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• (1100)

[*Translation*]

The Chair (Mrs. Shelby Kramp-Neuman (Hastings—Lennox and Addington, CPC)): I call this meeting to order.

[*English*]

Welcome to meeting number 135 of the House of Commons Standing Committee on the Status of Women.

To all members, please wait until I recognize you by name prior to speaking, and I remind you that all comments should be addressed through the chair. Thank you in advance for your co-operation.

Pursuant to Standing Order 108(2) and the motions adopted by the committee on Tuesday, June 4, 2024, and Wednesday, September 25, 2024, the committee will resume its study of breast cancer screening for women aged 40.

At this point, I'd like to welcome our witnesses, who are all appearing by video conference this morning.

From the Canadian Indigenous Nurses Association, we have Dr. Angeline Letendre, vice-president. From Ontario Health, we have Alethea Kewayosh, director, indigenous cancer care unit and indigenous health equity and coordination; and Dr. Amanda Sheppard, senior scientist. From The Olive Branch of Hope Cancer Support Services, we have Dr. Juliet Daniel, professor. Finally, from the University of British Columbia, we have Dr. Nadine Caron, First Nations Health Authority chair in cancer and wellness.

I'd like to thank all of you for coming back for today's discussion so we can have additional commentary.

We will begin with opening statements.

Dr. Letendre, you have the floor for up to five minutes.

Dr. Angeline Letendre (Vice-President, Canadian Indigenous Nurses Association): Good morning.

I'm very happy to be here to speak to this really important topic for indigenous women and men across Canada.

I recall attending a national cancer conference about 10 years ago at which the researchers were reporting on links between type 2 diabetes and breast cancer. I believe those linkages and the research have grown since that time.

The importance of breast cancer among these populations becomes even more critical when we begin to think about possible linkages between other comorbidities. With first nations women

and cancer, these rates have steadily increased. Of course, we have significant issues that impact outcomes. They include late-stage diagnosis, which leads to poorer options and choices for treatment and more deaths from the disease.

In Alberta, we've done a fair amount of research looking at the data on different cancers, including breast cancer. What we've found is that first nations women, when compared to non-first nations women in Alberta, are almost 24% more likely to have a breast cancer diagnosis. They're certainly more likely to be diagnosed with an invasive cancer at stages 2 through 4. We've also found that it's taken two to four weeks longer for first nations women to receive their first diagnosis, as well as a definitive diagnosis, when compared to non-first nations women. What this leads us to conclude is that collectively these findings suggest that access to and provision of screening services for first nations women may not be equitable when compared to non-first nations women.

We've also done some work with Métis women in Alberta. Cancer continues to be a leading cause of death among this population. Programs, of course, can detect cancer early at the most treatable stage, or when precancerous lesions can be noted. This can contribute to good cancer outcomes and decrease cancer mortality, incidence and morbidity.

In Alberta, provincial screening programs are available for breast cancer and are publicly funded through Canada's universal health care system. Despite the availability of these screening programs, we are still noting disparities in cancer screening for breast, colorectal and cervical cancers. We also believe from our research that some of these disparities can be addressed by leveraging the experiences of indigenous women and people to inform the development of more meaningful interventions that reduce these disparities. Because breast cancer appears in indigenous women at higher rates, both first nations and Métis women, we need to be looking at distinct indigenous services or services that meet the needs of both of these populations.

According to a 2024 publication on some research that I was involved in, both cervical and breast cancer screenings of Métis women were shown to be fewer than those of non-Métis women. This leads us to the fact that we need to have more studies across Canada, and certainly within Alberta, that look at breast cancer rates among the indigenous-distinct populations to get a better understanding of what's going on with indigenous women and breast cancers.

- (1105)

When we start talking about outcomes and needs going forward, more work is definitely needed in this area. We need to raise awareness around prevention and screening. Most of my work is in prevention and screening, and it's becoming more evident that we need to shift the thinking and knowledge indigenous women have when it comes to breast screening. It needs to be seen as a healthy lifestyle choice and something you regularly participate in, not just an action you take when you believe there's an issue or a problem.

