plans in terms of the transportation and how we get more vaccines and who gets vaccinated. How soon we can do all those things, that's what we need to do right now.

Thank you.

The Chair: Thank you, Grand Chief.

We'll now go to Dr. Carrie, who will share his time with Mr. Clarke.

Mr. Colin Carrie: Given the time, I think maybe Mr. Clarke may not have time with this, but if he does....

I want to say that I agree with the grand chief. I think it's very important that everyone works together and that, as these plans move forward, we do have the opportunity to make sure they're tested.

I do have a question, Dr. Kettner, because I understand the Government of Canada and the Province of Manitoba have been working very closely together on the pandemic preparedness for Manitoba first nations communities. I know that Minister Aglukkaq has had many teleconferences with her colleague Minister Oswald. During the first wave we worked together, and we monitored and were able to relocate human health resources such as nursing staff and physicians to those communities most in need. We also coordinated our efforts through tripartite planning tables with the Province of Manitoba and first nations.

I was wondering, would you agree that we do have an effective, collaborative relationship?

● (1540)

Dr. Joel Kettner: I love general questions like that.

More so than before.

Mr. Colin Carrie: Okay. No, that's good. I think it is important to —

Dr. Joel Kettner: I don't mean to be glib about it. You're asking me a very complex question—

Mr. Colin Carrie: I know it is.

Dr. Joel Kettner: —and you're asking me to distill it into a simple answer, so I will do my best.

I think there has been great progress in collaborative work between provincial and federal organizations in both preparing for and implementing the response to the pandemic plan. Has it been perfect? No. If we had more time and it was of interest, could we discuss where there are some areas that need some strengthening and further improvement? Yes. So for me, most of these questions are not a matter of yes or no, or satisfactory or not satisfactory. They're really a matter of keeping moving towards progress, because we have a long way to go before we can address problems like this.

Actually, the evidence is obvious that we have a long way to go in the outcomes.

Mr. Colin Carrie: I think that with the pandemic plan, the good news is that we do have a plan in place and we are working together.

Would you be able to describe what has been achieved with the first wave? What have we learned? What have we achieved? What successes have we had?

Dr. Joel Kettner: The first thing that happens from a public health point of view after any event like we've had is that we understand, as much as we can from our experience, who was mostly affected, who had the most severe outcomes, and how big a problem it was all around. I think we've learned a lot. We're now analyzing much of that data, and again, I tried to summarize that in my opening remarks.

I think so far it looks like, compared to what some people feared, and certainly compared to the 1918-19 pandemic, which many of us were preparing for, overall this has been much less severe than most of us expected from a pandemic. This is not comparable to 1918 so far. It's more comparable to a bad flu season of seasonal flu, with a couple of important differences. One is a higher rate of severe disease among previously healthy people in their twenties, thirties, and forties. The other is—and this is not different by quality, it's different by quantity—a higher differential of severity between aboriginal people and non-aboriginal people. The reason I say it that way is that when we have analyzed seasonal, regular influenza, just like most infectious diseases and other injuries and other health outcomes, there is almost always a differential. That was true for seasonal influenza as well. This differential, certainly in Manitoba's experience, has been more striking, wider, and more severe.

I could speak more about what we've learned about the disease, but if you're asking me what we have learned about our plans and our effectiveness and how to get ready for the next wave, that would be another conversation, which I'd be happy to have if there's time for it.

The Chair: Dr. Kettner, could we just give the national chief a chance?

National Chief Atleo, I have a sense you want to make some comments.

Chief Shawn Atleo: On the point about the health officer, respecting what has been said in the question, in British Columbia the tripartite plan did result in the chiefs—and that's important because it's a jurisdictional matter as well, it's a treaty matter—participating in supporting the appointment of a first nations provincial aboriginal health officer. He's a medical doctor, Dr. Evan Adams. He's of *Smoke Signals* fame as well, but he is a qualified medical doctor, somebody who is firmly embedded in the communities and is working side by side with them. So the recognition of the treaty relationship is given expression.

There's the notion that with H1N1 perhaps there's agreement about it being too late, as it were, to get the fulsome planning that we might all want. But it's never too late to do the right thing on the broad notion, in that we don't lose this opportunity, the focus, and that we get everything as right as is needed to make sure our people are cared for. But make no mistake about the broader piece of work. I think it would be helpful if this committee also considered that deeply.

● (1545)

The Chair: Thank you, National Chief.

We've come to the end of the first panel, and because of time, I'm going to suspend very briefly. But prior to that, I want to thank you so very much. I know we've had a lot of witnesses today. I'm going to ensure that all your presentations are sent to each member through the clerk's office.

Thank you.

I will suspend while the second panel takes their seats.

Thank you.

● (Pause) ●

The Chair: The committee will now resume. We'll go to the second panel.

I would like everyone to be seated and any interviews to be done outside. I would ask the media to move outside, please, so that we can conduct business.

Thank you.

We have before us Pamela Nolan, who is from the Garden River First Nation; and Maxine Lesage, who is the supervisor of health services for its wellness centre. Welcome.

I very much want to acknowledge Chief Jerry Knott, from the Wasagamack First Nation—welcome, Chief—as well as Joseph Richard Harper, the assistant health director. Thank you so much.

We'll have our other guests continue later on.

We'll start, please, with Ms. Nolan.

Ms. Pamela Nolan (Director, Health and Social Services, Wellness Centre, Garden River First Nation): Good afternoon, and thank you for inviting us and giving us the opportunity to be here.

We are not politicians, by any means. We represent Garden River First Nation. I'm the health director, and Maxine is the health services supervisor. We're here representing—

● (1550)

The Chair: Excuse me, we're going to have to suspend. I'm sorry. The interviews have continued. We're not going to be able to have televised meetings if we don't have a chance to do our business, so we will have to suspend for a couple of minutes. They have to leave.

Thank you.

My apologies. Could you please continue on?

Ms. Pamela Nolan: Should I start over or just carry on?

The Chair: Just continue.

Ms. Pamela Nolan: Okay.

We represent, really, the grassroots, because we are the first response in the community.

Our community has a membership of approximately 2,000 people. We are located outside the city of Sault Ste. Marie, in Ontario.

We first began our pandemic planning in 2005, post-SARS. SARS really had an impact on us and our community. Although we don't have any close contact with H1N1—it hasn't been in our community, really; we've only had two cases in the Algoma district—we felt that we needed to take it seriously, because we understood that the disease didn't have any boundaries. It didn't matter where you lived, where you came from, whether you were first nations, who you were, it was going to come. We thought we might even be a little more at risk because of our prevalence or high rate of chronic disease and because we're first nation populations.

