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Chair: Mr. Ron McKinnon



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• (1600)

[English]

The Chair (Mr. Ron McKinnon (Coquitlam—Port Coquitlam, Lib.)): I call the meeting to order.

Welcome to meeting 24 of the House of Commons Standing Committee on Health.

Pursuant to the order of reference of May 26, 2020, the committee will now continue its briefing on the Canadian response to the outbreak of the coronavirus.

Pursuant to the motion adopted by the House on May 26, 2020, the committee may continue to sit virtually until Monday, September 21, 2020, to consider matters related to the COVID-19 pandemic and other matters. In addition to receiving evidence, the committee may now also consider motions, which shall be decided by way of a recorded vote. Finally, the House has also authorized our committee to conduct some of our proceedings in camera specifically for the purpose of considering draft reports or the selection of witnesses.

In order to facilitate the work of our interpreters and ensure an orderly meeting, I'd like to outline a few rules to follow.

Interpretation in this video conference will work very much as it does in a regular committee meeting. You have the choice at the bottom of your screen of either “floor”, “English” or “French”. Please speak slowly and clearly, and hold your microphone in front of your mouth as directed during the sound check.

If you will be speaking in both official languages, please ensure that the interpretation is listed as the language you will speak before you start. For example, if you're going to speak English, please switch to the English feed and then speak. This allows for better sound quality for interpretation. Before speaking, please wait until I recognize you by name, except during questioning of the witnesses when the witnesses may respond appropriately as the questioner requires. When you're ready to speak, click on the microphone icon to activate your mike. Should members need to request the floor outside of their designated time for questions, they should activate their mike and state that they have a point of order. I would remind everyone that all comments by members and witnesses should be addressed through the chair. Should any technical challenges arise, please advise the chair or clerk immediately, and the technical team will work to resolve them.

I also draw your attention to the upper right-hand corner of your screen. There is a choice between “speaker view” and “gallery view” if you're on a PC. If you click to the “gallery view”, you'll be

able to see all of the participants in a grid-like manner, and it will ensure that all video participants can see one another.

I'd now like to welcome our witnesses. Each witness will have 10 minutes for an opening statement followed by the usual rounds of questions by members.

From the Battered Women's Support Services, we have Angela Marie MacDougall, executive director. From the Canadian Red Cross, we have Conrad Sauvé, president and chief executive officer. From the Carnegie Community Action Project, we have Fiona York, project coordinator and administrator. From Ornge, we have Dr. Homer Tien, president and chief executive officer. From the Region of Peel, we have Nancy Polsinelli, interim chief administrative officer.

We will begin with Ms. MacDougall.

Ms. Angela MacDougall (Executive Director, Battered Women's Support Services): Good afternoon and thank you, honourable Chair, Madam Clerk, and all the members of the House of Commons Standing Committee on Health.

Battered Women's Support Services, BWSS, was formed in 1979. Our mission is to end gender-based violence by changing the historic underpinnings of discrimination against women through education, advocacy and support services to assist all women affected by gender-based violence as part of our aim to eliminate violence, and to work from an intersectional anti-oppression feminist and decolonizing perspective, which is one that promotes equity and liberation for all women.

Based in Vancouver, British Columbia, we are a non-partisan, incorporated, non-profit society and federally registered charity. We are governed by an independent board of directors, and we work in collaboration with similar organizations across Canada and internationally.

Over the past 17 years, BWSS has developed a unique expertise and intersectional approach to the complex and overlapping identities and factors of oppression, disadvantages that impact women and contribute to their subjugation and vulnerability to gender-based violence, including and not limited to domestic and sexualized violence.

We do this through direct service provision. In 2019, we responded to over 18,000 requests for service through our intake and crisis line, counselling, support groups, legal services and advocacy, employment, indigenous women's program, black women's program and Latin American women's program.

- (1605)

We also deliver skill-based training for professionals, systems and community groups, volunteers and other individuals. Training and educational workshops are grounded in sound theoretical frameworks that include trauma, socio-cultural and intersectional theory and practice.

Our advocacy reach includes legal, institutional and systemic advocacy to improve the status of women in Canada and the response to gender-based violence.

I speak today on behalf of Battered Women's Support Services, where our volunteer and staff team continue to provide support services on the front line, supporting survivors of gender-based violence with crisis intervention, counselling and legal advocacy.

Like our counterparts across British Columbia and Canada, the women who access our services are navigating violence against women and gender-based violence including domestic and sexual violence, poverty, substandard and precarious housing, substance use and ill mental health, sex work and sexual exploitation, as well as compromised immune systems resulting from all of these factors.

The COVID-19 pandemic poses very specific challenges for women in our communities. Our services and programs are the vital community-based response positioned to make a difference. The work of our organizations includes alleviating isolation, as well as providing vital support services that increase women's safety and keep women alive. Our support services span crisis, domestic and sexual violence intervention.

Last year I had the privilege of visiting China and through those contacts and networks we learned that quarantine was increasing the instances of domestic violence. In those cases, our Chinese counterparts cited the COVID-19 pandemic as the major contributing factor in 90% of the cases. This feedback from our Chinese counterparts in Beijing, Guangzhou, and Jinzhou was clear. It was important to ensure the continuation of services, expand or modify services and take every action available to advise women of services.

In early March, Battered Women's Support Services thoughtfully and strongly considered these potential increased rates of violence and worked to get out in front of the problem. We recognize the importance of being nimble and creative, so our actions involved scaling up our direct service provision to 24 hours a day, seven days a week. We included email and text options as well as a toll-free number.

We dedicated the homepage of our website to COVID-19 and violence-specific information including safety plans; how to help a friend, neighbour or family member; and a listing of shelters and transitional housing in Canada and internationally. We continue to

deploy a comprehensive communications plan utilizing social and mainstream media, advertising, blogs and email blasts.

We advocated as strongly as we could with municipal, provincial and federal governments for unrestricted funding for supplies, service modification and increased staffing levels. We sought engagement with provincial and federal health offices to deliver messaging through their platforms to advise victims of gender-based violence that their physical safety was more important than social distancing, and to seek out crisis line and text support.

We continue to utilize alternative measures to conduct outreach and follow up through remote networks, and we maintain our physical office for drop-ins and individual, in-person appointments.

Through these efforts, demand for our services increased upward of 300%. Calls fell into seven general themes: women who were out of abusive relationships and were experiencing increased post-trauma reactions and suicidality; women currently living with abusive partners who were looking for opportunities to ensure their safety and to understand their situation; co-workers of women who were living with abusive partners where work from home had impacted their ability to assist their co-workers as they had been previously; family members who wanted to know how they could assist their sister, mother, aunt, cousin, who they knew were in abusive relationships; neighbours who had a previous awareness or who had just become aware of a woman in their apartment building or community and were looking for options; professionals who wanted to consult on how they could support their clients under COVID-19; and children and youth who had witnessed their mother's abuse their entire lives and were calling to discuss how they could plan for their safety, their mother's safety and that of their siblings.

• (1610)

The contributing factors we have identified through our front-line work over the last three months have been economic insecurity and poverty-related stress; the very real impact of social isolation and quarantine; increased alcohol consumption and the consumption of other substances, licit and illicit; exposure to exploitative relationships; reduced health service availability and access to first responders; reduced contact with schools, neighbours, hairdressers, etc.; fear to seek help and/or leave the house; the inability to temporarily escape abusive relationships and partners; and exposure to ongoing violence, including violence in the community, such as sexual harassment from landlords. Women were profoundly impacted by the scaling back of services, as each service was navigating its own needs in terms of staffing and social distancing. There was also a profound lack of funding support at the front end of social distancing mandates.

In the past, women would contact their support service over the phone while they or their abusive partner was at work or otherwise out of the house. With the COVID-19 restrictions, women have fewer opportunities to leave the house and fewer opportunities to call a support service such as a shelter. Many shelters and transition houses are communal living areas, with shared kitchens, laundry and common areas, and in some cases shared rooms, and in most cases shared bathrooms. This kind of environment is not conducive to social distancing, and numerous women whom we have placed in transition houses have left, citing too much isolation during the lockdown. We have since engaged the private sector as we continue to work with transition houses, and have a floor of rooms in a Vancouver hotel, where we have housed and are housing 15 women and six children on a temporary basis.

Combined with the escalated COVID-19 home-quarantine measures, abusive partners are using isolation, coercion, threats, emotional abuse, economic abuse, abuse of children and companion animals, and their privilege to fully maximize their power and control and exert violence on their victims, with lethal effect.

In one month, we've experienced 11 killings of women. On April 1, a 41-year-old woman was murdered by her 35-year-old partner in Ontario. On April 1, a 33-year-old woman was killed by her domestic partner in Brockville, Ontario. On April 2, Tracey MacKenzie was killed by her partner in Hammonds Plains, Nova Scotia. On April 8, 61-year-old Tina Seminara was assaulted by her husband in Osoyoos, British Columbia, and died a week later from her injuries. On April 11, Julie Racette, a 33-year-old woman, was killed by her partner in Winnipeg, Manitoba.

On April 17, a woman was assaulted in Portapique, Nova Scotia, by her long-term common-law partner. She managed to escape and hid in the woods. The man proceeded to murder 22 people, the deadliest mass shooting in Canada's history. The same man intended to killing his ex-wife. Brittany Ann Meszaros, a 24-year-old, was killed by her common-law partner in Calgary on April 27. On May 1, Tina Tingley-McAleer, a 43-year-old woman who was called an amazing sister and great mom, was killed by her domestic partner in Hillsborough, New Brunswick. On May 4, Lois Paterson-Gartner, 55 years old, and her 13-year-old daughter and their family dog were found dead in a murder-suicide carried out by a man they lived with in rural Strathcona County, Alberta.

This number of killings represents a statistical spike in lethal misogynist violence. It is up to Canada to reinforce the community-based matrix of women- and gender-based violence services. For us, it doesn't really matter whether we're talking about pre-COVID-19 or now, with the lessening of social distancing measures. We continue to do the work, and we know that gender-based violence was already a pandemic. For every woman who is killed, we know from our front-line work that there are thousands more living in fear.

Thank you.

• (1615)

The Chair: Thank you, Ms. MacDougall.

We will now go to Mr. Sauvé.

Mr. Sauvé, please go ahead for 10 minutes.

[*Translation*]

Mr. Conrad Sauvé (President and Chief Executive Officer, Canadian Red Cross): Good evening, Mr. Chair. Thank you for having me here.

My name is Conrad Sauvé. I'm the president and chief executive officer of the Canadian Red Cross. I'm honoured to be here today to update you on the important work, as outlined in the documents provided, that the Canadian Red Cross is carrying out across Canada to support individuals and communities and to help the municipal, provincial and federal governments respond to the COVID-19 pandemic.

[*English*]

While we've been gradually increasing our responses to this and our responses to natural disasters here in Canada, it goes without saying that the size and scope of this response is unprecedented in our history. We have been responding from the first days of the outbreak by providing support to the Public Health Agency of Canada in helping some 1,200 Canadian travellers and crew members who were quarantined in Trenton and Cornwall in the early days, as well as providing psychosocial support in Japan for the more than 50 Canadians who were in 40 different hospitals in Japan.

It's important to note that we had the ability and the expertise to do this because we have been engaged internationally, thanks to the support of the Canadian government, in deploying both cholera and Ebola clinics in the last number of years. We reassigned our international health experts to help with the early stages of the response to the quarantine, in setting up, with the public health agencies, the appropriate protocols to ensure for our staff, our volunteers and those we helped that it could be done safely.

We are also in partnership with Global Affairs Canada in supporting the shipping and receiving of international donations and protective equipment.

[Translation]

The Red Cross is also continuing to provide assistance in a variety of ways to seniors or vulnerable people here in Canada.

In Toronto, for example, we distributed over 5,000 food hampers to seniors or vulnerable people who couldn't leave their homes.

In Ottawa, we launched a home support program and we visited almost 3,000 seniors to make sure that they had what they needed.

Together with Indigenous Services Canada, we created a virtual operations centre to provide mental health information, assistance, guidance and support to indigenous communities across the country.

For several weeks, the Red Cross has been providing support to seniors' centres in Montreal, particularly in the West Island. Our support is focused on three areas: personnel recruitment, which is a major concern; the training of personnel and volunteers who enter the facilities; and the deployment of personnel to different facilities to ensure that infection control measures are being properly monitored. We started with eight health care facilities and we're now at over 40. The demand keeps growing. With the Ontario government, we're even looking at the possibility of deploying similar teams in that province.