There are many issues that underlie that. Some of them are related to indigenous women having regular access to a primary care provider. This depends sometimes on the area they live in. Of course, trust, racism and all those types of factors come into play.

- (1110)

The Chair: Thank you.

Next I'll welcome Alethea Kewayosh, director, indigenous cancer care unit and indigenous health equity and coordination at Ontario Health.

Please go ahead.

Ms. Alethea Kewayosh (Director, Indigenous Cancer Care Unit and Indigenous Health Equity and Coordination, Ontario Health): Thank you for the opportunity to appear before the committee again.

Joining me is Amanda Sheppard, senior scientist for the indigenous cancer care unit.

When it comes to breast cancer and indigenous women, recent data suggests lower participation in breast cancer screening among first nation persons in Ontario. First nation communities in Ontario have raised concerns about cancer diagnosis at younger than screen-eligible ages and about difficulties accessing screening. The joint Ontario indigenous health committee shared these concerns with our team and provided a recommendation to apply for research funding to learn more, a recommendation we are looking into.

We have found that trends in getting and dying from breast cancer have improved over time for first nation women in Ontario. However, once a first nation person has breast cancer, they have a lower chance of surviving compared to other Ontarians. Specifically, first nation women are 41% more likely to die 10 years after their cancer diagnosis. Descriptive data also reveals that first nation women are diagnosed with breast cancer four years younger than other women in Ontario and that the interquartile range starts at age 48.

Research data has highlighted the breast cancer experience of first nation women in the context of screening for those aged 50 to 74. We do not have data to describe the benefit of screening commencing at age 40. Therefore, research is required to learn about breast cancer prognosis among indigenous women aged 40 to 49 and to better understand how a cancer screening program can be tailored to best provide equitable access to screening in this age group.

As outlined in my November 18 presentation to the committee, the Ontario breast screening program is a province-wide screening

program that aims to reduce breast cancer deaths through regular screening. The program offers screening to two different groups of people who qualify for breast cancer screening. One group is people aged 50 to 74 who are at average risk for breast cancer, which was expanded to include people aged 40 to 49 as of October 8, 2024. The other group is people aged 30 to 69 who are at high risk for breast cancer.

Indigenous adults are often underscreened or never screened when it comes to cancer screening. There are many reasons for this, including intergenerational trauma and social determinants of health. Some reasons specific to health and cancer care are stereotypes and prejudice, communication barriers, the need for translation services, a lack of trust for the medical system, no primary care provider, poor coordination of care, jurisdictional issues between the federal and the provincial governments, racism in the health care system, transportation issues, not having a valid OHIP and many others. We need to do everything we can to ensure that indigenous women have the same health outcomes as other women in Canada.

Recently, members of my team were invited to two remote first nation communities in northern Ontario to talk about cancer screening and preventative health care. Almost every single person they met in those communities had been personally affected or had a first degree relative affected by cancer. The major issue flagged was that community members do not have access to health care in a timely manner.

The non-insured health benefits program provides medical transportation for eligible first nations clients and Inuit clients who are travelling out of the community for a range of health benefits, including breast cancer screening and follow-up. We have heard directly from community members that issues with NIHB medical transportation are one of the main factors in accessing health care in a timely manner.

Lately, there have been significant delays in booking travel for appointments, including mammograms and associated follow-up, which cause patients to miss appointments. This is especially a concern when the appointment is for a mammogram and leads to a later missed cancer diagnosis or for a specialist appointment that the community member will have to wait six to 12 months to reschedule. We heard from community members that when they have to wait such a long time for a rescheduled appointment, they often choose to just not go. As a result of all this, as we heard from one community, people they know are being diagnosed at later stages and are choosing not to get treated.

There's also a large Inuit population in Nunavut; however, there is no breast screening in the territory. The current process is for Inuit women to be flown to Ottawa for mammograms. As a result of this, it was noted that mammograms are typically only requested when an Inuit woman finds a lump. At this point, the woman would be sent for diagnostic testing and not for a mammogram. Early detection should be easier to access to ensure that indigenous women can access breast screening at a younger age so we can catch cancers early.