So we asked what we were going to do, because it's just the two of us. We have a few nurses in our community and some health educators. If the pandemic hit, if we had a pandemic in our community, what were we going to be able to do, just the two of us? We decided that we should start getting ready. We said we needed to start teaching people how to take care of themselves and each other by giving them the information they needed to be able to do that. So that's where we started.

In regard to some of the initiatives we have been working on, creating, and developing in our community, we're going to pass some things around here. This is probably not the usual way you do things here, but we didn't know. We have never been here before, so we're not really aware of what we can or can't do.

The Chair: I'll let you know.

Ms. Pamela Nolan: If we can't do something, just let us know.

The first thing we did was develop this kit, which we called “My flu kit”. We thought it would be a good idea if we hand-delivered it to every single person, every household in our community. There's a thermometer in it, there's a fridge magnet, there's information on flu, there's handwashing gel—different things that you can use to get people thinking about the flu.

The Chair: Might I interrupt you for just a moment? It's not bilingual, but I have permission from the clerk to pass it around. If you wanted to give some packages to the clerk, we could send them to the offices so each person could have one. We can't hand them out right now, but please continue.

Ms. Pamela Nolan: Okay.

The flu magnets that we developed are in the kits, and we thought people could just stick those on their fridges so it would be a really quick reminder of what they could do if they were experiencing flu symptoms.

We always put information in our community newsletter. We're fortunate enough that we have a newsletter. It's online, it's for the community, people can subscribe, and it's a really quick, easy way of getting information out. So we'll just pass that along.

We also developed a pandemic plan. Our pandemic plan is a living, breathing document. It's updated on a regular basis. As we're building our plan, things keep getting added and changed. I want Maxine to talk about a couple of sections in the plan that are really neat, that we think are really going to help us.

Ms. Maxine Lesage (Supervisor, Health Services, Wellness Centre, Garden River First Nation): *Ahniin*. *Boozho*. Welcome to everybody here today. Thank you for inviting us. We are very honoured, and we'd like to say hi to everybody in our community back home.

● (1555)

The Chair: We just have a minute for you to speak. Thank you, Maxine.

Ms. Maxine Lesage: Yes, very quickly, there are approximately 12 sections in the chart, but I just wanted to point out that probably the most interesting and useful sections would be our at-risk list that we've developed. That would be for our vulnerable clients, the chronically sick, physically handicapped, and the children, especially the age groups that are targeted by H1N1 right now. We've developed these lists so that we have phone numbers and contact lists.

Ms. Pamela Nolan: We also developed an emergency preparedness guide. There's a section in here on the pandemic. We talk about what we do before an emergency, during an emergency, and after an emergency. This was delivered to every house in our community as well.

We also purchased this book, *Do I Need to See a Doctor?*. We didn't develop this, but we felt it was an awesome resource. It's really easy to understand. It's illustrated well. We felt our community could really understand this information.

We also developed a flu kit, an emergency response kit, and this went to all the people in our community who were at most risk. So 40 to 45 people got this, and here's a list of what's in this kit. We dragged this all over Ottawa today, wondering, should we bring this kit, should we not? We don't know. We're asking people, calling, what do we do? We took the scissors out, we put them back in. We took the canned stuff out, put it back in. Anyway, here's the flu kit, and here's the list of what's in it. We tell people, "Here's your list. Keep it and replenish it if you take anything out, and then put in what else you think is necessary." It's available to take a look at later.

We did a couple of other things. We have an outreach team in our community, promotion, prevention workers. We're not just a health centre, we're a wellness centre. We have health and social services in our community. What we've done is asked our prevention and promotion workers to be part of our team, and they give the message on H1N1 as well. They all have scripted messages. When they call people to invite them out to their activities, they say, "Although we'd really like to have you out to our activity, in light of flu season, we ask that if you're not feeling well, could you please stay at home." We do all these little extra things. It's not just the clinical area working on pandemic planning and preparation; it's a whole team effort, a whole community effort.

What I wanted to say before I'm finished is that—and I know we're wrapping up—I've noticed something in Canada. This is just my personal observation coming into your community and your area, but I walked through two checkpoints, two stations, and was never screened once for H1N1. There were no handwashing facilities. I think it's really important, if you're really serious about giving the message, that you have to do it all the time.

The Chair: May I take some leverage here, as chair, and say thank you? I'm blown away.

Some hon. members: Hear, hear!

The Chair: I mean, that's amazing.

Ms. Maxine Lesage: Can I just add one thing very quickly?

The Chair: Yes, very quickly.

Ms. Maxine Lesage: This is in terms of the emergency kit we developed. We had done up a poster of one of our elders. The home and community care nurse delivers it with her worker, and they just provide information on health teaching on H1N1, emergency preparedness.

So this is just a picture of one of our elders in the community.

The Chair: Oh, thank you. Hold it up for the cameras.

Beautiful. Thank you.

Now we'll go to Chief Jerry Knott.

Thank you.

Chief Jerry Knott (Chief, Wasagamack First Nation): Good afternoon, Madam Chair and members of the Standing Committee on Health. I want to thank the committee for your kind invitation to present to the government on the status of preparedness of Island Lake communities on the matter of an anticipated H1N1 pandemic for this coming fall season.

The population exceeds 10,000 residents, comprised of first nation, Métis, and non-aboriginal peoples. The communities are located approximately 600 kilometres northeast of Winnipeg. The communities are remote, accessible by air transportation year-round, except for six to seven weeks within the winter road season during January and February, weather permitting.

All four communities have the limited community infrastructure in place ordinarily granted by society. Most of our homes lack water and sewer facilities. Hauling drinking water in containers is not an uncommon occurrence in our communities. But when you do not have the proper infrastructure, what is the alternative? The alternative for the lack of sewage facilities is to construct makeshift sewage disposal units in very close proximity to the actual living quarters. For the purposes of clarity, I am talking about outhouses.

Our people live in crowded conditions. It is not surprising to find two or three or four family units in one house. The quality of housing, coupled with the wear and tear of overcrowded housing units, has rendered housing conditions deplorable. The present housing backlog will quadruple every two years. Managing the present housing shortage is just abysmal.

The reality is that we are losing our battle, to the point where we cannot provide adequate and decent shelter for our people. Shelter needs for the first peoples are reaching beyond the crisis state. The housing crisis will be further accelerated as young people reach adulthood. With the high aboriginal youth population, the fact is that their time is upon us.

Honourable members of the standing committee, the living conditions of our people that I am describing to you are central to the question of preparedness and response to the potential H1N1 pandemic. The prevailing conditions that I have tried to describe are the actual existing conditions. It's in these conditions that we, the people, are expected to respond to and prepare for the H1N1 pandemic that has claimed thousands of lives throughout the world.