Our work with Employment and Social Development Canada is another very important part of our activities. From the start, we've been talking about the importance of providing training and protective equipment, not only in the various facilities, but also in the community.

• (1620)

We now have a support program that includes personal protective equipment for the community and training. The program targets about 5,000 organizations. We also have a funding program for non-profit organizations that don't have charitable status. This program has just been launched.

[English]

As you can see, there's a large-scale increase in our operations throughout the country, but just because we have COVID-19 doesn't mean there are no longer natural disasters. We're active, of course, in many places presently. Again, with flooding in Fort McMurray, we are there. Following the request of the Government of Nova Scotia, we're raising funds for the victims of the terrible tragedy that happened there, which we were talking about a little earlier.

These events are a reminder that there are factors we can plan for in our response, but there are also many risks we cannot plan for. I'm not going to get into all of the types of responses that the Red Cross has had, but when we're looking ahead, there are really three areas that we can continue to invest in regarding our response.

One is the focus on vulnerable populations, not just in institutions but in the community. We're doing work in Toronto and Ottawa, going door to door in some communities. We need to map out and understand where vulnerable people are, not just during these events but also on an ongoing basis. We are also doing friendly calls throughout the country, again to ensure that people are safe in these communities. We're seeing that the outreach, what we're doing around Ottawa for example, is essential.

In the case of COVID-19, we've deployed some of our [Technical difficulty—Editor] we have purchased. We have an expertise globally in this area. This has been funded by Global Affairs Canada, so we can do work internationally. We've deployed field hospitals in many parts of the world, from Nepal to the Philippines to Congo. As I mentioned earlier, we're managing Ebola clinics and cholera clinics as well.

It is the first time we've deployed this equipment in Canada. We've deployed part of our field hospital in Vancouver and Montreal, and we have been supporting communities in the north with mobile capacity. Obviously we need to again look at building up a stronger capacity for a national response as well. We're looking to work with the provinces on what the needs are moving forward.

We have been increasing our operations throughout the country. Again, we're dealing with a combined issue of the pandemic and natural disasters. This will require us to think about how to increase our base capacity and what new level of base capacity we must maintain to support municipal governments, provincial governments and the federal government with moving forward.

I'd be happy to answer questions.

Thank you.

• (1625)

The Chair: Thank you, Mr. Sauvé.

We will now go to Ms. York.

Ms. York, please go ahead for 10 minutes.

Ms. Fiona York (Project Coordinator and Administrator, Carnegie Community Action Project): Thank you for inviting me to be a witness at the House of Commons Standing Committee on Health.

I would like to first acknowledge that I'm speaking to you from the unceded traditional territory of the Coast Salish peoples, including the territories of the Musqueam, the Squamish and the Tsleil-Waututh nations.

My name is Fiona York. I'm the coordinator and administrator of the Carnegie Community Action Project. I've worked in the Downtown Eastside of Vancouver for 10 years.

I'm speaking today about those who are homeless, under-housed or inadequately housed, and impacted by poverty and trauma in the Downtown Eastside. Among the most impacted by the current crisis are those who are homeless and living in shelters and SROs, single-room occupancy hotels.

The Chair: Pardon me, Ms. York. Maybe you could slow down a bit so that it won't be hard for the interpreters to keep up.

Ms. Fiona York: The last City of Vancouver homelessness count showed that there are over 1,200 homeless people in the Downtown Eastside, including 600 unsheltered, which is an undercount. In March, the City of Vancouver declared a homelessness emergency in the city of Vancouver. This is a population that has sustained trauma—personal, systemic and colonial trauma, poverty and stigma, and the trauma of the HIV epidemic in the 1990s.

Now it is in the midst of one of the worst traumas: the opioid crisis that has claimed almost 1,000 lives in the last four years. Added to this is the current pandemic, which both directly and indirectly impacts people in many ways.

The CDC explains that COVID-19 most affects older adults and those with pre-existing health conditions, such as those with heart disease, diabetes, asthma, HIV, COPD and lupus. Housing activists have stated over the years that housing is health care. Homeless people already die at a rate that is twice as high as that of the rest of the population.

Diane Yentel, president of the National Low Income Housing Coalition in the U.S., says it has never been so obvious that “housing is health care” and that we must provide resources to protect people who are homeless from infection and contagion. We also need to prevent others from becoming homeless during a public health emergency. It's really critical. Not only is it a moral imperative that we do so, but a public health necessity.

Homelessness is currently at an all-time high. Numbers increased by 1% to 2% over the last few years, and homelessness counts are always undercounts. SROs, shelters and supportive housing went into lockdown early in the pandemic.

The Chair: Pardon me, but you're still a little fast. People tend to read faster than they speak, so could you just slow down a bit? Thank you.

Ms. Fiona York: This has added more homeless who used to shelter with friends and family. One estimate is as high as an additional 400 homeless due to no-guest policies. As well, shelters reduced capacity by up to 50%, meaning even more people in the street.

Privately owned SROs are often poorly maintained and have shared washrooms and kitchens, meaning that residents are in close contact and unable to safely self-isolate. Government funding pro-

vided meals and cleaning in only 11 SROs, which will be ending soon.

Peers and non-profit groups have been providing meals, supplies, information and support to people living in tents, on the street and in inadequate housing in the Downtown Eastside. Over 10,000 meals and hygiene kits have been provided by CCAP volunteer efforts.

Coming out of this crisis, housing needs to be radically rethought. The lack of housing is devastating and contributes to unsheltered deaths through exposure, violence, substance use and ill health. Now it is clearer than ever that housing is essential to support the most vulnerable.

A demand for hotels from the province and city was answered by the targeted evacuation of Oppenheimer Park tent city, bypassing those most in need and most at risk of COVID.

Taking into account the homeless population, the newly homeless, those in SROs and shelters, close to 9,000 hotel rooms would be needed; 262 were offered to Oppenheimer Park residents, with a reported 638 rooms being provided in total.

As borders closed, the illicit drug supply closed and drugs became even more lethal. Several overdose prevention sites, OPS, closed, and OPS use went down from 6,000 per week to 2,000 per week. Overdoses spiked in March, with eight deaths in one week in March. Safe supply measures have helped to address the crisis, but there is no confirmation that it will continue past the pandemic.

Sex workers are another group that is disproportionately impacted by COVID-19. Sex workers have been pushed into more unsafe situations, unable to work at home due to no-guest policies and left without an income.

Lack of communication and Internet contributes to lack of safety and health-related information. Community centres, libraries and daytime drop-in spaces all closed, eliminating access points for information, phones, charging phones, Wi-Fi and Internet, and pushing people into the street. On one side of one block at Hastings and Main streets 167 people were counted. These enforced crowded conditions contribute to lack of social distancing and inability to follow health directives.

Community groups have called to open the streets to pedestrians to give those displaced from other spaces somewhere to go, and to close a portion of Hastings Street to non-emergency vehicular traffic. Once again these displacements from public spaces, services, housing, shelters and parks displace the most vulnerable and, disproportionately, the indigenous and those affected by trauma, poverty and colonialism.

Over-policing has been the response to the crowded conditions outdoors. Overuse and misuse of policing is a way to respond and control a community facing a pandemic and unprecedented closures and lack of supports, once again stigmatizing and pathologizing those most in need.

The lack of indoor and daytime services has also led to a massive failure of sanitation and washrooms. Handwashing stations and porta-potties were placed on Hastings Street and a few other locations. These inadequate facilities led to two deaths in two weeks, including an infant found passed away in a porta-potty.

Many peers found themselves out of work when facilities and services shut down. Community members subsist on punitively small incomes and the small amounts received from peer work are essential supplements.

Food security was immediately, and continues to be, one of the major concerns during the pandemic, with so many daytime facilities and resources closed. Community members and groups responded with donations, in-kind donations and support for meal distribution programs.

The issues of housing, food security, washrooms and handwashing were nowhere more apparent than the tent city at Oppenheimer Park. There were over 200 tents and 250 people in Oppenheimer Park until May. The provincial announcement on April 25 was welcome news that hotels would be leveraged to safely house those who are homeless, but didn't go nearly far enough and clearly targeted the eyesore of very visible homelessness in Oppenheimer Park.

Once again, hotel units and SROs were stockpiled for those in the park and bypassed others far more in need and at risk.

- (1630)

The hotels offered did not address community needs or respond to community input. Restrictive guest policies, no pets or partners and punitive and restrictive rules have made them inaccessible to many vulnerable people.

A new tent city has been established in the federally owned parking lot at CRAB Park nearby in the Downtown Eastside, with 40 community members who were unhoused or inadequately housed after Oppenheimer Park, or the many others who are homeless. Park bylaws in Vancouver have lagged behind the provincial requirements that camping be allowed overnight, and street sweeps displace those sleeping in the street on a daily basis. For many, there is simply nowhere to go.

My recommendations are as follows.

Call on the federal government to have a national plan and to work with all levels of government to immediately house the home-

less by securing empty hotel rooms to house the homeless and the under-housed. Secure the hotels now and turn them into permanent housing.

House the most vulnerable, not just the most visible. Follow the examples of other cities by triaging and housing those with the highest risk factors, those who are over 65 years old and with underlying health conditions.

Have an open and honest sit-down dialogue about any plan to house first peoples in urban environments and about what plan is coming to provide homes for on-reserve families with all the basics, including drinking water.

Make homes available for the 2,000 plus sidewalk-dwelling persons, especially during this coronavirus, and secure federal funds to open the Balmoral and Regent hotel rooms, which would give downtown residents a home in a known service-providing community.

The national housing strategy only suggests reducing homelessness by 50% over 20 years. Instead, we need a federal commitment for the prevention and elimination of homelessness, with expanded federal investment in community-based homelessness responses.

We recommend the construction of over 300,000 new permanent shelter-rate housing units and enhanced rental supports for low-income Canadians.

We recommend the meaningful implementation of the right to housing. Immediately purchase or build 3,000 homes that are shelter-rate homes.

Develop and fund an aggressive acquisition strategy and work in partnership with provincial, municipal and non-profit sectors to purchase properties and assets for shelter-rate permanent housing now.

Prevent those with deep pockets from sweeping up assets and protect against predatory purchasing of properties.

Make reconciliation a reality through respectful engagement with indigenous peoples and no pipelines on unceded territories and by following the recommendations of Red Women Rising, the UN Declaration on the Rights of Indigenous Peoples, and the Truth and Reconciliation Commission.

Given that urban indigenous people are overrepresented among the homeless population, the federal government needs a national strategy addressing urban indigenous, one that is led by indigenous people for indigenous people.

Don't further displace indigenous people from unceded land by moving people encamped on federal lands or spaces. Let the homeless—mostly indigenous people—stay at CRAB Park, where they are safely encamped now but are facing an injunction that will displace them into streets and alleys that are more dangerous.

Enact the national protocol on tent encampments written by former UN rapporteur on adequate housing, Leilani Farha.

Invest in the guidance and direction of peers to ensure the efficacy and appropriateness of any response to homelessness.

Work with provinces and territories to provide adequate supplies of personal protective equipment to peers and front-line workers.

Finally, ensure access to real safe supply. The opioid crisis remains the biggest health and safety threat in the Downtown East-side.

Thank you very much for your attention.

• (1635)

The Chair: Thank you very much.

We will go now to Dr. Tien.

Dr. Tien, please go ahead. You have 10 minutes.

Dr. Homer Tien (President and Chief Executive Officer, Ornge): Thank you very much.

Good day. I want to thank you for the opportunity to address the Standing Committee on Health today for the briefing on the Canadian response to the outbreak of the coronavirus.

My name is Homer Tien. I'm the president and CEO of Ornge, the provider of air ambulance and critical care transport services to the province of Ontario. I assumed my role in January 2020 after serving as the organization's chief medical officer for five years. I'm a surgeon by training, and I was previously medical director for trauma at Toronto Sunnybrook Health Sciences Centre where I still maintain a practice as a trauma surgeon.

I also spent 25 years in the Canadian Armed Forces and retired from the forces as a colonel in 2015 after deploying multiple times to front-line field hospitals in the former Yugoslavia and Afghanistan.

I'm here representing the more than 600 people who are part of the team at Ornge. We're the largest air medical and critical care transport organization in Canada, and we conduct approximately 20,000 patient-related transports per year.