To reduce barriers and support first nations, Inuit, Métis and urban indigenous adults in accessing cancer screening in Ontario, we have developed an indigenous cancer patient navigator program, mobile cancer screening coaches and a Sioux Lookout and area FIT kits on-hand program to screen for colon cancer. These first nation, Inuit, Métis and urban indigenous cancer strategies are developed in collaboration with first nations, Inuit, Métis and urban indigenous partners.

Thank you.

• (1115)

The Chair: Thank you very much for your testimony.

I would like to remind and encourage all witnesses to speak a little slower, just for the ease of our interpreters.

At this point, I welcome Professor Daniel.

You have the floor for up to five minutes.

Professor Juliet Daniel (Professor, The Olive Branch of Hope Cancer Support Services): Good morning, everyone.

First, I'd like to thank the Standing Committee on the Status of Women for inviting me to reappear as a witness for its study on breast cancer screening for women aged 40 to 49.

As a reminder, I'm a professor and cancer biologist at McMaster University, a 15-year breast cancer survivor and a member of the research subcommittee of The Olive Branch of Hope Cancer Support Services.

I have been working with TOBOH for the past decade to organize and host "Think Beyond 'Love Pink'" breast cancer awareness and education workshops and symposia, specifically for Black and other racialized women who consider a breast cancer diagnosis to be a curse or a stigma. The Olive Branch of Hope's mission is to tackle the stigma head-on, since we know that knowledge is power and that an early diagnosis of breast cancer correlates with good survival outcomes.

Due to advancements in early detection, screening programs and treatment options, breast cancer mortality rates have declined almost 50% in the past four decades, from 41 deaths per 100,000 women to 21 deaths per 100,000 women now. However, current epidemiological data continues to describe cancer disparities among racialized women, which contribute to overt inequities in lived experience during the cancer care continuum, as well as in survival outcomes.

Over the past two decades at McMaster, my research team has been focusing on the novel protein that I discovered and named Kaiso. Kaiso is implicated in many aggressive human cancers, in-

cluding breast, prostate, lung and pancreatic cancers. More importantly, and what's really interesting, is that Kaiso expression correlates with disparities in breast and prostate cancer outcomes in Black women and men, respectively, suggesting that Kaiso could be a biomarker for aggressive breast cancers in women of African ancestry.

My research team is specifically interested in determining whether there is an ancestral genetic predisposition or susceptibility to triple-negative breast cancer, which is an aggressive breast cancer subtype. TNBC prevalence in West Africa ranges from 40% to 70% in Ghana and Nigeria, and is approximately 20% in the Caribbean and the U.S., compared to 10% among white women in the U.S.

What is most concerning about breast cancer in Black women is that despite having a lower incidence of breast cancer than white women, Black women have the highest mortality rate from breast cancer, and Black women under age 50 have twice the rate of death compared to white women. This is in part because there are no targeted therapies for triple-negative breast cancer, which is most prevalent in Black women. In contrast, white women tend to be diagnosed with estrogen receptor-positive breast cancers, which are effectively treated with the drug tamoxifen.

Because there are no targeted or specific therapies or drugs to treat triple-negative breast cancer, or TNBC as we sometimes call it, any woman diagnosed with triple-negative breast cancer—be she indigenous, Black, Latina, white, Asian or other—has a poor prognosis because she can only be treated with radiation therapy, which targets the breast itself, and standard chemotherapy, which affects all proliferating cells in the body, such as our hair and intestinal cells.

Canadian epidemiological data, along with data from the U.S. and the United Kingdom, shows that racial and ethnic differences exist in cancer morbidity and mortality among Black, indigenous, Asian and Hispanic populations. As I mentioned earlier, although white females have a greater incidence of breast cancer, racialized women tend to be diagnosed at younger ages and present with more aggressive cancer subtypes and advanced cancer stages. Consequently, they all experience earlier mortality compared to white females. Despite this, the current Canadian guidelines regarding breast cancer screening for females with average cancer risk recommend a biannual screening via mammogram starting from ages 50 to 75, and they currently recommend against screening individuals aged 40 to 49.