I beg your indulgence. Health care is the right accorded to every citizen in Canada. I believe it may be enshrined in the Constitution. The four communities do not have a primary health care centre. Our communities have nursing stations manned by committed nurse practitioners, who work endless hours to provide medical health care services. Our communities have doctor visits. Our communities do not have any form of residential doctor permanently to respond to the 10,000 residents in our community. The wait time to see a doctor is not an issue; our people are just lucky to see a doctor.

The alternative to lack of immediate access to a medical doctor is the continual medical evacuation of our patients. Thirty-five cases were confirmed as H1N1 this past spring. More than 20 people with the virus were taken by medevac to hospital in Winnipeg for treatment.

The cost of medical response to the last pandemic outbreak demonstrated that communities, governments, and other agencies were not prepared for such outbreaks. The cost for additional nurses and doctors and support resources, coupled with high transportation costs, resulted in extraordinary expenditures to respond to the H1N1 outbreak.

It would be wrong for me to state that we are adequately prepared to respond to the H1N1 virus outbreak for this coming fall. The four communities have instituted the Island Lake region pandemic working group to coordinate the regional planning and to secure resources for a pandemic response. Furthermore, each community has organized a local pandemic working group. Each community has designed their incident commanders, who have the responsibility of coordinating intercommunity responses. There is only so much each of these units can accomplish without the required resources to make plans and to execute plans.

● (1600)

During the last outbreak, the Wasagamack First Nation, my community, had to institute response measures in an effort to contain the outbreak. These measures included quarantining family homes and the community at large, limiting intercommunity travel, launching mass communications processes, educating people on H1N1, meeting with the nurse in charge and incident manager on a daily basis, executing pandemic team recommendations, treating people with traditional medicine, and preparedness.

The Island Lake region had 35 confirmed cases of H1N1 in its first outbreak, which is 28% of the confirmed cases in northern Manitoba. The communities are bracing themselves for a higher incidence. The absence of economic well-being and the prevailing social challenges of our community present a formidable undertaking that must be addressed, not merely to respond to a pending outbreak but to plan to develop a long-range response to the present conditions of our communities.

On behalf of Island Lake first nations, we recommend that governments respond with the following: acquiring an assortment of adequate antivirals; engaging and supplying medical staff and resources reflective of the population and some circumstances; supplying assorted and accessible preventive goods, such as antibacterial lotions, etc.; plans for field medical unit and operations; upgraded medical equipment at the nursing stations; and financial resources to respond to the standard acceptable measures for first nations communities' prevention and intervention.

After mentioning the recommendations to address the immediate pending pandemic outbreak, strategy planning is crucial to the ongoing well-being of our people. The H1N1 pandemic outbreak is not our first experience with epidemics. Our history tells us that in comparable tragedies suffered by our nation, we have survived such pandemics in spite of circumstances, intended or otherwise. Our people continue today. In spite of the present danger of H1N1, our people—

● (1605)

The Chair: Chief, I'm so sorry, but we're way over time. Do you mind, Chief, wrapping it up so we can get to the questions? Thank you.

Chief Jerry Knott: Okay.

The economic and housing crises are questions as well for long-term purposes.

In closing, I want to commend the Standing Committee on Health for its diligence in the search for preparedness of first nations to respond to the pending H1N1 pandemic. The answer is no. The communities are vulnerable, and if tragic consequences should occur, then we should not be surprised. We, as communities, can only plan and execute what's available through the limited resources we have at our disposal.

Thank you.

The Chair: Thank you, Chief.

I would like to welcome to the panel today Chief Albert Mercredi from the Fond du Lac First Nation. Chief, would you like to give your presentation, please? I understand you have Mr. Robillard with you as well. I welcome you both. Thank you.

I also acknowledge Joseph Harper. I forgot to do that when you were sitting down, sir. Thank you for being here.

Go ahead.

Chief Albert Mercredi (Chief, Fond du Lac First Nation): Thank you, Madam Chair, members of the House of Commons Standing Committee on Health, and other participants in the panel discussion. I wish to express my appreciation on behalf of the Athabasca Health Authority for this opportunity to share our experience to date in preparing for the next wave of the current pandemic influenza, H1N1.

In a very real sense, the Athabasca Denesuline have been preparing for pandemics at least since the first contact with Europeans. The region of the Athabasca Health Authority, or AHA, is in northernmost Saskatchewan and encompasses approximately 150,000 square kilometres of much larger traditional territory of the Athabasca Denesuline. The total population of the AHA region is 3,500, of which more than 90% are Denesuline and other aboriginal peoples. More than 80% of the population lives on reserve at Fond du Lac and Black Lake first nations, while the remaining residents live in the three provincial communities of Stony Rapids, Uranium City, and Camsell Portage.

The Athabasca Health Authority was created through the independent and unanimous agreement of the members of the first nations and the provincial communities a decade ago in order to create an integrated and interjurisdictional health organization committed to the provision of comprehensive health service to all residents on an equitable basis. There were a number of foundation agreements to which AHA members, the Government of Canada, and the Government of Saskatchewan are parties, and both levels of government continue to provide significant funding to AHA operations. The Athabasca Health Authority's vision and mandate is funded on the principles and understanding that are currently described as “population health”.

In a region primarily populated by aboriginal peoples, we understand very clearly that the colonization; loss of control of territory, resources, and the ability to make a living from the land; dependency; poverty; inadequate infrastructure, housing, and culture; and community and family crises are determinants of health. Our approach to pandemic preparedness begins with the same understanding. We can never really be adequately prepared until we have addressed the determinants of health that make our region and our residents so vulnerable to the disease.

Two documents attached to this presentation contain summaries of the current measures and the determinants of health and health status of the Athabasca region in northern Canada. Copies can be picked up through the office of the MP who represents our constituency.

During the first six years of AHA operations, various emergency preparedness plans have been developed to respond to natural and industrial disease crises, both at the community and, more recently, at the regional level. With the assistance of Health Canada's First Nations and Inuit Health Branch and Saskatchewan Health, community-based pandemic plans have been developed. During the past year, through agreement of the AHA board and the regional leadership, AHA has been developing, in cooperation with local communities, an integrated and comprehensive regional pandemic influenza preparedness plan.

● (1610)

There is now a regional operational plan for preparing and responding to a pandemic influenza outbreak. Again, the attachment to this presentation is part of the presentation and documents that we distributed to our MP. While further development and refinement of the regional plan continues, there's support throughout the region to work within the provisions and protocol of the plan as it continues to evolve.

Discussions, partnerships, and collaborations continue outside the Athabasca region with health and environmental agencies and transportation and various material and service sectors to address a range of issues related to the security of the supplies during a pandemic. While we have made significant progress in planning, our preparedness will be limited by our capacity to implement the regional pandemic plan. Currently our community primary health care—

The Chair: Chief, I'm sorry to interrupt you. If you wouldn't mind, sir, could you wrap up, because I let you go way over time. That's so we can have questions.