Ornge is an integral part of Ontario's health care system, which is based on a hub-and-spoke model of care. In this model, patients are transported from smaller facilities in rural and remote communities to larger hospitals to receive a higher level of care. To preserve capacity for the next patient, these same patients are then repatriated back to their home hospital when it is appropriate and safe to do so.

More than 90% of our work is devoted to this type of inter-facility transport. To carry out our mission, we have a mix of helicopters, fixed-wing aircraft and land ambulances staffed by highly skilled paramedics and pilots. They are supported by aircraft maintenance

engineers, communication officers, physicians and administrative staff.

Our operations are based in 11 communities across Ontario with our head office in Mississauga.

Today I would like to share with you the details of our operational response to COVID-19 and provide the committee with some ideas for consideration.

Caring for a patient effectively and safely in a mobile environment is challenging. It's about safely and efficiently getting the right patient to the right place with the right assets and crew at the right time. In the case of air transport, we even need a bit of luck with the weather.

COVID-19 has added entirely new complications to this mix. You need to optimize staffing to create search capacity. You need to re-evaluate your personal protective equipment needs in order to reduce risk to staff and patients. If you think about it, we're operating within the confined space of an aircraft or a land ambulance, a little box, while that patient is coughing or being mechanically ventilated within a couple of inches of the paramedic.

As COVID-19 first began to unfold, our organization had three basic objectives—protecting our staff, maintaining service delivery, and planning for a surge. These objectives have informed every decision and every action we have taken.

As of May 15, Ornge has transported 531 patients with either a confirmed or suspected COVID-19 diagnosis. Nearly half of these were transported by our critical care land ambulances, about 30% on our fixed-wing aircraft, and about 20% in our helicopters. These were all terribly sick patients. Nearly half of these patients were intubated and being mechanically ventilated. I'm pleased to report that to date no Ornge staff members have tested positive for COVID-19.

I would like to spend some time on one particular aspect of our operation. Ornge is the agency responsible for transporting stretch-bound patients in and out of rural and remote indigenous communities in the north, many of which are accessible only by air. Our air ambulance crews respond regularly to approximately 30 nursing stations across northern Ontario performing more than 2,500 transports annually from these communities.

If one of these communities suddenly found itself with a number of severe cases of COVID-19, the local health care resources would likely become overwhelmed quickly. This situation would lead to a sudden and immediate demand for air medical transport, and in order to protect the other people in the community, those exposed would need to be tested. Those tests would need to be processed quickly at labs in larger centres, but with commercial carriers ceasing or scaling back operations, this becomes much more challenging.

● (1640)

Planning for these scenarios has been a central focus at Ornge since the crisis began. Ornge is a tool for health equity, particularly for rural communities and remote indigenous communities. We realize that we need to be creative, innovative and thoughtful about how we use our capabilities in order to provide the needed access to care.

Since mid-April, Ornge has been coordinating weekly logistical flights to transport samples from northern communities to the labs in the south for processing. To date, more than 2,000 COVID-19 testing samples have been transported via Ornge contracted aircraft. This has dramatically increased the speed of processing results, which we all know is critically important to preventing the spread of COVID. In addition, there's been considerable interest in reducing unnecessary travel to hospitals, particularly to those in the south.

For the past two years, Ornge, with its partners, has been supplying point-of-care lab tests to remote indigenous communities in the northwest. This has allowed members of these communities to access the appropriate diagnostic care in their communities and avoid unnecessary transport to southern hospitals, where they could be exposed to infection. As well, there's tremendous interest in telemedicine across the entire health care sector for the same reason. We've already been offering virtual consultations to northwest nursing stations in partnership with Thunder Bay hospital.

Last month, Ornge began providing additional telemedicine support to the rest of Ontario in partnership with CitiCall Ontario, a provincial bed-finding agency. Under this arrangement, any physician in any Ontario hospital can reach out to an Ornge emergency medicine physician, ICU physician or pediatrician to receive assistance in managing a patient, 24-7. This service is not specific to COVID and can be used for patients with general, acute and other critical care needs.

We're also working with some of our system partners to look at novel technological solutions. Specifically, we're exploring remotely piloted aircraft systems, or drone technologies, for the purpose of improving health equity for northern communities. This could involve the delivering of critical medical supplies to nursing stations and the shipping of medical lab samples to health centres.

From a surge planning perspective, we're tapping into our most valuable resource, our people. Ornge has solicited paramedic volunteers to form a COVID-19 Ornge surge response team. There are 46 Ornge paramedics from across the province who have volunteered. They can be dropped off at any facility in the province to help with airway management and mechanical ventilation prior to transport. The team's deployment kit has the equipment and medications to be able to function independently, and includes the fully equipped airway management bag, a portable mechanical ventilator, monitors, medications and infusion pumps.

None of this could happen without the tireless dedication of our staff, which is why they need whatever support we can provide them during this stressful period. Whenever one of our crews transports a patient with a confirmed case of COVID-19, upon completion of that transport, we automatically put them on an operational pause. The crew is taken off-line temporarily in order to facilitate a

debrief and a check on their personal needs and anxiety levels. In doing so, we're hoping to take care of their mental well-being as well as their physical well-being.

The Canadian health care system is one of the best in the world. Unfortunately, disasters like the COVID-19 pandemic reveal that our rural and remote communities are more vulnerable to disruptions in care pathways than our more urban communities. Air ambulance and critical care transport services are nimble, operationally focused organizations. We have the ability to innovate and adapt quickly to unconventional problems that affect access to care and health equity. I'd ask leaders and health care organizations to just ask us if they have a problem, and we will find a way to help.

Thank you to the committee members for inviting me to speak. I look forward to your questions and discussions later.

● (1645)

The Chair: Thank you, Dr. Tien.

We will go now to Ms. Polsinelli.

Ms. Polsinelli, please go ahead for 10 minutes.

Ms. Nancy Polsinelli (Interim Chief Administrative Officer, Region of Peel): Thank you, Mr. Chair, for the opportunity to present to the Standing Committee on Health. And good afternoon to members of the committee.

My name is Nancy Polsinelli, and I am the interim CAO for the Region of Peel, which I will refer to in my presentation as "the region". The region is an upper-tier municipal government providing services across the geographic area of Peel in Ontario. Peel is made up of our partner communities Brampton, Caledon and Mississauga. Peel is home to approximately 1.5 million people and over 175,000 businesses. The region delivers health, human services and public works across Peel.

COVID has brought unprecedented economic, social and health impacts for all Canadians, including those living and working in Peel. The social impacts are highest among the most vulnerable and marginalized in our community, as you heard from the witnesses this evening. This can be the result of social isolation, inadequate housing, loss of jobs or food insecurity. As I am sure this committee has previously heard, these social determinants impact personal health.

One of the most challenging social determinants of health in a pandemic is homelessness. Approximately 4,000 homeless people live in Brampton, Caledon and Mississauga, based on a point-in-time survey done by the region in 2018, so it's already outdated.

When the crisis began, homeless residents in shelters were offered hotels to encourage physical distancing. We acted quickly on that. About 50% of homeless residents now reside in hotels across Peel.

We rapidly scaled up testing at the sites where the region and its partners were offering services, with the region's paramedics assisting. The region's public health staff ensured shelters and other services were operating safely. An isolation program provides shelter for those who have risk factors for COVID-19 exposure or have been tested but who can't self-isolate. Those who test positive are provided with a secure, safe place for recovery and support.

Let me share one person's story; it shows how interconnected challenges can be in a pandemic. For the sake of privacy, I'm changing the name, but this is a true story. Donovan is 20 years old and he is definitely a front-line hero. He works as a cleaner in one of the 28 long-term care homes located in Peel. The region itself operates five municipal long-term care homes, but Donovan does not work in one of our homes. Although Donovan works full time, he finds it difficult to afford housing in Peel, where nearly 70% of low-income households live in unaffordable housing. While supporting the comfort and care of seniors in a home that is facing chronic COVID outbreaks, Donovan himself was going to sleep at night in a local shelter for young people.

Unfortunately, he tested positive for COVID-19. Donovan was immediately connected to our recovery program for the homeless where he can have the proper care, space and peace of mind to recover. Of course, Donovan had contact with other shelter staff; 13 of this staff are now in temporary self-isolation hotel spaces for essential workers. But this is not the end of Donovan's story.

The region's recovery program provides more than a self-isolation space. Once someone like Donovan is introduced to our program, all of their immediate acute-care needs are met. Donovan will see a physician, a nurse practitioner, and have access to 24-7 nursing care on site. The region will also provide additional health and social services support to provide a path to long-term housing, health and well-being. It truly is a wraparound service. For example, Donovan may be connected to primary care that he can continue using after isolation.

As we meet immediate needs in the COVID crisis, we are also addressing other health issues and seeking permanent housing for homeless clients. To do this, the region mobilized non-profits, community agencies, the region's paramedics and public health experts and health care providers.

- (1650)

COVID has called on communities to partner and collaborate on a whole new level. Another example of this collaboration is the Region of Peel's community response table. The response table addresses a broad range of needs, such as poverty, food insecurity, isolation, domestic violence, racism and mental health.

In the early weeks of the crisis, the region sent a survey to community agencies. We wanted to know what was keeping them up at night. The survey found, among other things, that 57% of those surveyed were facing immediate program closures. Like other organizations, not-for-profits needed support to adapt to the crisis so they could support the community.

The region's council approved over \$1 million in funding to provide one-time grants to Peel community agencies that support the most vulnerable. In addition to financial support, the community re-

sponse table helps providers find strength in numbers. It's made up of people from the region's human and health services departments, representatives from our partner communities and leaders from over 90 community agencies across Peel. The virtual table meets twice per week and it has self-organized even further to create task groups that address family violence, the needs of seniors and youth, and systemic discrimination.

The pandemic has called for us to locally develop solutions through innovation and partnerships. Beyond the immediate crisis, the community response table can be a continuing force for positive change in Peel through the recovery and beyond.

As the communities across Canada have found, seniors in long-term care are among the most vulnerable in the pandemic. As I mentioned, the region operates five long-term care homes, and there are 23 additional homes within Peel. To address the needs of these vulnerable residents, we also participate, as a region, in an integrated response table. This includes Ontario health partners, local hospitals, and the region's own public health, long-term care and paramedic services. This work features a rapid-response testing strategy in long-term care homes, in at-risk retirement homes, in shelters and in group homes. They have done over 8,400 tests for residents and staff beyond the amount the homes themselves have tested.

COVID-19 is also amplifying system pressures for mental health and addictions services. In the pandemic, many programs have been put on hold. Wait-lists are growing. This is unsustainable over the longer term. There is, and will be, a human and community cost. Before the pandemic, the region had created a community safety and well-being action table. It's this group that is helping to coordinate community partners as we mitigate mental health crisis situations and strengthen system navigation with local services.

In closing, municipalities like the region are on the front lines working to protect our residents, including the vulnerable. Every day we see opportunities to do more. We're committed to working with our provincial and federal partners to ensure a strong crisis response and gradual, careful recovery.

The pandemic is an unprecedented crisis that called for new forms of partnership. I'm proud to say that the region has done that work.

I hope that the members of this committee will see that the partnerships that municipalities have developed to help the vulnerable during the crisis should be maintained and even expanded. There is opportunity here. As senior governments seek to target human needs, it's these networks that can help to ensure that investments reach the most in need and support strong community recovery. There is great value and opportunity in having the federal government investing strategically with municipalities.

I want to thank you for your time today. We look forward to working with you to support Peel's diverse and growing community.

Thank you.

• (1655)

The Chair: Thank you, Ms. Polsinelli.

We will now go to our first round of questions.

Mrs. Vecchio, please go ahead. You have six minutes.

Mrs. Karen Vecchio (Elgin—Middlesex—London, CPC): Thank you very much, Mr. Chair.

I'm going to start with the Battered Women's Support Services.

Thank you very much for sharing all the information you have.

Ms. Angela MacDougall: You're welcome.

Mrs. Karen Vecchio: I understand this is an incredible time. In my community, we've seen about a 45% increase...and you're saying there are over 300 times those calls, which is incredible.

For those women trying to flee, are you finding that the majority are single or with families? What do those numbers look like?

Ms. Angela MacDougall: We're seeing that it's about split down the middle between women who are leaving without children—either their children are in care or are older or in some other situation—and women who have one or up to six children, depending on how large the family is.

Mrs. Karen Vecchio: Of the money that came out, \$50 million was provided to shelters and services. Were you one of the recipients?