The Canadian Task Force on Preventive Health Care recently released its updated draft guidelines for breast cancer screening in Canada. Unfortunately, it reiterated that screening should commence at age 50. Both the existing and proposed draft guidelines fail to account for the unique cancer burden among Canadian racialized and indigenous populations, and they risk further perpetuation of existing racial and ethnic disparities by underscreening racialized patients and women.

• (1120)

These recommendations do not reflect the current practices in P.E.I., Nova Scotia, British Columbia and the Yukon, where mammography is available for individuals starting at the age of 40. In Alberta and the Northwest Territories, breast cancer screening is recommended for individuals aged 45 to 74. This fall, the Ontario government approved self-referral of individuals aged 40 to 49 for breast screening mammography through the Ontario breast screening program.

Although the updated draft guidelines note that Canadian data shows racial and ethnic variability in incidence, mortality, subtype and stage at diagnosis with younger age cohorts, they state there is a lack of data regarding the benefits and harms, as well as preferences and values of racialized communities. The task force, therefore, does not appear to consider how breast cancer screening recommendations may be interpreted by racialized groups, who typically do not trust the health care system, as was alluded to by my other colleagues on the call and other witnesses. This mistrust of the health care system is due to historical and continuing systemic racism of Black and indigenous communities.

One size does not fit all, and on behalf of The Olive Branch of Hope, Black Canadians and other racialized women, I urge the Canadian task force on breast cancer screening to revise their recommendations to account for populations at risk of early onset and aggressive breast cancer subtypes.

Thank you.

The Chair: Thank you, Professor Daniel.

Next we have Dr. Caron.

You have the floor for up to five minutes.

Dr. Nadine Caron (First Nations Health Authority Chair in Cancer and Wellness, University of British Columbia): *Aaniin. Meegwetch.* I'm joining you today from the traditional and ceded territory of the Lheidli T'enneh peoples, which is in Prince George, British Columbia, up in the north. I'm a surgeon and professor at the University of B.C., and I'm joining you today as an indigenous woman, daughter, mother, sister, auntie, cousin, and a member of the Sagamok Anishnawbek First Nation. I strongly recommend moving the breast cancer screening guidelines to commence at the age of 40, as opposed to the current recommendations set forth by the task force of 50.

I truly appreciate being here once again with my colleagues from the previous panel on November 18 so we can share more of our thoughts and ideally answer any questions you may have that cause you to either pause or not support this recommendation.

To remind you of what was said previously in November, there is a difference between the recommendation to participate in a screening mammogram program at the age of 50 and the option of a screening mammogram simply being available in your forties after discussion with a primary care provider, as in British Columbia. There is a paucity of data and research in this field, but there is data, and my colleagues have already shared some of it. Knowledge does exist that supports the need for earlier screening mammograms and for improving the rates of screening mammogram participation.

In British Columbia, we have a manuscript undergoing final review at the First Nations Health Authority that was completed in partnership with B.C. Cancer and the First Nations Health Authority chair in cancer and wellness. As I stated in November, when first nations women are compared to the rest of the women in B.C., their breast cancer is diagnosed at a later stage, as Angelina told us, and their survival rates are lower. These things could be addressed with screening mammograms by adjusting to this known data and moving to the age of 40.

The paucity of specific research regarding indigenous peoples and cancer is unto itself an entity that needs to be addressed, but I suspect that the persisting inequity in access to health research is beyond the scope of this meeting today. If we don't have data to support screening mammograms at the age of 50, why can we not start to err on the side of caution, unless you have firm proof that you will not be harming indigenous women by maintaining the recommendation that we are asking you not to maintain? There is some data to support screening mammograms at the age of 40 for indigenous women, given their later stages of diagnosis and poorer survival, but as a researcher in this field, I have seen no data to support screening mammograms for indigenous women at the age of 50.

Currently, it is recommended that screening mammograms start at the age of 50 unless you have known risk factors that increase your risk of breast cancer. This has also been referred to by my esteemed colleagues. You should start screening mammograms at the age of 40 if you have these risk factors. These risk factors can be related to family history or genetic test results that increase your risk, such as BRCA1 and BRCA2. Dr. Daniel described some amazing research she's doing to increase our knowledge of what risk factors can be.