Thank you.

Chief Albert Mercredi: In conclusion, we are requesting additional resources to take us into this pandemic stage and be prepared for it. We are requesting funding for pandemic coordinators in our communities and additional primary health care nurses to assist us at the community level during this crisis.

Thank you for this opportunity, and in my own language, [*Witness speaks in his native language*].

The Chair: Thank you very much, Chief Mercredi. We appreciate your input in this very important meeting this afternoon.

We will now go with the will of committee. I'm asking that we have another five-minute round so that everybody can have a chance to answer questions. At the will of the committee, can I have your permission to do that?

Some hon. members: Agreed.

The Chair: Thank you so much.

We'll start with Dr. Duncan.

● (1615)

Ms. Kirsty Duncan: Thank you, Madam Chair, and thank you to everyone for travelling such long distances to be with us.

Ms. Nolan, can you tell us what officials got in contact with your community, with you, to suggest developing a pandemic plan?

Ms. Pamela Nolan: We weren't really approached by any one individual. We were told there was a pandemic planning template that was produced by Health Canada. We pretty much just thought we needed to get ready and we just went with it—with or without the resources or assistance from anyone.

Ms. Kirsty Duncan: Did the officials come back and check and see it was being done, and did you get funding for this?

Ms. Pamela Nolan: No, no one really knows what we've done. No one knows that we've produced this or this or whatever we've done to get ready. We were lucky that you visited our community, and now a lot more people know what we've done.

Ms. Kirsty Duncan: Well, we celebrate what you've done. It's remarkable, the planning that you have done. Were you given information on what supplies you could order, or did you do that on your own?

Ms. Pamela Nolan: No, we worked with a pandemic planner at Health Canada. We did attend a pandemic planning session for Ontario funded by Health Canada and held in February 2009. We were told that we were getting a list of pandemic supplies sent to our community—which we did get. We have gloves and so on.

Ms. Maxine Lesage: Yes, we have supplies that Health Canada had sent initially. I think they did that across the board for the communities.

But we've been doing this post-SARS. In January 2005, when the ministries were mandated to get these plans done, we started. We've just been slowly building, and without much help.

Ms. Kirsty Duncan: Did you feel supported through this? And how did those supplies come?

Ms. Pamela Nolan: The supplies were sent in bulk, in boxes. They just arrived. They were just there. We thought, "Okay. So what do we do with these?" We had to sort through the boxes, find out what was in them, unpack everything, and find space to put things in our already overloaded, packed wellness centre. We had to find out what was in those boxes.

Ms. Maxine Lesage: We pretty much had to scramble on our own to figure out what we were going to do to make the best of it.

Ms. Pamela Nolan: Although we did appreciate the supplies and the different things, it was just....

Ms. Maxine Lesage: It would have been nice to have a list in terms of what we do with it.

Ms. Kirsty Duncan: It came with no list? There was no list?

Ms. Maxine Lesage: No. There was just a packing slip. We just had what was delivered.

Ms. Kirsty Duncan: Thank you both.

Chief, may I ask what percentage of your community lacks water?

Chief Jerry Knott: Only 10% of people have water; 90% don't have water.

Ms. Kirsty Duncan: So 90% don't have water. Thank you.

We really feel that you should be celebrated. The work you've done should be emulated. Has there been any attempt from officials to ask for some out-of-the-box thinking in terms of social distancing within homes where, as one person said, in some cases we have two, three, and four family units in a house?

Ms. Pamela Nolan: I'm sorry, I didn't hear you. Can you rephrase the question?

The Chair: You can repeat the question, Ms. Duncan, but you have half a minute, please.

Ms. Kirsty Duncan: Okay.

I'm sorry, Ms. Nolan.

Was there any support from the officials in terms of how you do social distancing in a house where you have two or three or four family units living in close proximity? How do we keep people safe? We need some out-of-the-box thinking.

Ms. Pamela Nolan: No, it hasn't occurred that way at all, ever, from any pandemic information we've received. It's just been, "You need to get ready, and here is the template. Go for it." We're saying, "Okay...."

We were fortunate because we went for it, but we know that other communities in our area didn't, and they're not ready. Our next-door neighbours are not ready, unfortunately.

● (1620)

The Chair: Thank you so much, Ms. Nolan.

Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Thank you, Madam Chair.

Chief Knott, your testimony sounds very much like what we heard a little earlier. Indeed, we were told that the communities you represent are dealing with systemic issues in terms of access to water and adequate numbers of decent housing. Factors such as that can exacerbate any situation where people's health could be at risk.

Are the Department of Indian and Northern Affairs and Health Canada aware of these conditions? Is this the first time you have made this information public?

[*English*]

Chief Jerry Knott: We have submitted some proposals in terms of the need for adequate housing and infrastructure. We are told, in terms of the policies, that they have put us for future years. They've told us that the allocation is not enough. There is no funding in place. But we still hear that there is funding available for overseas and for other subsidies where Canada provides funding. It's in the back door of Canada that they don't provide enough funding for sufficient housing for water and sewers.

I was glad and honoured that MP Bennett visited my community and saw the first sight of it.

So it's the policies. They are what stunts or blocks access to the funding that would ensure that we get good housing.

[*Translation*]

Mr. Luc Malo: Do you believe that, when the vaccine does become available, you will be in a position to immunize people in your communities quickly and efficiently?

[*English*]

Chief Jerry Knott: Yes, we can administer that. In fact, just last fall I had a meeting with a provincial official. I live in a remote community, I have no airport. I live in pretty well a very remote community. The closest airport is half an hour, driving range, by boat. I have requested that the minister do the testing in a remote area of how fast and how efficiently they can do the job of dropping off the vaccines and all the medication, all the supplies. It hasn't been done yet, but we're prepared to accept.

[*Translation*]

Mr. Luc Malo: Ms. Nolan, have you had an opportunity to tell other communities about your prevention tools? Have you had a chance to share your experience, as a means of helping other communities, or is today the first time you have spoken publicly about this tool?

[*English*]

Ms. Pamela Nolan: Yes and no. We really haven't had the opportunity to present the information or the tools that we've developed to anyone, although we did manage to show one of the pandemic planners at Health Canada our magnet. She was so excited about that, she took our magnet and said, "Can we reproduce it and send it across Canada?" We said, "Great, take it, do what you need to do." So that was, what, four or five years ago? Since then we haven't had anybody come to say, "What else have you been doing? This might be a good idea. This might be able to be shared with other first nations." We'd love to be able to share with other first nations what we've developed. We think that's the right thing to do.