Ms. Angela MacDougall: Unfortunately not. I think that was a really important investment in funding for shelters and sexual assault services. Organizations like Battered Women's Support Services, and 500 organizations all across the country provide similar services to ours—not specifically sexual violence and not sheltered transitional housing. We fell through the gap there.

Mrs. Karen Vecchio: Those are exactly my concerns. That is what I'm hearing from many women's organizations across the country, that there is this massive gap.

We know that only about \$10 million is left in the contingency fund. Of course, money is one of the issues, but what are some of the solutions we can do? We don't know how quickly the money in this contingency fund is going to go out the door.

Ms. Angela MacDougall: Do you mean in addition to that \$10 million or with that \$10 million?

Mrs. Karen Vecchio: In addition to, or some of the things that you see may be a solution, recognizing that funds might be very tight as well. What can we do?

• (1700)

Ms. Angela MacDougall: I always hope very much that the Canadian government would recognize how important women are in Canada from an intersectional lens and would understand that gender-based violence is one of the most pressing issues for us, whether it's sexual harassment, sexual assault or domestic violence, and the range and the ways that gender violence spans our lifetime from the cradle to the grave. It's baked into Canadian society.

I wish Canada cared enough about that to increase the level of funding, to understand that matters very much that women feel safe and are able to navigate the world, navigate Canada and all aspects of our lived experience, so that \$10 million would double.

I recognize the role of the private sector and that we want the private sector and the larger community to engage. Government has a role, but this is a social problem that we all need to be a part of.

Mrs. Karen Vecchio: Excellent. I wasn't thinking about this, but you prompted a new question by me.

One other thing I think is very important are organizations for men. We know that many of them are the perpetrators. Are you familiar with community organizations that have received funding to assist men who are trying to move forward—a change in ways type of program?

Ms. Angela MacDougall: Interestingly, the first part of my professional life was working with men who were court ordered to what we call “batterer's treatment”. That is a piece of expertise I have, and I pay close attention to it, but there has not been an investment in that. There has been an investment in bystander intervention.

It's good for us to have a healthy level of appreciation for those services, but the biggest message within Canada is to recognize on a broad scale how endemic gender-based violence is and that this should be front and centre all the time. It should be part of all COVID-19 advertising that comes through the federal government. It should be front of mind for everybody right now; this is a key moment for us. Changing culture involves services and recognizing the social inequality, and the role men and boys play.

Mrs. Karen Vecchio: As I said, I've heard so much about this. Across the country, we've seen these increases. We know there is the financial stress, but the biggest issue is that women are stuck with their abusers, because they're not going to work or to school. Even a moment to have a breath is gone for these women.

For many of the women you're speaking to, what are some of the greatest challenges right now to their ability to escape their abusers, specifically with COVID-19?

Ms. Angela MacDougall: We wanted sufficient advertising and media attention to this issue. Every time we had media or did campaigns through social media, our calls increased, and we're not the only ones who had that experience. That was really important for women to find a way. If they knew that services were available, they found a way to reach out.

We've been able to help women to leave, and I have to honour their courage. Imagine leaving your home and an abusive partner during a pandemic. Hundreds of women have done that in British Columbia, and we've been able to support many of them through Battered Women's Support Services.

Mrs. Karen Vecchio: Gosh.

Mr. Chair, how many minutes do I have left?

The Chair: Just under two minutes.

Mrs. Karen Vecchio: Fantastic. Thank you.

Just carrying on with that line—

The Chair: Correction: just under one minute.

Mrs. Karen Vecchio: That's not a problem.

Thank you so much, Ms. MacDougall.

Switching over to the Peel region, you've been offering a lot of places for shelters. What specifically are you doing for those domestic abuse cases?

Ms. Nancy Polsinelli: We're doing a couple of things. Through our community response table, we have a group working on domestic violence. That group is also linked with our community safety and well-being team. In that team a group of community agencies have come together. They are working actively on domestic violence. Through our agency partnerships, we are providing on-the-ground support to anyone who comes forward with those issues. A campaign is also in the works to ensure that we're capturing as many of those cases that may exist across the Peel region.

While Peel is a funder of some of those community agencies, we truly are working through those community agencies to get to the community and to those residents who need our help. We're also working with the Peel Regional Police. They too are part of the community safety and well-being group.

We're really trying to build a web of support. Even with this group, it really depends on what residents' needs are. We're trying to look at how we can provide for needs based on individual cases as opposed to blanket support.

Mrs. Karen Vecchio: Thank you so much.

Thank you, Mr. Chair.

The Chair: We will go now to Ms. Sidhu.

Ms. Sidhu, please go ahead for six minutes.

Ms. Sonia Sidhu (Brampton South, Lib.): Thank you, Mr. Chair.

I'd like to thank all of the witnesses for being here with us.

Like many Canadians, I was deeply horrified to read the Canadian Forces report. One of these homes is in my riding. The abuse allegations described in these homes should alarm all of us. I worked in the health care field for 18 years. I know how important it is to administer compassionate care. We need to do a better job of caring for the people who built this country and who need our help during the crisis.

My first question is for the CEO of the Region of Peel, Nancy Polsinelli.

First, Nancy, thank you for all the work you are doing. The Canadian Armed Forces report identified numerous issues in long-term care. As an operator of five long-term care homes, what do you think are the underlying causes of these issues? What has the region been doing to address the needs of seniors living in region-administrated homes? Do you think there's a difference in the quality of care between region-administrated homes and private care homes in the Peel region?

• (1705)

Ms. Nancy Polsinelli: Thank you for the question. Through the chair, I'm going to separate the question in two and speak first to what I think are the underlying causes of these issues. Then I will certainly provide some comment on your question about the private homes with respect to municipal homes.

The first question is a very important one because, if anything, COVID-19 has exposed various issues in long-term care. When we look at the issues, certainly we will hear about things like staffing ratios, funding and increased complexity of resident needs, which are part of an ongoing discussion about change in long-term care. These are very important, and they're absolutely necessary. However, I want to dive a little deeper, because there are also cultural issues that are at the core of how we approach long-term care. These, I'd like to highlight a little more for the committee.

For a variety of reasons, long-term care has become inherently task based. Our staff rush to bathing, to feeding and to documenting. It's one resident after another, on a very strict schedule, with very little time for anything further. The issue is that when we approach long-term care like a set of tasks—a checklist, if you will—we make the needs of the person who's living in that home secondary to the completing the task. In many cases, it becomes fear-based care by the staff member and not the emotional-based care these seniors deserve.

Here are some thoughts about solutions. We hear a lot about person-centred care; it gets tossed around all the time. But at the core, it does offer solutions, so while we're looking at funding, we also need to look at creating a culture that enables staff to understand and meet the needs of unique people, the people living in the home, for their physical and emotional well-being. This is what helps to improve well-being, and it certainly avoids problems before they arise.

One example I'll give is that of a person living with dementia. We know that people with dementia sometimes wander or pace endlessly. This is an issue, both during the outbreak, because wandering can put them at risk of exposure, and in general, because they can become exhausted and it's a detriment to their own health in increasing their risk of falling.

A task-based approach looks at the wandering as a problem. The wandering becomes the problem. A person may recommend to put this individual on an anti-psychotic medication, or to restrain them, or to allow them to keep on walking all day.

A person-centred approach looks at wandering as the symptom and tries to understand why the person is wandering. We're not fixing the wandering. We're trying to understand why the person is wandering.

Through our work at the Region of Peel, we've implemented the innovative butterfly model of care for dementia care. For people who wander, what we've realized is that they wander because they need something. They're looking for something. They're looking for engagement, affection, security or love. They're also wandering because we put them in environments with long corridors that look endless to them, and they just keep walking. By understanding how we can support them through activity and conversation, we are creating a home environment, a safe one.

To close this, I'm going to suggest that when we enable true person-centred care, it isn't easy. It's not about the surface. It's actually about getting deep into the way we work and the way we think as the staff in those long-term care homes.

Some things need to be considered. We certainly need better staffing ratios so that staff have time to spend getting to know who is in their care, meeting with them, holding their hand and sitting with them. We need regulations that are less focused on documenting the completion of tasks and more focused on measuring the emotional care and well-being of those individuals. We need training programs and the funding to undertake them so that staff can have a better understanding of complex conditions like dementia and how to understand and meet individual needs.

• (1710)

Ms. Sonia Sidhu: Thank you.

On a different topic, as you said, currently the region is using hotels to house 51% of shelter residents and at-risk Canadians. Many of these residents include women fleeing domestic violence. How will the federal government's investment of \$157 million in organizations that support the homeless help the region and help women in particular?

Ms. Nancy Polsinelli: The federal funding provided to the region to date, under the reaching home program, has been critical and essential to the entire regional response. This money has supported region-led initiatives, such as expanding the shelter capacity into vacant hotels—and we have just over 350 homeless individuals in hotel rooms right now—and the development and operating costs of isolation and recovery sites in the program. It has also increased outreach into the community to support safe public health practices. It's all made possible through federal investment.

The region has been able to support funding applications from community agencies as well, so that we can work directly with the homeless population for basic needs like food, cleaning services, enhanced staffing requirements, transportation, as well as supporting those women who are in trepidation and in difficult situations at home.

Further funding will allow these regional programs to run until approximately the middle of August. Further to that, we know that the pandemic is not going anywhere anytime soon. Even as we get into recovery, whether these individuals are homeless or are in domestic violence situations, they will need support, whether it's financial support, food support or general well-being support, far longer than when the emergency is declared over. That's where the funding needs to go.

Ms. Sonia Sidhu: Thank you.

[*Translation*]

The Chair: Thank you, Ms. Sidhu.

We'll now give the floor to Mr. Thériault.

Mr. Thériault, you have the floor for six minutes.

Mr. Luc Desilets (Rivière-des-Mille-Îles, BQ): Mr. Chair, I'll be speaking instead of Mr. Thériault. Mr. Thériault won't be here today. I'll be speaking three times, if that's fine with you.

I want to thank all the guests and witnesses for being here. Every day, we have the opportunity to hear from witnesses like you, and this really gives us valuable food for thought.

I want to take the time to remind everyone that this week is paramedic and pre-hospital emergency care week. I want to acknowledge their front-line work, which is essential in the current difficult period caused by COVID-19.

My first questions are for Mr. Sauvé. The federal government provided almost \$100 million to meet the new requirements created, whether we like it or not, as a result of COVID-19. I believe that this funding is also meant to meet other needs that fall within the purview of your organization.

I want to know how much money is being directly or indirectly invested in connection with COVID-19 and your organization.

Mr. Conrad Sauvé: A large part of the funding announced supports COVID-19 activities that are already in progress, as I said. The Red Cross, together with Health Canada, has significantly increased its support for people in quarantine. These are obviously past operations. There are also the current operations in all airports and the purchase of additional equipment to replenish the mobile equipment deployed, which we'll need for the future. Lastly, there has been an increase in the level of emergency preparedness. As we know, the Red Cross has significantly increased its involvement in emergency operations across the country, particularly in cases of fire or flooding. Since this is taking place in the context of the current pandemic, more training and more volunteers are needed to support people.

I'll digress for a moment. The Red Cross is supported by thousands of volunteers that we train each year and that provide assistance in emergency situations. Many of these volunteers are new Canadian retirees. This creates an additional challenge in the context of COVID-19, since some of these people are more vulnerable. We must recruit younger people for these operations. This contributes to the significant growth and the particular context surrounding COVID-19.

• (1715)

Mr. Luc Desilets: Thank you.

The third area of focus that you referred to earlier was the deployment of personnel directly to the centres or on the ground.

Could you elaborate on this, but with respect to the city of Montreal? Are you talking about deploying personnel to CHSLDs?

Mr. Conrad Sauvé: For Montreal in particular, the answer is threefold. First, the main focus is on supporting the integrated university health and social services centre, or CIUSSS, on the West Island of Montreal. There are three areas of action.

First, we help them recruit personnel. We know that there's a significant need. As a result, we've set up teams to help them with recruitment.

Second, there's also personnel training. We trained about 800 military members, in addition to all the people heading to these different centres.

Third, we've deployed specialized teams to the facilities. Infection control in facilities is obviously an issue. We've deployed teams of two or three people per facility. These teams often remain at the facilities for up to nine days, to help the management team strengthen infection control and limit infections. This type of assistance, which was initially provided in eight facilities, is now available in 40 facilities on the Island of Montreal. The demand could increase to 80 facilities. Right now, there's also demand for the same type of support in Ontario facilities.