These risk factors lead to being a barrier unto themselves for first nations women, because they have to have knowledge that they have these risk factors so their health care providers can subsequently recommend a screening mammogram at the age of 40. However, there is inequity in access to the knowledge of risk factors given that one's family history for breast cancer or genetic testing results for indigenous women can be greatly impacted by the legacy policies and programs in our country, whether regarding residential schools, the sixties scoop, forced relocation or inequitable access to medical genetics or hereditary cancer programs so you can know these genetic factors. I think there are also inequities upstream that block our ability to have a family doctor recommend that someone start at the age of 40.

In B.C., the recommendation is to start at 50, but it is available in your forties with your first step being to talk to your primary care provider. However, we know that access to primary care is in crisis in the health care systems in Canada, and this is worse when considering indigenous communities and challenges regarding access to primary care. Dr. Letendre was talking about this in more detail with respect to other barriers.

Finally, as an indigenous surgeon, I see women who have breast cancer, like a palpable mass. I see women who are referred due to an abnormal screening mammogram, and I see women who are already diagnosed with breast cancer. I have seen women who are devastated when the diagnosis is late and the outlook is bleak, and I have seen the relief when the results are reassuring, early-stage or negative.

- (1125)

Screening mammograms save lives. No one is denying that. Abnormal mammograms that turn out to be normal have been said to be stressful experiences. However, I think we need to start believing in the resiliency of women and give their voices back. We can handle the stressful experience of a test or tests that result in empowering results much easier than a diagnosis at a late stage of breast cancer that could have been completely prevented.

Chi-meegwetch. Thank you.

The Chair: Thank you, Dr. Caron.

Thank you all for your opening remarks.

At this point, our opening remarks are concluded, and I'd like to move to our first round of questions.

The first six minutes go to MP Ferreri.

Ms. Michelle Ferreri (Peterborough—Kawartha, CPC): Thanks, Madam Chair.

Thank you so much to our witnesses for being here today as we continue to study breast cancer screening across the country.

The common theme throughout this study, with the exception of the chair of the task force, has been to reduce the recommended age of screening to 40. Through a show of nodding, does everybody here agree that it should be? Yes, there are big nods there.

This doesn't happen a lot in the House of Commons, but I think we all agree, even in this room, on this. It's shocking, and many of the women in this committee have their own personal experience. I

know that even my colleague who's filling in today, the Honourable Ed Fast, has the personal experience of his mother being diagnosed with breast cancer.

I'll start with Professor Daniel. I guess the question this comes down to is, "Why?" Why do you think the chair of the task force failed to listen to every single expert we brought forward, who have publicly spoken to this? The provinces said it should be 40. Why do you think she is not listening? What is the reason?

Prof. Juliet Daniel: I can't see into her mind; I'm not telepathic, but I speculate that her and the the task force's decision was based on the absence of data. I think many of us wish the recommendation had been that we invest in collecting data, evidence and more anecdotal stories to recognize that there are differences. Maybe the task force was rushed and had a tight deadline. As I said, I don't know why the task force and the chair feel the way they do.

I, myself, and some of the other witnesses found it interesting that one reason she gave for that when she was asked about it was that many women don't like the experience of a mammogram—it's painful and they prefer to not know. To me, those are disturbing reasons to keep the recommended age at 50 rather than 40, because, as I said, knowledge is power. Yes, many of us are afraid. I was afraid when I found my lump as well, but as a scientist, I knew that it was in my best interest to know, because the earlier it's diagnosed, the better.

As I said, I can't speak to what was going on in her mind. I don't know what the committee discussed and how much evidence they had, but I think they acknowledged that there was very little evidence.