● (1625)

[*Translation*]

Mr. Luc Malo: And you haven't heard anything from Health Canada for four or five years!

[*English*]

The Chair: I'm sorry, Mr. Malo, I have to stop now and go to Ms. Wasylycia-Leis.

[*Translation*]

Mr. Luc Malo: I simply wanted to mention that a second time, Madam Chair.

Thank you.

[*English*]

The Chair: I'm sorry.

Ms. Wasylycia-Leis. Thank you.

Ms. Judy Wasylycia-Leis: Thank you, Madam Chair.

Thank you very much for being here and taking the time.

Chief Knott, you made a very clear statement that I think we should all take note of, and that is that unless we take some major steps now, we could be facing some very tragic consequences. I think that's why we're all here, to prevent that from happening.

I think what Pamela and Maxine have shown us is that there are some very good initiatives out there and that Health Canada is in part doing its job, but that there seems to be an overall lack of coordination and communication in terms of a strategy for all first nations and Inuit communities.

So I want to know from all of you, what's the best way to do that right now? What advice should we give to the minister and the officials, who will appear after you, about how we can get the kind of program you have in your community, Garden River, and take that experience and that wealth of knowledge and share it among all, what, 600 first nation and Inuit communities across this country? Does anybody have any ideas on that?

Chief Knott.

The Chair: Chief Knott, would you go ahead?

Chief Jerry Knott: I'm glad you've mentioned that and inquired about it. I think today, at this table, the colleagues here and our sisters here have demonstrated that a community has the potential to produce their policies, to improve their lives. They know what the problem is and they can correct the problem. We are never given a chance to that extent, and we don't have the resources to produce these types of projects, the pilot projects that we have. If every first nation is given an opportunity, I'm sure they can make improvements to their lives that they can forward to the government.

Thank you.

Ms. Judy Wasylycia-Leis: Maxine or Pamela, do you have any suggestions for us in terms of taking your example and making it a national project? One idea I've thrown out before would be to appoint an aboriginal adviser to the minister and to the Public Health Agency, as we've done in Manitoba with Dr. Cathy Cook—just someone to coordinate and pull it all together. Does that make sense, or is there another way?

Ms. Pamela Nolan: I think in order to find out what we've done, you're going to have to have somebody who has power come to our community, because we feel—and I think any other community is going to feel the same way—that they're not going to know that any of this was any good. We had no idea that what we were doing in our community was any different from what other people were or were not doing. We were shocked to find that out when Dr. Bennett came to our community. We kept saying, "Is she kidding us?" We didn't believe that she was so impressed with what we were doing, because we assumed other people were doing exactly this. We would never have known.

So I don't know if a position at that level is going to really find out what's happening at the grassroots level. It might have to be more about communicating with the communities, trying to pull that information out from me, saying, "Okay, Garden River health director, what have you been doing for the pandemic? Where are you now, what have you produced, and what are you willing to share?" Bringing the grassroots people together in a more coordinated fashion—I think it would work this way instead of that way.

I'm not really sure if I....

● (1630)

The Chair: Thank you.

Ms. Judy Wasylycia-Leis: Fair enough. Can I have one more quick question?

The Chair: Make it very fast.

Ms. Judy Wasylycia-Leis: You're equipped in terms of prevention and getting your message out. Are you equipped in terms of actually delivering the vaccine, if and when it arrives?

Ms. Pamela Nolan: We have our plan.

Ms. Maxine Lesage: In our pandemic plan, there is a section that talks about mass immunization. So when that happens, when the H1N1 vaccine is ready, we've identified different designated points on our reserve that we want to get set up so that nurses and health workers can come in. I heard you talking about vaccinating earlier, and who would be in a position to vaccinate. We would set up all of these volunteers as well to help us out. We're ready to go. We have our lists. All our team is together. Everyone has been alerted. This is what we need to do, so we're ready to go.

The Chair: Thank you, Ms. Lesage.

We'll now go to Mr. Clarke.

Mr. Robert Clarke (Desnethé—Missinippi—Churchill River, CPC): Thank you, Madam Chair, and thank you to the witnesses who are attending here today. I know some of you have travelled a great distance to get here.

Chief Mercredi, thank you. Regarding your area and the AHA, or Athabasca Health Authority, can you explain more what steps you've taken for the H1N1 or pandemic planning? I toured the community and I noted that there were some supplies that had been stored as well. Can you explain what steps are being taken in regard to the H1N1?

Chief Albert Mercredi: Thank you for the question.

From the Athabasca perspective, the region that I come from and the community I represent are very unique. We work together as a region, meaning we have Denesuline people, we have Métis, we have Cree, and of course, people from the outside who come in and live in our region. We work together as a team. I personally believe that in a time of economic crisis throughout the world and with the plague that is coming down, which we as a nation do not even know how we're going to deal with, by working together, planning together, preparing together, and putting in some of our knowledge by backing each other up, all nationalities, we create a position where I believe a region can work together. In that respect, to make a long sentence short, that is my vision.

The Chair: Mr. Robillard, would you like to make some comments as well, please, sir?

Mr. Vince Robillard (Chief Executive Officer, Athabasca Health Authority): First of all, I'd like to thank the Standing Committee on Health for inviting us here today, and good afternoon. I have to commend the other communities as well for all of the work they've done.

As the CEO of the Athabasca Health Authority, I will say that we have worked relentlessly since April with all of our partners, both federal and provincial, to ensure that we have a comprehensive pandemic preparedness plan ready. It has taken a lot of work to ensure that the partnerships are there with our communities, our outside agencies, and the medical health officers throughout the ministry of health in the Province of Saskatchewan, as well as working with our federal partners through Health Canada. We wouldn't be in the position we are right now if that cooperation had not taken place.

We're in a unique position. We're funded by both provincial and federal authorities. So that cross-jurisdictional boundary whereby we work on first nations reserves as well as in provincial communities is part of our day-to-day operations, and we're comfortable with that. But we also understand and know from the first nations side not just the health status and determinants of health but also the day-to-day issues they face. So we have to find balance with everybody to ensure that we work hand in hand in the best interests of these communities with the resources we have in hand.

As we've said in the past, it takes a team effort to ensure the best service delivery to any resident, no matter their race or colour. We don't discriminate; we try to work with our partners. People have talked about taking their plans through a test run, hopefully. For us, the litmus test will be the actual pandemic itself, to see if we are as prepared as we say we are.

Thank you.

● (1635)

Mr. Robert Clarke: At the Athabasca Health Authority, can you explain the geographic challenges you face on a daily basis—I know that northern Saskatchewan is quite remote—and also the challenge that could come into play with the H1N1 virus?