We're also discussing the possibility of providing training or training materiel to the Government of Quebec to help it train the people heading to the facilities and the teams of experts that it wants to deploy. This sums up all our efforts.

We're also looking at the situation in the Montreal North community to see how we could meet the demand from local organizations.

Mr. Luc Desilets: What type of support are you receiving from the Government of Quebec or the health department in this case? What type of relationship do you have?

Mr. Conrad Sauvé: We have very close ties with the West Island of Montreal CIUSSS and the Government of Quebec. We're in constant contact. We work all the time, in every province, with provincial and regional authorities. It's an ongoing relationship. The demand has increased in Quebec government facilities.

Mr. Luc Desilets: So you're telling me that—

The Chair: Thank you, Mr. Desilets.

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

[English]

The Chair: Thank you.

Ms. Kwan, go ahead.

Ms. Jenny Kwan (Vancouver East, NDP): Thank you very much, Mr. Chair.

I want to say thank you to all the witnesses for their thoughtful presentations.

My first question is for Ms. MacDougall.

First, I want to thank you tremendously for the work you have done in our community for so many years. Funding was short for your organization even prior to COVID. With a 300% increase in demand for your services, I can't imagine the situation and the pressure that's being put on your entire organization.

You touched a little on the funding aspect. When the government announced its funding for shelters and for transition houses, your organization and others like yours did not qualify for funding.

In light of this, in terms of recommendations, did I hear you correctly that you would like to see a \$20-million investment from the federal government to support your work at this time?

• (1720)

Ms. Angela MacDougall: Yes, we could easily double that \$10 million that has been earmarked for...

And thank you for your comments, Honourable Jenny Kwan. I will share them with our team.

The challenges that we have right now are not going to stop. We've already had a pandemic. We're moving into the next phase of lessening social distancing. There is some sense that things are going to get even more pronounced as we move into this next phase, as women are making decisions. We're not done by any stretch. The \$10 million that has been earmarked, and even the \$50 million that was already provided, has only gotten us to this point, and it's only going to get us to this.

We need a long-term strategy because the lethality has increased. We haven't seen this many killings of women in such a short period of time in Canada. That should jar all of us to recognize that in addition to the many women who are killed, there are so many more living in fear of lethal violence. This is a time for Canada to make a bold step to redress and address what is clearly one of the most pressing social issues emerging in this health crisis.

Ms. Jenny Kwan: Would you say that with the funding, often what governments do is to provide program funding as opposed to core funding, which is essentially what organizations like yours need? I wonder if you could address the issue of core funding.

Ms. Angela MacDougall: We need core funding. Our services our essential, especially now during this pandemic, which has not ceased. We do not have core funding in the same way that health services do, and that is required. If we really understood how significant the social problem is, with its extraordinary impacts on the social determinants of health, we would have core funding. It is mandatory for us to move in that direction and for it to be a part of the next budget. That would be a bold step for Canada to take today.

The Chair: Ms. MacDougall, can you remember to hold up your mike?

Ms. Angela MacDougall: My apologies to the interpreters and to those listening.

The time to act is now. Core funding is one major thing that Canada can do right now to make a measurable difference for women victims of violence today.

Ms. Jenny Kwan: Building on the need to recognize the social inequality that exists in the community, you mentioned the issue of poverty, the lack of housing and so on. What would you recommend to deal with the social inequality that exists today?

Ms. Angela MacDougall: Women are stratified in Canada, so the experience of gender violence is overlaid by other aspects. The amount of violence, deaths and disappearances among indigenous women is higher due to the very reality of their status within Canada. They have been deemed to have a lower status in Canada through the Indian Act and through all the policies and the relationships. Others are stratified along those same lines: women of colour, immigrant women of colour, migrant women and women with precarious immigration status. The social aspects are gendered. They are not created equal and don't roll out equally for

women in Canada. Our policies have to recognize that Canada does have a race and class hierarchy. It is very important that we acknowledge that obvious reality, and that the services, our programs and our policies draw on it too.

Ms. Jenny Kwan: My next question is for Ms. MacDougall and Ms. York.

One of the critical issues of course is access to safe, secure, affordable housing. We already know, from the 2019 homelessness count, that in Vancouver alone over 2,000 people are homeless. The government's national housing strategy talks about reducing homelessness by 50% within 10 years. That's a long ways to go when we're talking about addressing immediate needs for people who are homeless today, especially women and families who are trying to escape violence.

To that end, would you say it is essential for the government to seize this moment to ensure that there is a significant stimulus package in the budget to address the homelessness crisis? As for immediate action, should the government secure all empty hotels right now to house people?

• (1725)

Ms. Angela MacDougall: Fiona, do you want to respond?

Ms. Fiona York: Sure.

I would say that I absolutely agree a hundred per cent that there needs to be immediate, very aggressive and very assertive action around housing. Since the seventies, there's been a real dire shortage of housing and social housing being built and a shortage of funding to the CMHC from the federal government. That's resulted in this really dire lack of housing, affordable housing and especially shelter-grade housing, which is what's really needed. There needs to be a real focus on returning to those levels and building housing for people who are homeless right now and also for people who are under-housed. That needs to be done in a very definite and assertive way immediately.

There's been all this research over and over through the years about how housing reduces other costs in terms of the justice system, the health care system and for so many other costs that are impacted, and how it actually would be more effective to build the housing. Despite all of that over the years, and all of the evidence about how people are impacted by homelessness, it's probably been harder to see the impact than it is currently. During this pandemic, everything is heightened and everything has sped up, and you see it much more clearly.

Just in these few months, it has become so much more obvious and so much more apparent that housing is health care and that it's really needed. Not only are we seeing that people are impacted around the pandemic and the health issues with COVID-19, but all of those connected harms that relate to the shutdown and the way we're responding to the pandemic are also impacting people. Those are the things that I touched on, like the fact there's nowhere for people to go outside and people are being displaced and there's a lack of sanitation. All of those other impacts are related to housing as well, and we see this being really heightened by the current pandemic.

Certainly, there needs to be a real change in how we think about housing and homelessness. With the hotels, what has been offered so far was really targeted and was more of an evacuation than really addressing health issues. When hotels were offered to people in Oppenheimer Park, it was certainly a targeting. That wasn't given to those most in need. We saw younger able-bodied men in Oppenheimer Park being offered hotels—

The Chair: Ms. York, could you please wrap up?

Ms. Fiona York: I'm sorry?

The Chair: Wrap up.

Ms. Fiona York: What was the question?

Wrap up. Yes.

The hotels were offered to only about 5% of those in need. Including those who are homeless and those who are under-housed in SROs and other inadequate housing, the hotels offered addressed about 5% of the need.

The Chair: Thank you, Ms. Kwan.

We go now to Mr. Jeneroux to start round two.

Mr. Jeneroux, please go ahead. You have five minutes.

Mr. Matt Jeneroux (Edmonton Riverbend, CPC): Thank you, Mr. Chair, and thank you, witnesses, for being here today.

I was hoping that Mr. Sauvé would be able to help shed some light on this and answer some of our questions when it comes to that shipment that was sent off to China, the 16 tonnes, through the support of the Red Cross. We know from internal memos that it was rushed, essentially, because of the repatriation flight. From your perspective, we would love to hear your replaying of the events for us to help us maybe connect some dots on our end.

Mr. Conrad Sauvé: I'm sorry. Could you be more precise in the question?

Mr. Matt Jeneroux: I'm hoping you can walk me through what happened in the lead-up to and then after the 16 tonnes of PPE was sent to China early in February.

Mr. Conrad Sauvé: I think from the early stages there was a request for some additional support. This, I think, is what we normally do in terms of the Canadian government assets to facilitate that send-off of equipment to China. You're mentioning 16 tonnes. We're also on the receiving end of gifts as well from China. To date, we've received 42 tonnes donated by China in response, and an additional 5 tonnes from Taiwan. We're expecting another arrival

from Taiwan soon, on top of a number of gifts from corporations as well that are not in this.

We manage both sides of this. We've done this in the past. Mostly, Canada has always been shipping aid to the outside. This is one of the first—certainly in my experience—where we've been on the receiving end of gifts as well.

• (1730)

Mr. Matt Jeneroux: I know that you're kind of caught in the middle of all of this.

Do you know how much of that 42 tonnes you said was shipped to us from China was usable? Does it equate to the entire amount, or did we send some of that back again?

Mr. Conrad Sauvé: In terms of the gifts—and we're in that process—we're working very closely with the Public Health Agency of Canada. All of that has been compliant with our norms. I'm not aware of anything what was given to us that was not useful. We knew beforehand what was being shipped. It is of quality and it's validated by the Public Health Agency process.

The way it works is that we are on the receiving end, but we're working closely, again with the Public Health Agency and PSPC, to send all of that equipment on to the provincial reception centres. It's done on a priority basis.

However, to answer your question, nothing has been shipped back. Everything is of quality.

Mr. Matt Jeneroux: Help me again with this bit at the beginning, this initial.... You said that the government had requested that you procure the PPE. How did that happen?

Mr. Conrad Sauvé: Well, it was to do the shipping, actually. We did some of the procurement outside, but the Chinese Red Cross was on the recipient end of this. This is very common in these types of emergencies.

We're used to, as I said, not just in this situation but in previous situations, to handling humanitarian gifts. This is what was at play. It is a normal practice for us to do that, and we did so.

Mr. Matt Jeneroux: Sorry, still again, did the Public Health Agency call you up and say, "Mr. Sauvé, I need you to send a bunch of PPE to China"? I'm curious as to how this all ended up happening.

Mr. Conrad Sauvé: No. We have a partnership. We have an ongoing partnership to help with GAC, Global Affairs Canada. We do this on a regular basis. They activated that agreement in terms of facilitating that.

This is what we do. We've been doing this for some time. We have the logistical capacity to do that and—

Mr. Matt Jeneroux: Sorry to interrupt you, Mr. Sauvé; I have only about 15 seconds.

It was approved by the Minister of Health, Minister Hajdu. These internal documents say she's the one who ended up approving it.

If it's an existing agreement with GAC, then how did the Minister of Health weigh into this?

Mr. Conrad Sauvé: Well, GAC has to go outside, I guess....

I'm not sure I have the answer to your question. We have a system to send this off, in terms of a previous agreement that we activated.

I could get some additional answers to you, if you want. Again, this is something we have done in the past.

Mr. Matt Jeneroux: Mr. Chair, do you mind allowing Mr. Sauvé to perhaps submit some additional documents to the committee to help clear up some of what happened early on with this shipment?

The Chair: Absolutely.

Mr. Sauvé, if you wish to send more information, please send it to the clerk of the committee. It will be translated as appropriate and distributed to the whole committee.

Mr. Conrad Sauvé: Absolutely.

The Chair: Thank you.

Thank you, Mr. Jeneroux.

We go now to Mr. Van Bynen.

Mr. Van Bynen, please go ahead, for five minutes.

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

Thank you to all the witnesses who are here today for the important work you do in protecting our communities and those who are most vulnerable throughout these difficult times.

My first question is for Mr. Sauvé.

Last month, Leger conducted a study for the Canadian Red Cross on the social and psychological impacts related to COVID-19. I'm hoping you can share that study with the committee after the meeting, as I'm very interested in reading it. I'm sure that my colleagues would be interested in seeing it as well.

In the meantime, could you please share with the committee some of the findings of that study?

• (1735)

Mr. Conrad Sauvé: Absolutely. I think the important thing is that this is a poll we're doing every two weeks. We wanted to establish a bit of a baseline, because, of course, this is a new reality to have so many people quarantined at home. It's to understand what they're living through. What you saw was the first of those polls.

I think what we saw from the first one was a high level of anxiety among young Canadians—20-year-olds—about their future. Of course, it's understandable given how they're embarking on life with a lot of uncertainty, and it appeared that way in the study.

I can share the first report. It's in both languages.

In the second report, which we released today, we dug a little further into this situation, on vulnerabilities of seniors as well. It's coming out, again, that people living in the community are feeling anxieties. This one is just coming out now.

In the first one we highlighted the concern—maybe not as visible—of people who are starting their lives seeing a lot of uncertainty and feeling anxiety related to that.

Mr. Tony Van Bynen: Thank you.

There is a general acceptance that there will be a second wave, or even a third wave, of this pandemic. Beyond that, with all the global travel that we've been seeing, we'll be faced with these kinds of situations more often.