What's interesting is that there's significant evidence from the U.S., and it was surprising that they weren't willing to use that evidence to guide the decision or recommendation for the Canadian context. I know we like to differentiate ourselves and say we have to do what's best for Canadians, but we also need to recognize that in the absence of data, perhaps we should be using data from a country that has been doing this kind of research for at least three decades, as compared to Canada, where we're not collecting any demographic data on any patient for any disease, not just breast cancer. That is a huge oversight in Canada, and many of us have been advocating for that for at least a decade.

- (1130)

Ms. Michelle Ferreri: Thank you for that. I really appreciate it. I think you touched on something very interesting.

The chair wrote a letter, an editorial, during this study, doubling down on the task force's recommendations. Where is the accountability for that? It seems more malicious than I think you're approaching, because nobody is denying this. I think that's where people's frustrations lie. Survivors really feel like that and ask, "Why have this chair at all? What are the modes to remove her? Why were there no experts or survivors on this task force?" I see a lot of heads shaking because nothing is adding up. I'm sitting here and looking at the Liberal members across the way, and as I said, we don't always agree—that's putting it nicely—but this doesn't make any sense.

Prof. Juliet Daniel: I don't know, but who struck the task force? Who selected the members for the task force?

Ms. Michelle Ferreri: I think you've just hit the nail on the head. That in itself is the answer, because that's what it comes down to. Who's appointing these people, and isn't there push-back and accountability? With all of this testimony, why hasn't it been reversed?

Thank you so much.

Prof. Juliet Daniel: Thank you.

The Chair: MP Serré, you have the floor for six minutes.

Mr. Marc Serré (Nickel Belt, Lib.): Thank you, Madam Chair.

Thank you to the witnesses for their very valuable information today.

I want to thank MP Ferreri for what she just mentioned. We're in agreement. The recommendations will be clear about age 40. We'll have to look at the Public Health Agency of Canada and how they recommend individuals for this task force. Clearly we're all in agreement on that. We heard from every single witness, except one, that that's the case.

I want to turn my attention to the next steps. Madam Kewayosh, from Ontario Health, mentioned visits in northern Ontario. I want to talk about how the system can improve and recommendations along those lines.

I want to talk about the visits, but as some of you may know, in Ontario there are 116 first nations. Of those, 110 are located in northern Ontario, with nine fly-in first nations. Northern Ontario has the first new medical school in 30 years, NOSM, in Sudbury and Thunder Bay. They focus on rural and indigenous. A lot of the doctors, who are trained for about six years, also go into the communities.

Madam Kewayosh, do you have any recommendations along the lines of the primary care training that is happening? What did you see on the ground in your two visits in northern Ontario?

I'll ask the other two witnesses that also.

• (1135)

Ms. Alethea Kewayosh: In terms of training, we do provide cultural safety training to all of the locum doctors. That's accessible to them. We are working very closely with the Sioux Lookout First Nations Health Authority, which holds the contracts for locums and works with nurses from the communities. They are federal nurses, by the way. It's about working directly with the community to im-

prove communications and education for the community to understand screening, for one thing.

There are 29 remote communities in northwestern Ontario. We have been able to bring screening closer to communities by providing FIT kits, which are for colorectal screening, to the community for them to access and by providing mobile screening coaches that go to Sioux Lookout. People only have to go to Sioux Lookout instead of Thunder Bay.

There's definitely a lot more work to be done with primary care providers. They go to communities. They're assigned to different communities. It's not the same doctor. There's no chance to create trust or any kind of rapport with the physicians. We still have incidents of community members not feeling that health care providers are listening to them, or they're just being sent home with an aspirin when in fact they have a stage 3 or stage 4 cancer.

There are things we are trying to do to make sure everybody is brought together and is having that conversation. However, we do need more supports when it comes to, as my learned colleagues have mentioned, research to understand why cancer seems to be exhibiting at earlier ages for indigenous people than for people in the rest of Ontario. We do have some studies that substantiate this.

We did an impact assessment to find out what people think of cancer today using a needs assessment we did 20 years ago. Things haven't really progressed all that much in 20 years when it comes to cancer, except that people can now talk about it, whereas before they didn't even want to mention the word because there was such a stigma associated with it.

Mr. Marc Serré: Professor, thank you. The time is running.