Mr. Vince Robillard: We're in the northernmost part of Saskatchewan, and as a health authority, all of our communities are isolated. They are air accessible, and we have winter seasonal roads. So for us transportation is always a challenge in the best of days, and we have a high cost of living to prove it. But in saying that, we've become very, very cognizant of the fact that we need to come up with innovative ways to deliver these services and also to create those vital partnerships necessary to make any venture successful.

We're of the opinion that we're on the right track, and we'll continue to strive even harder in the future.

The Chair: Thank you so much.

I want to thank our witnesses for being here today and being part of the second panel. I'm going to call Dr. Butler-Jones to the table, but you've had amazing testimony, and thank you for it.

I'm not going to suspend the meeting, but I am just going to ask that we change quickly because of the time element. Thank you.

So we'll go right into the second phase of this. We have Dr. Gully, Dr. Butler-Jones, and Ms. Shelagh Jane Woods. You've already had the presentations, so we'll go right into a five-minute round of questions and answers.

Who are we going to start with? Who wants to start?

Dr. Bennett, do you want to start the questions?

Hon. Carolyn Bennett: The purpose of this was just to give the officials a chance to respond to what they heard with the witnesses, so maybe we could just put it open to that.

Mr. Mike Wallace (Burlington, CPC): If we're doing a regular meeting, I want to be on the list.

The Chair: Okay.

Dr. Butler-Jones, did you want to make any comment on what Dr. Bennett was just saying?

Dr. David Butler-Jones: I'm not sure where to start. So many pieces were covered. Clearly, as you parse it out, there are the issues or the challenges for many communities, aboriginal communities, remote communities, in terms of their capacity, in terms of issues of housing, sanitation, water, etc. These are long-standing challenges that ultimately are essential to good health and to the resilience of communities.

The other that I think I heard spoken to was how different communities have approached the issues and planning. As an aside, it was quite gratifying for me because I used to be the medical officer in Algoma, and Garden River was one of the reserves that I related to. And I was the chief medical officer in Saskatchewan when we actually set up the conditions with public health medical officers, nurses, and others so that the services on and off reserve were coordinated between the province and the federal government and with the band councils' support. So to actually see some of those things pay off, I think, is very gratifying.

But it does speak to the many challenges, ultimately, and the value of the sharing of experience and expertise across communities. I'll leave Shelagh Jane and Paul to speak to some of the things that they're looking at around that.

In terms of the advice, whether or not it's a structured position, we've often talked about that, but we've also been consulting with national aboriginal groups and others in terms of the most effective way to engage around public health. Representatives of AFN, ITK, and others are involved with us on an ongoing basis in terms of our planning, reviewing our plans, the development of plans, etc. So I think that's important. And whatever best ways we can do that, we're obviously interested.

And then, finally, it is about how we actually apply this, given the diverse country that we are, at the time of the pandemic. I remember a great many years ago working with municipalities, band councils, etc., around emergency planning, around pandemic planning, and it's obvious that in spite of all that work over these years, across the country communities are at very different stages of planning. We might have hoped that we would have another year or two, or three or four, to get those things in place, but obviously we don't. So right now it really is key to focus our attention around addressing those issues that we can in the short term, recognizing that there are many, as members have identified, long-term challenges to be addressed to ultimately get at this in the long term.

But in the short term, access to vaccine, access to antivirals, access to knowledge and information and the kinds of resources that communities can do, I think, is key. I very much appreciate the committee's comments, and certainly those of the witnesses today.

● (1640)

Hon. Carolyn Bennett: Shelagh Jane, what would you say about Regional Chief Garrioch's assessment of the preparedness in his region?

Ms. Shelagh Jane Woods: I would say that evidently I'm going to go back and talk to my Manitoba colleagues and all of my regional colleagues to make sure we have a really good handle on things, that they have their plans in place, which I've talked about before, to make sure they're putting their focus on the communities that appear to be most in need. That's what I'd like to—

Hon. Carolyn Bennett: And that would include resources?

Ms. Shelagh Jane Woods: I don't know. I have to have a discussion first with them to see where they are in their planning, what they're strategies are.

Ms. Kirsty Duncan: Shelagh Jane, if I may, is it possible to know where those 600 communities are in the planning, whether they have a plan or not? I think someone needs to be looking at these plans. We saw one from Garden River versus a community a short way away that hadn't started one and didn't know to order supplies. Unless someone's bringing in these plans and looking at them, we just can't assess the level and we can't be saying there's 90% coverage when we hear it's two out of 30.

Is there a website where you could—

The Chair: I'm sorry, we just have one minute. Could you answer Dr. Duncan's question, please, Shelagh Jane? Thank you.

Ms. Shelagh Jane Woods: I think I kind of missed the question.

Dr. Paul Gully (Senior Advisor to the Assistant Director-General, Health, Security and Environment, World Health Organization): I've been on the job for two days, and therefore it'll be a short answer.

What I've learned is that there has been a huge amount of work done on the side of the First Nations and Inuit Health Branch and the Public Health Agency of Canada, and the provinces and territories, in collaboration with first nations and other aboriginal peoples. However, there clearly is a difference in information. I won't say perception, because that would imply that it's incorrect, but there is a difference in information that exists on one side to the other.

I take your question, and we will go back, we will look at the information we have, and we will present what we have, and we will have to check that.

The Chair: Thank you so much, Dr. Gully.

Monsieur Malo, I know you're next, but Ms. Wasylycia-Leis has to catch a plane. May she go first?

Stop hugging him, Ms. Wasylycia-Leis.

Some hon. members: Oh, oh!

The Chair: Would you please ask your question quickly?

Ms. Judy Wasylycia-Leis: Thank you very much.

I have three quick questions.

Number one, given what we heard about the need for better coordination on first nations communities—and I don't think anybody here will dispute that—have you thought about a way to do that in terms of either hiring and putting on staff an adviser to you and the minister, as we have in Manitoba with Cathy Cook? Or do you have another suggestion to respond to the clear need today to get this information out and to start dealing one on one with reserves to make sure they're actually up and running?

Number two, would you be able to say, here and now, that aboriginal people will be put at or near the top of the list in terms of vaccinations and access to quick delivery of the vaccine and other necessary services, something I think Manitoba has recognized? I think Dr. Joel Kettner has stated that in one way or another, and I think we're waiting for an answer about where you stand in terms of prioritizing first nations and Inuit people.

Third, will you support flu kits financially?

● (1645)

Dr. David Butler-Jones: I can't speak to the financial; that's in another area. I do support families having things in their households, as we've talked about before, and the items that I've talked about before and that Dr. Kettner has spoken to as well.

On the issue of prioritization—or it's really, again, sequencing of the vaccine—clearly, while the final decisions, which are a collective decision across the country, are not finalized yet, isolated and remote communities are going to be at the top of the list in terms of prioritization because of the nature of health care access. And if you are wrong and they do get sick, they're going to have to be flown out, etc.