What have you learned so far that you need to consider in building capacity for the likelihood of another pandemic of this scope and scale?

Mr. Conrad Sauvé: Certainly until there's a vaccine, but even if there is a vaccine, there's no guarantee that there won't be another element of pandemic. I think the area where the Red Cross contributes the most is in the surge capacity. We've been building that up to face natural disasters, again supporting provinces and municipalities as well as the federal government.

I think the added area here is the whole health care side. As I mentioned earlier, we've supported 40 institutions in infection control, and we've elaborated a whole program to support community organizations. We're seeing a big need for understanding how we protect ourselves and live in an environment of COVID.

What's the appropriate training, not just in terms of PPE? There's a lot of talk about PPE, but I think we also have to emphasize training on how to use protective equipment, how to manage social distancing and how to work in this environment.

This is the area where we're growing. With regard to the standing capacity, as we're increasing this capacity to support public authorities, what do we need to maintain afterward, going forward?

Finally, as I mentioned, we've deployed two parts of our field hospital. This was all funded for international work. We've deployed that domestically, so we're looking at what kind of standing capacity we need to maintain in terms of equipment.

I will add one other thing that I didn't mention earlier. At one point we're obviously going to go into mass vaccination campaigns. How can the Red Cross support that, and how can we make sure that we support access to vaccination for vulnerable communities in the north?

Mr. Tony Van Bynen: Dr. Tien, could you answer that question as well?

Dr. Homer Tien: The support for mass vaccinations in the north?

Mr. Tony Van Bynen: Not necessarily. I mean what you've learned so far from this pandemic, and how we should give some thought to building capacity for the likelihood of another pandemic of this scope and scale.

Dr. Homer Tien: Thank you for the clarification.

Like my colleague from the Red Cross, I think that surge capacity is an important aspect of it. I think part of the challenge for our northern communities, particularly remote indigenous communities, is getting that surge capacity to those communities in a timely fashion. Certainly, across Canada there are multiple air ambulance and critical care transport organizations that have dedicated airlifts.

One of the things that we've learned during this pandemic is that the commercial air carriers aren't immune to major business disruptions. When they go down, a lot of the supply chain and HR resources that are dependent on travel by aircraft, such as diagnostic support, are not able to reach the remote north.

I think the air ambulance services that have dedicated aircraft can play a large role in that and need to be part of that thinking.

• (1740)

The Chair: Thank you, Mr. Van Bynen.

We will go now to Dr. Kitchen.

Dr. Kitchen, please go ahead for five minutes.

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

Thank you, everybody, for being here today and for your presentations.

Dr. Tien, my wife is going to be impressed that I've had a chance to talk to you today. When I was doing my residency, she was a pediatric intensive care nurse at The Hospital for Sick Children and flew with Ornge. That was just 37 years ago.

I appreciate your point. Since I've been out here in Saskatchewan, I have been able to talk with Andrea Robertson, who is the CEO of STARS. I'm interested to know what sort of communication you've had with organizations like STARS, and LifeFlight in the Maritimes, on this issue.

Dr. Homer Tien: We actually work very closely with all of them to share best practices. I think we realize that STARS does a wonderful job in what they do; LifeFlight as well. As we know, it's about sharing best practices. In fact, we set up a Canadian organization, the Canadian Transport Medicine Association, that meets annually to share best practices, and we have a lot of collaboration back and forth.

We actually have an academic symposium where we have a supplement to publish some of our learning, including some of our stuff on what we've learned about the COVID-19 pandemic and how we conduct air ambulance transports in that environment.

To answer your question succinctly, we collaborate a lot with them and appreciate that relationship.

Mr. Robert Kitchen: Are they experiencing similar challenges to you?

Dr. Homer Tien: My understanding is, and this was based on a conversation maybe a month ago, I don't think they've seen the same spike in volumes—lucky for them. I think Ontario, unfortunately, has more COVID patients and more ICU patients. Because we do the transports in between, to access critical care capacity, we've actually done quite a few and I don't think they've had as many in Alberta or in Saskatchewan, thankfully.

Mr. Robert Kitchen: I was intrigued by your comment on your surge team and in particular your 46 paramedic volunteers and obviously the challenges that you have with them in providing services, as you indicated, in confined spaces to make certain that they're protected...and the airway management. Is that something that you're actually putting out there to these other air ambulances across the country?

Dr. Homer Tien: I think we had the opportunity to present that but, to be honest, I think in the time of COVID it's been more about communicating the capability to our northern partners. Certainly, I think our remote indigenous communities are particularly interested. I've spent a fair bit of time trying to communicate that capability because, unfortunately, if there is a surge in the northern indigenous communities, or any rural community for that matter, we can't predict where and we can't augment all of the hospitals all at once for an indefinite period of time.

From my point of view, I think the surge team is the way to go in terms of one hospital or one area having a regional surge in COVID cases because we have air assets. We can transport these people quickly to augment their hospital staff while we arrange with the provincial government transport to disperse the patients across the system.

Mr. Robert Kitchen: That sounds excellent, especially when we have hospitals in rural parts where they're shutting down their emergency departments in order to prepare for those surges, etc. I appreciate that.

Ms. MacDougall, we've heard a lot of talk from everybody on the big cities: Vancouver, Montreal, Ottawa and Toronto. I come from rural Canada, and we're having a lot of the same issues that you're having. In my community, Envision Counselling and Support Centre, which has centres in Estevan, Weyburn, Carlyle and Oxbow, is being challenged with issues. For example, I had the opportunity to talk to them in the last couple of days and they mentioned things that they're looking at, in particular appropriate data management systems. My understanding is just to purchase such a thing is \$25,000 to start and then \$6,000 a year just to maintain it.

In rural communities where we have towns that are hours away from bigger centres, we're seeing that people aren't able to escape because there are no jobs. These abusive partnerships are there, where you have spouses who are contained, you have youth who are in there, and there are no transition houses to go to. There are no bus services for them to actually get there—

The Chair: Could you wrap it up, please?

Mr. Robert Kitchen: I'm wondering if you could comment on that from a rural point of view.

• (1745)

Ms. Angela MacDougall: Thank you so much for the question and for the comments, and for setting out the context of rural Canada and rural Saskatchewan. I have so much love for Saskatchewan. It's a beautiful part of the world.

Yes, everything you said is correct. For women in rural communities, everything that we've talked about is compounded. As it happens, we've been receiving calls on our crisis line from rural Canada where women and young people are in the homes; and there are more guns as well because of hunting and the lifestyle around outdoor sports. The lethality factors are compounded and, of the deaths that I talked about in my remarks, many of the women were living in rural Canada.

Absolutely, rural Canada faces so many more challenges and we are so far away from addressing those needs. Everything you said about transportation and about having the support services available...but we can go a long way by using technology. We felt so strongly about the importance of having Internet access for women, for everybody, all over British Columbia and all over the provinces in Canada so that women in our rural communities can be able to reach out and connect remotely to services such as ours and others that may be in Saskatchewan, or may be somewhere else, in order to get support and make a plan. Lots can be done through the Internet and if we can build that kind of capacity, we'll go a long way to supporting women who are extremely and profoundly isolated in the way that you've just described.

The Chair: Thank you.

Mr. Fisher.

Mr. Darren Fisher (Dartmouth—Cole Harbour, Lib.): I want to thank all of you folks for being here today.

Mr. Sauvé, MP Jeneroux touched on the international aid topic a bit. I think many of us can agree that international aid is important, and especially during a health crisis like this.

I'm interested in your views on why Canada ought to provide equipment and supplies to other countries when they are experiencing health emergencies. Doing that helps that country; it helps Canada and it helps the world. I'm interested in your thoughts on why we do that and whether we should continue to do that.

Mr. Conrad Sauvé: First of all, we need to maintain an expertise. Of course the best way to prevent pandemics is to help address early onset and provide all the support, but also, if we're going to fight this pandemic, we need to help countries eradicate it as well, not just in Canada but in the rest of the world.

We've been providing a lot of support to Canadian institutions. We worked with PHAC at the beginning, and a lot of that expertise we brought from the fact that we have been deploying Canadian medical personnel and running cholera and Ebola clinics around the world. This is where we gained a lot of expertise.

It's important to maintain our expertise in times when we don't have a lot of major issues in Canada. We maintain that by helping others. We're also in a time where we have organized direct conferences for Canadian health care experts in real time; we are having webinars with Chinese authorities, medical authorities on the

ground, with South Korean medical experts and with doctors, and with Italian personnel on the ground. Those have usually been successful for us to get in real time what the experience is there and how they address certain issues.

I think we need the same thing. Of course when we're in the middle of something, we need to concentrate on dealing with it domestically, but hopefully, as we come out of this we will continue to share what we've learned and we will learn how others have dealt with the same thing.

Again, I know we've received some gifts. The Canadian Red Cross has been managing the stockpile to help others and we've been doing that quite generously. This is the first time, to my knowledge, that we've also received help from others in this time of need.

• (1750)

Mr. Darren Fisher: I'm sticking with you, Mr. Sauvé. You talked about the first days of the outbreak and how you've been responding. You've been on the ground since the first days, and you talked about capacity. It seems to me that the Canadian Red Cross is always there, or it's everywhere.

In your opening remarks you talked about building stronger capacity. Are you talking about building stronger capacity for COVID for phase one, phase two, phase three or whatever, or are you just talking about the Canadian Red Cross wanting to build stronger capacity? Maybe you can also touch on what those early days looked like. Are you talking early days domestically here in Canada or were you paying strict attention to what was going on with the pandemic in those days?

Mr. Conrad Sauvé: To start with your second question, early days were the immediate response. We all know about the Canadians caught on the cruise ships who needed to be brought home and be treated in the most humane way possible at the same time as being quarantined. We provided immediate assistance as well as for those in Japan. We're talking about direct operations.

I think the key when we talk about surge capacity is that the Red Cross, as you say, is present everywhere and everybody congratulates us for that, but what you don't see is the amount of training we do to make sure that people, volunteers and pre-positioned materials are ready. We've been talking the last few years about increasing that base capacity to deal with natural disasters. I think we've helped some 260,000 Canadians displaced by fires, floods and so on in the last four years. Now we have an additional component, a pandemic, which requires a little more specialized surge and a little more capacity in terms of infection....

We want to take stock with public authorities on the expectation for the Red Cross to support them at the municipal, provincial and national levels. Then, we want to look at how we increase that base capacity and what kind of equipment we need to restock. I am talking about equipment and about our partnership in supporting provincial health authorities: what has worked, what is needed for a second wave and what is helpful. As a first reaction, we tend to throw everything we have at something. After that, we can say what exactly we need to restock.

I was talking about the north in terms of the 80-bed full hospitals We've deployed parts of those. Again, this expertise was developed on the international side. We are very strong, and this expertise was used efficiently in Canada. When we look at the north, we look at smaller mobile capacity, and we got a lot of requests from first nations communities to deploy equipment and support them.

We're taking stock of the fact that we have to stop treating these surge events as exceptional. We need a standing capacity that's a little more elevated to support all these needs.

[*Translation*]

The Chair: Thank you, Mr. Fisher.

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

Mr. Luc Desilets: Thank you.

Mr. Sauv , I want to go back to what you said about the \$100 million provided by the Canadian government.

We hear that Red Cross funding is slow to reach Quebec. Is that true? What would be a reasonable time frame?

• (1755)

Mr. Conrad Sauv : Are you asking me whether funding is slow to materialize to support our operations in Quebec?

Mr. Luc Desilets: Yes, exactly. We're hearing this from funded organizations. Do you think that this is true, and what would be a reasonable time frame?

Mr. Conrad Sauv : The allocation of emergency funding is a broader issue. Obviously, in an emergency situation, we must be able to access funding quickly. The Red Cross had reserve funds that it could use right away. We have the government's support and we're dealing with this issue. This hasn't slowed down our operations in Quebec. The Red Cross showed up when it was asked for help. We've increased our operations significantly.

The funding that we recently received from the federal government seeks not only to meet current needs, but also to establish a fund to increase our capacity more quickly.

I must say that we received support in this area. This hasn't affected the quality of our operations on the ground.

Mr. Luc Desilets: I'll provide an example. According to the president and executive director of the Centraide of Greater Montreal, two weeks ago, two months after the start of the pandemic, her organization hadn't yet received a cent. I don't know whether this issue was resolved or whether this is a reasonable time frame. This may be outside your purview. I don't know.