Professor Caron, your testimony was bang on about the barriers, early detection, screening and saving lives. On the issue of primary care providers in first nations communities, do you have any specific recommendations for us to address the clearly atrocious lack in service that indigenous women are experiencing?

Dr. Nadine Caron: Thank you for that. I think it's a great question.

I am based up in Prince George, which is where the northern medical program is. It's a very similar model to that of NOSM and came around the same time. The purpose is to develop a health care resource with respect to physicians who want to be in the north, who want to be in rural communities and who are perhaps better trained. At the University of British Columbia, we have mandatory cultural safety training for every health care provider student across disciplines, not just medicine but also pharmacy, dentistry, midwifery, social work, nursing, dietetics, speech and audiology—across the board. That helps, but I think we need to keep the focus on screening mammography.

First of all, I have never met a physician who did not start screening mammography in the forties, even after it was really hammered down that you start in the fifties. I do not know someone who, after seeing the end result of an undetected malignancy that was not detected with a screening mammogram, did not choose to pursue that.

In the data we have seen, over 30% of women in British Columbia choose the route of talking to their family doctor and getting a screening mammogram at the age of 40. Less than 20% of first nations women have done that. I think part of that is about the barriers that have been well described by Dr. Letendre and others. It's sneaking in anyway, but it's really a disparity about women, even without the firm guideline that women who are not first nations—because the data is specifically on first nations in the study I've done—should access screening mammography in their forties.

I think there's a mixed message, and it's unfair to health care providers. When there are recommendations and guidelines to start at the age of 50 but consider starting at the age of 40—some provinces say 45—it is stressful. It is hard to explain. When you hit age 40, you ask what screening is and why you do screening. It's hard to access, and you're dealing with other issues with respect to racism. There are mixed messages. In Ontario they do this; in B.C. they do that. I think we need to get a clear message.

• (1140)

The Chair: Thank you.

[Translation]

Ms. Larouche, you have the floor for six minutes.

Ms. Andr anne Larouche (Shefford, BQ): Thank you very much, Madam Chair.

I thank the witnesses for offering us their expertise today as part of this extremely important study on breast cancer screening standards at age 40.

We talked about this issue at length. The Standing Committee on Health also talked about it. We had the opportunity to raise the issue when we talked about women's health. There seems to be a consensus on the matter. However, for my part, I am trying to go further to find other ways of thinking and other solutions.

Ms. Letendre, you talked about the issue of comorbidity and the link between diabetes and cancer among Indigenous people. You also talked about the importance of enhancing knowledge and making healthy life choices. You raised all those issues. This leads me to something else. In fact, beyond the issue of screening at 40 years old, on which seems to be a consensus, we need more potential solutions, to study other recommendations and to go further.

As for me, I am trying to understand why there are still so many cancers in Indigenous communities. We talked about the importance of making healthy life choices when it comes to preventing cancer. It is being talked about more and more. We also talked about the consequences of not acting sooner and letting people live in conditions that are disgraceful in 2024.

For example, there is more and more talk about contaminants in the environment and what is being dumped into it. There is also

talk about the fact that certain Indigenous communities did not always have access to drinking water. So, I am trying to see how these factors can add up and have consequences on the number of cancers in Indigenous communities.

[English]

Dr. Angeline Letendre: Those are really important questions. Thank you for thinking more broadly about the many issues that impact this.

First of all, accountability on the part of our health systems needs to be better understood and articulated. Often, as has been stated, their decisions rely on data and the availability of data, but there also needs to be a recognition—I know Juliet talked about anecdotal stories—of stories from indigenous perspectives. When these stories are repeated time and time again, they are not anecdotal; they are actually evidence. There needs to be some harmonized data and perspectives on the experiences of indigenous women.

Indigenous women at the age of 40 are experiencing lifestyle challenges and issues that are often very exacerbated when compared to other groups in Canada. They include the raising of their grandchildren, which many of them do due to overdoses and what's happening with their grandchildren's parents.

The other thing that is really important is what Dr. Caron referred to, and that is the development of resources. Many of the mammograms in different provinces are very.... The buses are really old, so the capacity of the system to have up-to-date and really good equipment so we can make it to the remote and isolated regions where we find many of our indigenous people has to be significant.