In addition, antivirals are already pre-positioned in those communities to provide early treatment. So even in advance of a vaccine, that's in place at the nursing stations and others.

Third, those with underlying risk conditions—we recognize diabetes, pregnancy, etc.— are going to be at the top of the list whether they're aboriginal or non-aboriginal. What we have not been able to sort out scientifically is whether a perfectly healthy person of aboriginal descent is at greater risk or substantially greater risk of developing serious disease with H1N1 for no other reason than that they are aboriginal. That we have not been able to sort out. Even if it is a slightly increased risk, the logistical challenge is in reaching that group other than on reserves, etc., which will be obviously high on the list because it will be one in a thousand, and so you're chasing 999 to try to find that one.

But that having been said, regarding the provincial and territorial plans, the local plans to actually roll it out, you will be going into a community and doing a community. You will not be going into a community and asking, “Do you have diabetes or not?” You're going to do the whole community. So again, from a practical standpoint, once the vaccine is available, people will be getting it. In the meantime, there will be antivirals in order to address that.

The Chair: Thank you, Dr. Butler-Jones.

Monsieur Malo.

[*Translation*]

Mr. Luc Malo: Thank you, Madam Chair.

First of all, I hope there is general acknowledgement that the testimony we heard this afternoon was extremely worthwhile and brought to light a number of issues facing the different communities.

Dr. Butler-Jones, I understand that, at this stage, we cannot focus primarily on the long term, because there is concern about the fall, which is the short term. However, as we heard, it is clear that general living conditions in these communities have to be looked at. The fact is that the circumstances in which they live weaken the communities, making them more susceptible when pandemics occur, such as the H1N1 flu pandemic.

One of the witnesses told us that it may be because Health Canada is lacking information. I hope that is not the reason why no action has been taken to deal with these issues and make improvements to general living conditions in these communities.

Earlier, Ms. Wasylycias-Leis made reference to the availability of vaccine. That could also be a problem: when they receive the vaccine, will they actually be in a position to administer it? Have you also looked at that and have you taken steps to ensure that they will be able to immunize their population once the vaccine is available to them in the communities?

I also heard the representatives of the Inuit communities say that they do not have clear understanding of the federal government's role with respect to developing a strategy or plan to deal with the H1N1 virus. I am not necessarily asking you to provide clarification now, but at the very least, you should be cognizant of the need to work with these people in order to clarify everyone's role, so that the communities will have an effective plan to deal with the H1N1 virus.

Also, will those plans be tested? I know that Dr Duncan referred to this earlier. That is another interesting point.

As well, how is it that the tool developed by the Garden River First Nation was completed forgotten for four or five years? Is that because it fell between the cracks or because you lost sight of the need to pay close attention to the development of tools for prevention?

● (1650)

[*English*]

The Chair: Who would like to take a shot at that?

[*Translation*]

Ms. Shelagh Jane Woods: Once again, there are a lot of questions in there—

Mr. Luc Malo: That's true, but it's because the testimony was so instructive.

Ms. Shelagh Jane Woods: It was for me as well.

If I can begin with your final point, I think it's very important that we ensure the communities have plans. However, we do not require that they provide copies of the plans *per se*.

[*English*]

We generally do not insist that the communities deliver the plan. Communities all have different ways of developing their plans. You heard Ms. Nolan refer to the fact that she'd heard that Health Canada had a template, but they chose to go ahead and do things in a different way.

I think I mentioned—I guess it was probably on a teleconference—that one of the things we did a couple of years ago was give some money to the Assembly of First Nations to develop templates for holistic plans in three communities, a pilot project to test to see how things would work. So there are different ways.

I assure you that people are going out, one to one, to talk to communities. If the community doesn't choose to share its plan, we have to take their word that they have one. We don't demand as a condition that they must show us their plan.

I think one of the things I have learned most this afternoon is that testing is very important, and we should be making sure that we're putting a lot of effort into ensuring that the maximum number of plans are tested. Again, I want to make it very clear that it's terribly important that we do this in collaboration with provinces wherever possible.

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

Mr. Wallace.

Mr. Mike Wallace: Thank you, Madam Chair.

I'll be relatively quick. I have just a couple of points from the discussion we've had today.

The Inuit community talked about a separate plan, an appendix plan, and I think they indicated that you, Dr. Butler-Jones, had made a commitment to them to look at that. Probably that won't happen overnight, because we have these other issues facing us, but was their statement accurate in that you think we should be looking at a separate plan for northern Canada?

Dr. David Butler-Jones: We actually have a working group on remote and isolated communities in terms of how to adapt the recommendations to that. It's a federal, provincial, and territorial expert working group. They are correct in terms of the question, though, because of the differences, particularly in the remote north. They have some similarities with, say, northern Saskatchewan, but not completely. So an adaptation for that is appropriate.

Going through the full FPT process, etc., in the midst of this is not appropriate. That is why we've committed to working bilaterally with them, along with the isolated group, to make sure we actually have modifications in place.

That having been said, it's really interesting that Nunavut has done some tremendous work in this area already.

Mr. Mike Wallace: I appreciate that.

To Ms. Woods, I am new to the committee and I'm just coming in today to hear all this, but I've been reading and so on. I have a family member who was in the hospital with lung cancer during SARS, and it seems to me that there wasn't a lot of planning ahead for what happened with that issue.

Are we not much further ahead in this, facing the H1N1 issue, than we were at that time from a federal perspective?

● (1655)

Ms. Shelagh Jane Woods: Yes, that's absolutely true.

In my own case, I arrived in the job just as the last SARS cases were being dealt with. It was evident that our branch, the First Nations and Inuit Health Branch, learned a lesson from that. We said it was absolutely important that we started on pandemic planning.

We didn't have any resources to do that, so we organized ourselves to start in on pandemic planning. When resources were made available in due course, we started with information sessions to try to build awareness. One of the witnesses did refer to some of those.

We think the communities have actually done pretty well to get to the point they are now. It all comes down to the test, as several of them have said, but a lot of effort has been put in by communities. You heard it today. They haven't necessarily always waited for us, which is a good thing. We've been able to enhance some of their efforts in some cases.

I would say that generally speaking they have done a good job. There is almost no comparison between now and SARS.

Mr. Mike Wallace: I have one final question, and it's for Dr. Gully. He's not getting completely off the hook today.

As you said, you're new to the job. Obviously when someone of your stature takes over a new role, you have a vision of what you want to accomplish or what the job is. Would you tell us what you think your value-added is to this issue?

Dr. Paul Gully: Thank you for that question. I do come into it with a more global perspective, but what I've heard in the last two days has been very instructive. I've actually learned a lot.