Mr. Conrad Sauv : The broader issue concerns how we can provide funding more quickly and implement mechanisms in emergency situations. This is a real issue.

We're holding discussions with public safety and with the provinces about quicker access to funding. We've created reserve funds to deal with these situations. Of course, it's always difficult to access funding quickly. The magnitude of the crisis obviously makes this a challenge.

I repeat that this hasn't slowed down our operations. This is nothing new for us.

Mr. Luc Desilets: I want to ask one final quick question.

You helped the seniors' residences in Quebec—

The Chair: Thank you, Mr. Desilets.

[*English*]

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

Ms. Jenny Kwan: Thank you very much, Mr. Chair.

On the issue around violence against women, we know that in the face of the pandemic, the numbers are going up. Even at the best of times the situation is bad. In my community of Vancouver East, particularly in the Downtown Eastside, sex workers are particularly vulnerable. We're now even seeing people entering sex work for the first time. Much of this, of course, is tied to economic insecurity. The fact is that the government chose not to go forward with a universal direct payment. People who are in dire straits, people who live in situations of domestic violence, don't have the economic support to find alternatives.

Ms. MacDougall, if the government were to initiate the universal direct payment for all during the pandemic, and, I would argue, post-pandemic, would you support that?

Ms. Angela MacDougall: Yes, we have definitely made that case; I'm on record. I sent a letter to our Prime Minister and to our province and to the various ministries within the federal government making that request for the reasons you articulated here. We recognize that there is already a lot of gender inequality that is economic inequality and that the pandemic has ground down, in very specific gendered ways, women. There's also precarity around immigration. Desperate times call for desperate measures.

Many women have a number of different challenges with respect to feeding themselves and keeping a roof over their heads. That includes women who are involved in sex work and women who may be sexually exploited during this time through income inequality and insecurity as well.

Ms. Jenny Kwan: One of the issues that has been raised is that in recognition of essential workers, the people who are in community services or in the grocery stores and so on, there is courage pay. I'm hearing mixed stories about who is getting the courage pay and who might not be getting it.

Can you comment on that? Are people in your organization, Battered Women's Support Services, and other organizations like yours getting that courage pay?

• (1800)

Ms. Angela MacDougall: That is an interesting concept, isn't it? Yes, our front-line workers would be eligible for it. We already built it in. We already did that for ourselves, recognizing that on a wing and a prayer, in going 24 hours, we needed to have all clean hands on deck. We did institute a number of measures, in terms of ensuring that our front-line staff were receiving what could fall under the banner of courage pay, because of how essential this work was and how it was not recognized.

If I may, please, I would like to suggest that one thing it would be really important for the Standing Committee on Health to examine is the gendered impacts, and how the impacts for women have been profound and unique and differential. This is of critical importance.

I would also ask our witnesses to consider the gendered impacts in all of their areas right now, in their areas of focus and influence, and the ways in which women have been profoundly affected under COVID-19. We have a number of inequalities still, and a lack of equity in Canada, so it really matters that right now we are shining a light on the gendered impacts and are seeking to redress these impacts, which goes to the point around pay and courage pay and income equality.

The Chair: Thank you, Ms. Kwan.

We'll go to Mr. Webber, who will start round three.

Mr. Webber, please go ahead for five minutes.

Mr. Len Webber (Calgary Confederation, CPC): Thank you, Mr. Chair.

Thank you to everyone here today.

My first question is for you, Mr. Sauvé. You didn't talk about this today in your presentation, but I did get this information from the Library of Parliament. They indicate that at the request of the Public Health Agency of Canada, the Canadian Red Cross is providing services to Canadians returning to Canada in Vancouver, Calgary, Toronto and Montreal. Services offered include information services, safety and well-being support, and also meal delivery.

Can you perhaps elaborate on that a little bit and tell me why you are delivering meals to people travelling abroad and coming home?

Mr. Conrad Sauvé: I think it's the extension of what we've been doing in Trenton in terms of returning Canadians on cruise ship lines. We've extended that to support the Public Health Agency. People who arrive here who don't have a clear plan for their quarantine, we're supporting them in that quarantine period. That's what this is about.

I don't have the exact number, but that's what we're doing, basically. It's a continuation of what we've been doing, in this case to make sure that these people are being quarantined for the full period.

Mr. Len Webber: I see. It's for the individuals who were perhaps in tight spots such as cruise ships and such where there was quite of an appearance of COVID, people in distress, basically, coming back to Canada and being put into these Canadian Forces bases.

Mr. Conrad Sauvé: The cruise ship plan was the Canadian bases, and there were a number of them. That's what we did. There were about 1,200. Then following that, we're supporting—I don't have the exact number—I think eight airports. For a Canadian who comes back who does not have a clear plan, we will support that quarantine period as close as possible to the airport to avoid travel within the country.

Mr. Len Webber: You provide the quarantine spaces in these four cities to accommodate individuals who do not have any other way to quarantine or self-isolate for 14 days. It's where you feed them as well and provide all the essential services.

Okay. Thank you for that.

Mr. Conrad Sauvé: That's right, exactly.

• (1805)

Mr. Len Webber: I also want to ask you a question about the deployment of your mobile field hospitals. You mentioned that you had two field hospitals, one that went up in Vancouver and one in Montreal.

First of all, how many field hospitals does the Canadian Red Cross have at your disposal? Who decides where these field hospitals are to go?

Mr. Conrad Sauvé: I don't have the exact number, but we probably have two 80-bed field hospitals. We have a number of mobile units as well. These deployments have been done at the request of the health authorities in the province. In the case of B.C., it asked early on. We had done exercises. We had looked at the possibility that this could be used. The subregional health authority of Montreal west asked for the same thing. We have capacity on standby with the Canadian government as well for deploying in the north.

Mr. Len Webber: The reason I ask is, in my riding of Calgary—Foothills, a hospital in Calgary Confederation, set up a temporary tent, quite a large structure, to accommodate COVID patients there to keep them away from the general population of the hospital. That was at quite a cost. If the Alberta Health Services had asked the Red Cross, would you have deployed one there as well?

Mr. Conrad Sauvé: Yes, but I think what I was talking about earlier is that we need to go back and look at what the actual use of all this equipment was. What's the best way to do this?

We couldn't have answered all the requests; there are number of tented structures that have been everywhere. We responded in the way we could with what we had. I think we need to go back with the health authorities and look again at what has been required, what's useful, and what we can keep and stock that will be useful for these situations.

Mr. Len Webber: Thank you for that.

Dr. Tien, I have a quick question.

First of all, thank you for your service in the armed forces. We can't thank veterans enough for their service.

You talked a bit about point of care and sending lab tests to remote communities and doing lab tests and such. You talked a bit about sending deployment kits such as ventilators and personal protective equipment up to remote communities, I guess to temporarily ventilate patients up there, then send them back.

With respect to deploying a kit there on a permanent basis, such as to leave the patient in their community and to provide care there, is that an option, or do these patients need to be sent back to larger hospitals, which would again cause risk for others in these larger cities?

Dr. Homer Tien: I think it's important to realize that, for some of the communities that we're talking about for the surge, it wouldn't be just the equipment that would go, it would be the critical care paramedic who would go with the kit. They have very little infrastructure there. At some of these remote indigenous communities in northern Ontario, it's a nursing station with no in-patient facility. The model of care there would be to evacuate them as quickly as possible. If there were, say, six or seven community members, and they were waiting for the airlift out, at least we could leave some people there to keep those patients alive while awaiting transport.

The Chair: Thank you, Mr. Webber.

We will now go to Dr. Powlowski for five minutes.

Mr. Marcus Powlowski (Thunder Bay—Rainy River, Lib.): I have to thank Mr. Webber, because he set me up nicely for my question. I thank Dr. Tien as well.

I'll lob Dr. Tien a question, though I know the answer to it because we've talked about it before.

The problem in a lot of northern indigenous communities is that there is no infrastructure. Basically there's one solution to any real medical problem: if anyone's really sick, fly them out. They call Dr. Tien at Ornge and say, "Come and help us; we need to get somebody out of the community."

We know that if COVID gets into northern indigenous communities, it's likely to be bad. It's likely to spread quickly given the lack of housing, the lack of water supply and the fact that for some reason people in the north seem unusually susceptible to respiratory tract infections like influenza. H1N1 hit those communities very hard.

If we were faced with multiple very sick people who were sick at the same time, does Ornge have the capacity to get a lot of people out quickly, or does it have too limited an airplane capacity to move a lot of people quickly? I know you have a solution, so I'd like to hear it.

Dr. Homer Tien: Obviously we have some capacity, but in planning for the COVID surge, we have to think beyond the normal influenza season, with its one or two patients, or even three patients, who need immediate evacuation because they're in severe respiratory distress.

One of our surge plans, apart from having the critical-care paramedics, is that we've liaised with the Canadian Armed Forces to see whether we could use a request for assistance, RFA. We could leverage one of their military transport propeller aircrafts,

like the Hercules or even a C-17, one of the four-engine jets. We could drive our ambulances on board and bring the surge response team with the land ambulance capability to these communities. The idea would be to drive to the nursing station, load the patients, provide critical ventilator care, fly back to the regional hospital, drive to the hospital and keep making runs. Because they have such a large capacity, we would be able to move a larger number of patients more quickly.

We did the initial fit tests with our ambulances on the military airframes. They have to work out certain very technical things like where the ambulance needs to sit, given the axle of the aircraft and the load and weight. What happens to any air circulation in the ambulance? Does it actually leave the ambulance and enter the aircraft? They're working out some of those details from a doctrinal point of view, but we've already done the fit tests. Hopefully there is no second wave, but if there is a second wave that requires this, hopefully we'll have this capability on board to off-load some of these communities rapidly.

• (1810)

Mr. Marcus Powlowski: We've talked about field hospitals, and I know a lot of northern indigenous communities are interested in the idea of them. The Red Cross has already discussed that with us.

Dr. Tien, you suggested the idea of a minimal treatment centre. Could you explain what a minimal treatment centre is and the rationale for using it?

Dr. Homer Tien: I think it's very difficult for these communities to have field hospitals, at least as I know them from the military. We'd have an operating room, ventilators and ICU capacity for any prolonged period of time. These communities, even the largest of them, have maybe 3,000 to 5,000 people, so it would be hard to sustain field operations for a prolonged period of time.

I think they could have a fairly minimal set-up, with some sections of tentage, to provide primary-level care for patients with COVID so that they're separate from the rest of the community. It's basic nursing care, but with the idea that if they were developing respiratory distress, they'd be evacuated quickly. Those with relatively mild cases could be kept in the community, and then once COVID-negative, they could return back to their homes.

The Chair: Thank you.

Ms. Jansen, go ahead, please, for five minutes.

Mrs. Tamara Jansen (Cloverdale—Langley City, CPC): Thank you very much.

First of all, I want to quickly say thank you so much, Ms. Polsinelli, for your fantastic explanation of the difference between task-based care and person-centred care. That was very much appreciated. It's probably the best I've heard.

My question is for you, Dr. Tien. Have you seen the Nav Canada press release of May 5 that announced overnight air navigation services suspended at 18 airports across the country?

Dr. Homer Tien: I did hear about that, yes.

Mrs. Tamara Jansen: Would closures of this type affect your organization at all should they happen in your region?

Dr. Homer Tien: To date, my air-ops people have said not so much, so—

Mrs. Tamara Jansen: It would be no problem for you if ambulances could not stop at night in airports?

Dr. Homer Tien: Well, it would, but to my knowledge, because of that there hasn't been a cessation of service to my knowledge in Ontario, but—

Mrs. Tamara Jansen: Okay. It would affect you, though, if they had that kind of a closure.

Dr. Homer Tien: Absolutely. We're completely dependent on airports, so if an airport did shut down because of any reason—and there are many different reasons for a shutdown besides that reason—we would be affected. It would deeply affect our operations, particularly in the north.

Mrs. Tamara Jansen: Right, exactly.

For 11 of the airport suspensions, it turns out that they're all centred in a single province. Imagine that—11 of those airports in one province. Unfortunately, those are all planned for my province of B.C., which I imagine is going to significantly affect our air ambulance service here.

What would you say to our people here who are having to deal with these closures at night in 11 of our airports? I imagine that these would be airports that service rural areas.

• (1815)

Dr. Homer Tien: I think the airports fall within the jurisdiction of an essential service, especially in the pandemic. Not knowing the communities, I can't speak to the impact on the communities, but if they were rural and remote—and generally they tend to be rural and remote—there'd be a tremendous impact on their ability to access critical care services.

They wouldn't be able to get out of the community and, if they needed any critical supplies or HR resources, they wouldn't be able to get into their communities. I would think that it would have a tremendous effect.

Mrs. Tamara Jansen: Yes, exactly. I was looking at the list and I noticed that there are absolutely no suspensions in either Ontario or Quebec. I was wondering if you are at all concerned that they might announce expansions of these closures for your province.

Dr. Homer Tien: I would be, absolutely. There have been issues for a variety of reasons, and we're very concerned about airports and their ability to function, because we are completely dependent on them, especially for our fixed-wing aircraft.

Mrs. Tamara Jansen: I understand that you are short on PPE. I think I saw that in one of the presentations here.

Today, I asked the Minister of Public Services and Procurement exactly how organizations—for instance, fire halls, homeless shelters and paramedic and ambulance services—are supposed to ensure that they can access PPE when shortages continue to be a very serious problem. We're seeing that here locally.

She assured me that their government is doing an amazing job of sourcing PPE, both here and abroad, but have you seen an increase in PPE availability?

Dr. Homer Tien: When I said we were short on PPE, I think that was at the very beginning of the pandemic. We've been actively working with the provincial healthy ministry, and we've also been looking at reusable PPE as a backup. With our current run rate, we're not short of PPE because they—

Mrs. Tamara Jansen: You're not expecting that you would have to start to ration PPE at this point in time because you're actually able to reuse. Is that the case?

Dr. Homer Tien: We have a reusable stock. When we were short, we were looking for washable gowns, washable face masks and washable masks, and then the normal sorts of PPE that we'd get through the government as well. We pursued all avenues.

Mrs. Tamara Jansen: Okay.

Maybe I could go to you, Ms. Polsinelli. I have noticed that at least three of our witnesses today are talking about seeking PPE donations from the community, and I know that my local battered women's shelter, the homeless shelter and the fire hall are all seeking PPE.

With the current directive from Dr. Tam for all Canadians to wear masks in public, are you concerned that those types of donations will dry up going forward and you may have to either ration PPE or curtail services?

Ms. Nancy Polsinelli: At this point we have enough supply of PPE. We are looking at it from two perspectives.

We do accept donations today, and we are looking to continue doing that. Oftentimes the donations are for particular agencies, so we will reroute donations to those agencies or through our community response table. We do have agencies that continue to be concerned about their PPE supply. They don't have the amount, the money or the storage capacity. We are trying to provide support from those perspectives.

Internally, we do have front-line staff, whether it be in our long-term care homes, in our paramedic services or in shelters. Similar to Dr. Tam, in the early days of COVID, we had lots of concern. There has also been lots of learning. We have worked very closely with Ontario Health. We are using an equitable distribution methodology to get PPE out. We've also brought together, for the entire region, a central logistics division so that we can really make sure that we always have that threshold supply, and again, we are working with Ontario Health. We've also worked very closely with our hospital partners in Peel so that there's always at least a three-week supply in our storage and inventory, so that doesn't pose a problem for us. That's how we're looking at it today.

• (1820)

The Chair: Thank you.

I will go now to Mr. Kelloway.

Please go ahead. You have five minutes.

Mr. Mike Kelloway (Cape Breton—Canso, Lib.): Thank you, Mr. Chair.

Hello, colleagues.

To the witnesses, you have my sincere appreciation for the work you do on a daily basis.

I've had the opportunity to study leadership and I taught it at the University of Calgary for a couple of years. Often we would hit a chapter called "servant leadership". You folks, every one of you, and your colleagues are the embodiment of that. So thank you very much for your servant leadership in everything that you do.

I have two questions. The first one is for Mr. Sauvé from the Red Cross.

In my riding of Cape Breton—Canso, I often hear from first nations chiefs and leaders, Mi'kmaq leaders and chiefs, about what more can be done from a federal government perspective to support community development in first nations across Cape Breton and northeastern Nova Scotia.

I know you folks are in partnership with Indigenous Services Canada and you're working with indigenous communities across the country to provide support to communities in need. I'm interested in learning more about the work you're doing. Perhaps you can unpack that a bit and go a little deeper in terms of the work you're doing in first nations communities. How many communities have you been able to help across the country during COVID?

Mr. Conrad Sauvé: We've actually set up a virtual assistance program.

I'm going to go back a little bit to what my colleague from Ornge was talking about, as well. We have a modular capacity—so a small capacity—to deploy not full field hospitals but a smaller capacity. We've been getting a lot of requests around providing additional equipment as well so that communities that are isolated can set up quarantine structures. That's not medical stuff; it's basic blankets, cots, and so on.

I think one of the biggest areas we're looking at is training and advice. There was a big concern, of course, at the beginning of

COVID. We got a lot of requests to deploy full equipment in case something were to happen. Where we're getting a lot of questions is around deploying expertise, people who have experience in helping the communities set up, accompanying the community in terms of how to set up properly, and providing ongoing training. Ongoing training is a big area.

To refer to a previous question for all organizations, we have purchased, with the support of the federal government, some PPE for community-based organizations—and first nations fall into that, as well—in the form of kits that will be available for the next few months. We have enough kits for 5,000 organizations, and we want to increase that quite a bit.

We've set up a 24-hour call centre for first nations communities in five different languages to answer, basically, all the requests and to direct people to the right place for all the types of supports. There's a lot of effort in terms of training, ongoing training and building local capacity. In any situation, such as an emergency, the first response happens locally. We need to send in specialized teams after that, but it's first about how we can build local capacity.

Mr. Mike Kelloway: You speak of training. Can you give us a little more detail as to what areas of training specifically? I'm very curious about that.

Mr. Conrad Sauvé: I think the biggest area that has increased following this response is we've built an expertise in infection training and control internationally that we've brought domestically, so we're getting a lot of requests from institutions and organizations to send in an expert. A lot of material is available online, but to accompany them and understand the activities they're organizing, and how they can do that safely for their personnel, their volunteers and themselves is where we're getting the most requests.

Mr. Mike Kelloway: I'm glad to see you're looking at developing capacity in the communities, in collaboration with first nations communities, considering we're perhaps looking at a second and a third wave. I appreciate that.

Mr. Chair, how much time do I have left?

The Chair: You have 40 seconds left.

Mr. Mike Kelloway: Okay.

Ms. York, given that those experiencing homelessness don't have access to the same amenities such as Internet and cable, how do we ensure they know how to recognize the signs and symptoms of COVID-19? How can we raise awareness and reach those experiencing homelessness in other ways, perhaps looking at this from an urban and a rural lens? In urban often it's visible, in rural it's not, but it's still very prevalent.

• (1825)

Ms. Fiona York: We can, in a number of ways. Early on there is peer deployment. I think peers are really effective and a good way to provide information. A lot of that was done through direct one-to-one information sharing and posters. Even prior to the pandemic we often saw that doing things by word of mouth and through posters in the community is a really effective way to communicate. Also, there have been solicitations and donations of phones to people through companies and community groups. That's been really great. That was more recently.

There's also been advocacy around opening up Wi-Fi and making that available to people in the community, having even just a Downtown Eastside or community-wide Wi-Fi. I think those things could be replicated to some degree in smaller communities as well. I think peers always have a really important place. They're in the best position in many ways to speak to their peers, and have the lived experience to do that effectively. Making use of non-digital forms of communication, like posters and handouts, is really great, having that conversation one on one and then also advocating for the digital tools and resources as well.

Mr. Mike Kelloway: Thank you.

[*Translation*]

The Chair: Thank you, Mr. Kelloway.

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

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

Ms. Polsinelli, how do you view the current crisis in Quebec?

This may be a little outside your area of expertise. However, I'd really like to hear your views on this matter, please.

[*English*]

Ms. Nancy Polsinelli: Do you mean the crisis in long-term care?

[*Translation*]

Mr. Luc Desilets: Yes, exactly. I'm thinking of the situation in the residences.

[*English*]

Ms. Nancy Polsinelli: Thank you.

It is certainly a very unfortunate situation. I have every confidence that when individuals go to work in long-term care their expectation, their need, is to support residents. I think that what is happening, unfortunately—and you see some similarities in Ontario—is the inability to get the work done in this COVID environment.

What COVID has taught us is that there are staffing issues. If we do not have the staff, then we cannot provide the right care to our residents or those who are living in the homes. If we do not have the funding, then we cannot train our staff to be prepared for a COVID pandemic such as what we've experienced.

I do believe that, through the province and through the federal government, there will be improvements. This is a systemic issue. It is not an issue that has just arisen today. It's a systemic issue. I believe that, through the federal government, there should be a

component of long-term care as a national act, so that there is more oversight.

I have to say that I also believe that while we go in and improve the situation in this emergency, there are also long-term improvements that must be made. I'll go back to emotional care. It is not necessarily about making things more “command and control” through legislation, but about ensuring that legislation also involves emotional care, a different type of expectation for our staff in long-term care and one so that they too will thrive, one where staff will enjoy coming to work and supporting those residents they care for.

Those are some of the things. It is about staffing. It is about funding. It is about getting the feds to support, but certainly it is long-standing, and a lot of work needs to be done that is not—I'm going to say it again before I get closed—about the command and control. It is about how we support our residents and our staff in an emotional-based culture.

[*Translation*]

Mr. Luc Desilets: Okay.

In the few remaining seconds, I'd like to hear your opinion on the recommendations—

• (1830)

[*English*]

The Chair: I'm sorry, Monsieur Desilets. Your time is up.

[*Translation*]

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

[*English*]

The Chair: Thank you.

We go now to Ms. Kwan.

Ms. Kwan, please go ahead. You have two and a half minutes.

Ms. Jenny Kwan: Thank you.

Ms. York, you mentioned that at the moment, even with the provincial government's initiative in providing housing for the homeless population in the community, it's only really 5% of the population that this support is provided for. I know that the federal government has not provided any resources to the province to provide that housing. In the province's purchase of the Comfort Inn to make permanent housing for the homeless population, there was no contribution from the federal government either.

To that end, in terms of the need here, the federal government used to be a real partner in 1993, prior to pulling out of affordable housing. Do we need to go back to those days when the federal government actually engaged in real partnership with the provinces and territories to address the homelessness crisis?

Ms. Fiona York: Absolutely. I would say that is really essential. Definitely with the hotels, as I mentioned, it's for about 5% of those in need, which includes those who are homeless and those who are really inadequately housed in poorly maintained SROs that are not providing the opportunity for social distancing or sanitation.

It certainly would be good to see a partnership with the federal government. There was some action from the province, certainly not enough and not done in a way that targets those most in need, and there was a motion municipally for some efforts being made there. There's very little, but federally, it seems like there's the potential and the opportunity to do a lot more. We see as well that in other municipalities there has been more. For example, we've heard that it's about 50% in the Peel region, so certainly we'd like to see more.

Ms. Jenny Kwan: Thank you.

I have two other quick issues on safe supply. We have a health emergency with respect to overdose and we are now having some measures with respect to safe supply. Would it not be essential for this to be permanent and to also make this program available in other communities across the country?

Last but not least, on the question around protective equipment, some of the agencies got protective equipment, others not so much. I wonder if you could expand on the situation there and the need.

Ms. Fiona York: Sure. Regarding safe supply, absolutely, there have been calls for years for a safe supply since the overdose crisis began in 2016-17. As I mentioned, there have been about 1,000 deaths now, so it's really a horrifying crisis. Safe supply is a very essential way to address that. We'd like to see that extended. There's

been no notice nor confirmation that this will be a permanent program. It was implemented for the pandemic and it might be pandemic-specific. Certainly we'd like to see that made permanent.

As I mentioned, many aspects of the pandemic contributed to that overdose spike because of less use of overdose prevention sites and lockdowns in buildings where people are isolated and not able to be with a friend or use safely with a friend. That safe supply is really essential and absolutely should be made permanent and extended into other cities.

We know these things, again, happen everywhere in B.C. and across the country. There are tent cities; there's homelessness. It's happening everywhere, and the overdose issue happens everywhere as well. Safe supply is one very specific measure that will really do a lot to address that.

The Chair: Thank you, Ms. Kwan.

That brings round three to an end.

I would like to thank all the witnesses for sharing with us so much of your time today and for your excellent information and recommendations.

Thank you to the committee for your time as well.

With that we are adjourned.

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