My vision would be very short-term. It deals with leading up to the fall, and we don't know what's going to happen.

One would be to ensure that there is the capacity to enable very sick individuals to be treated appropriately, and that will be not in their communities but probably in tertiary care hospitals. How do we do that? We'll have to make sure and find out if that's possible.

Second, we have to then ensure that there are sufficient nurses and medical care in the communities to ensure that those individuals who are sick are adequately assessed and then medevaced or transported out appropriately.

Third, on the issue of availability of vaccine to those communities that, broadly writ, have this constellation of risk factors, we have to ensure that this is dealt with and discussed so that they receive the vaccine as one of the priorities.

That's what I would like to see, and that's what I intend to work on.

Mr. Mike Wallace: Do I have more time, Madam Chair, or am I all out?

The Chair: You have just 30 seconds.

Mr. Mike Wallace: With my last 30 seconds, then, I'll say that we've heard a lot today, and I think we all, regardless of which side of the table we sit on....

Take the issue of water, for example. We've recognized that in the budget. We put about half a billion dollars toward new infrastructure on reserves for water and so on. There's no short-term solution.

I'm assuming that Chief Knott grew up in the place where 90% of the people don't have water. He didn't just move to that community. From a long-term vision point, it has been a problem for many years in Canada. How big a factor is that in the flu issue that we're having here now? Is it a major issue?

The Chair: Who would like to answer that question?

Dr. Butler-Jones, to end off, please.

Dr. David Butler-Jones: Yes, I'll be very quick. I'll take it from a public health stance.

Whether it's clean water, sanitation, or adequate housing, all of those are essential protective factors in reducing the risk of getting disease and then, if you do have disease, the severity of it. So I think the work of governments to continue to ameliorate those factors is key.

In the meantime, I have a very short story. When I was chief medical health officer in Saskatchewan, we had a new outbreak of hepatitis A coming in every 10 to 15 years. Basically all of the northern communities and many other aboriginal communities, or basically anybody by the time they were 15, would have had hepatitis A. Many would have died and many been hospitalized, etc. The problem was inadequate housing, clean water, and sanitation, which allowed that spread and effect of hepatitis A.

At that time, though, there was a new vaccine for hepatitis A. So I purchased the vaccine and worked with the first nations health and the band councils that delivered health services to ensure that it was delivered. Within three years, not only had we avoided the next outbreak of hepatitis A—which would have been a lot worse—but also, after that, the rate of hepatitis A in the aboriginal population in Saskatchewan fell below that of the non-aboriginal population.

So while we work on the long-term strategies, we also need to address as best we can the immediate term with what we have.

● (1700)

The Chair: I want to thank Dr. Butler-Jones for that insightful comment, and I want to thank the committee for coming today and being a part of this very important initiative.

I also want to say that you will get all of the presentations at your offices. If there's anything further that we need to do—I know that I've talked to Dr. Bennett this morning and noted that—please write to my office. I'd be very happy to address them.

Dr. Bennett.

Hon. Carolyn Bennett: We did table a motion, but I don't think we really need it. Certainly I think on Wednesday at the Standing Committee on Natural Resources, it was very clear from the chair there that they wanted the isotope issue—on the medical side—to come to this committee. I spoke with the chair this morning.

Just because the week we come back is sometimes a bit scattered, could we have all-party consent to hear the nuclear medicine doctors at the regular meeting of the committee on the Tuesday we get back?

The Chair: Well, as I said, that motion was late, so I couldn't do it. So we can't do a motion right now.

Hon. Carolyn Bennett: We don't need a motion; we just have to agree. That's how we do a work plan.

The Chair: All right, then we need the consent of the whole committee.

Mr. Mike Wallace: Madam Chair, I have a question. I'm not on this committee, but do you not normally have a subcommittee that looks after the agenda for your own committee?

The Chair: Yes, we do. Normally what we have is a first—

Hon. Carolyn Bennett: No, we usually decide these things together.

The Chair: Can I just finish, just for a minute, please?

Mr. Mike Wallace: I was asking her, actually.

The Chair: Normally what we do is decide as a committee what we want to do for that term. This has been presented to me over the phone. We usually do it at the first meeting we are back after the session. We would need unanimous consent to do this at this committee

So I'm asking the committee, do you want to do this with unanimous consent today or do you want to wait till the first meeting?

Dr. Carrie.

Mr. Colin Carrie: I think that in principle we're in favour of doing this, but I think we should sit down and not rush into it. We should discuss the witnesses. Also, we have certain regular members of the committee who might want to have some input on this, so I think we can do it the first week we are back.

The Chair: Great, so there's no unanimous consent, but we will deal with it on the first day.

Hon. Carolyn Bennett: The other concern we had was how we as a committee will continue the oversight work of H1N1. We've been very lucky to have briefings from the officials, but those are really just for the critics. It's the whole committee that has responsibility for H1N1. So we were trying to figure out if we can deal with this structurally in a way, whether it's an hour of one of the meetings every week, or how we are going to go into the fall in a way that we don't have to have a big procedure every time we want to have a meeting on H1N1. So that is also at issue.

The Chair: I don't think we can decide that today, but I have brought it forward, and our steering committee...unless we have unanimous consent. Is there unanimous consent to do that?

Is there any comment, Dr. Carrie?

Mr. Colin Carrie: Yes, Madam Chair, I think we should be able to digest this at the first meeting and to discuss with all of the regular members how to move ahead.

Hon. Carolyn Bennett: Madam Chair, will the health committee meet that first Tuesday back; and if so, what will be its work?

The Chair: It's Monday and Wednesday, so I don't know about the first day back. I would have to consult on that.

Anyway, the meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

SPEAKER'S PERMISSION

Additional copies may be obtained from: Publishing and Depository Services
Public Works and Government Services Canada
Ottawa, Ontario K1A 0S5
Telephone: 613-941-5995 or 1-800-635-7943
Fax: 613-954-5779 or 1-800-565-7757
publications@tpsgc-pwgsc.gc.ca
http://publications.gc.ca

Also available on the Parliament of Canada Web Site at the following address: http://www.parl.gc.ca

Publié en conformité de l'autorité du Président de la Chambre des communes

PERMISSION DU PRÉSIDENT

On peut obtenir des copies supplémentaires en écrivant à : Les Éditions et Services de dépôt
Travaux publics et Services gouvernementaux Canada
Ottawa (Ontario) K1A 0S5
Téléphone : 613-941-5995 ou 1-800-635-7943
Télécopieur : 613-954-5779 ou 1-800-565-7757
publications@tpsgc-pwgsc.gc.ca
http://publications.gc.ca

Aussi disponible sur le site Web du Parlement du Canada à l'adresse suivante : http://www.parl.gc.ca