We also need to look at putting more energy, funding and research into building community capacity. When we build community capacity, we engage provincial screening services at a more meaningful level. With respect to many of the things you talked about and we've been talking about, such as raising knowledge and information, there needs to be a recognition that when a lot of these resources go into communities, they anticipate and expect that communities will pull together all of the engagement and will take capacity from their own centres and primary health care providers to set all of it up.

The level of evaluation and sharing of data is such that it's not very acceptable to communities. We'd be able to build the capacity of communities if health systems were more willing to share data and work towards shared capacity in having these services available.

• (1145)

[Translation]

Ms. Andr anne Larouche: Ms. Kewayosh and Ms. Sheppard, do you have something to add regarding other aspects affecting the community?

I am thinking, for example, about communities who are concerned that the Chalk River nuclear waste facility will have an impact on the water—specifically because of contaminants—and on the increased risk of cancer.

[English]

Ms. Alethea Kewayosh: We know there are many environmental contaminants in the communities that are likely putting people at risk for certain cancers. We work with the occupational cancer research unit at Ontario Health, and there are many studies to substantiate that.

When it comes to communities and the high number of cancers we're seeing, there are likely certain culprits, for sure, that have to do with contaminants. The other part of that is poverty, food insecurity, not having access to healthy foods, not having access to recreation opportunities and not being able to get out on the land because of the high cost of gasoline. People can't afford to keep their skidoos going or even go out in the boat to hunt for natural game and fish, which we know is a lot healthier than store-bought meats. No one is doing natural harvesting.

Those activities are out of reach for most community people, so more resources and more understanding of how we can support them to do those types of things would go a long way toward helping people be a lot healthier when it comes to nutrition, physical activity and emotional well-being.

The Chair: *Meegwetch.*

Next I would like to welcome MP Idlout.

You have the floor for for six minutes.

Ms. Lori Idlout (Nunavut, NDP): *Qujannamiik, Iksivautaq.* Thank you, Chair.

Thank you to the witnesses for appearing today for a second time for this very important study.

My first question will be for Alethea Kewayosh.

I understand, based on the previous meeting, that there were some discussions with regard to racism in the health care system and how a lack of access to health care is placing indigenous women more at risk of not being diagnosed at earlier stages of cancer.

I wonder if you could briefly expand on that.

Ms. Alethea Kewayosh: You only have to pick up a paper to see different incidents happening in hospitals across Canada, but in Ontario we have had recent incidents of racism happen in hospitals across the province, with some incidents leading to people not surviving.

We feel that if a bigger penalty was applied for a racist incident, those incidents would probably stop, but people get a little slap on the wrist or they're told not to come back to work for a few days and nothing happens. The community knows this. They know that if a situation occurs, they're not going to be the ones who are hurt.

We have the Patient Ombudsman's office, which we've been working closely with to put in an indigenous early resolution specialist position, and that's helping. We've also been working more closely with the Ontario Human Rights Commission, but the other

part of this is education and creating understanding across hospitals when it comes to cultural safety. We work closely with partners like the Indigenous Primary Health Care Council, which has done cultural safety training that helps to show people what's appropriate and what's not appropriate.

I think a lot of it is based on ignorance and people just not understanding how offensive they are when they say certain things to indigenous people. I don't think it comes from a place of malice necessarily, but one of ignorance. We need to do more to educate health care providers and the health care system about cultural awareness and cultural safety. We are working to do that, but there's an onus on them to step forward as well.

The other part of that is the need for resources so that workers in our health care system can afford to take time away from their incredibly busy schedules to take this type of training. I think it's really important that people understand the true history of this country and the role that first nations have played, and the other nations as well, but most people don't. A lot of folks in the health care system are newcomers to Canada and they don't have any concept of the history.

More needs to be done to improve understanding of the history of Canada, the role that indigenous people have played and the historical traumas that have been perpetuated on them, which have led to what we see in communities today. People are still struggling to break free of that and come out from under the shackles of residential schools and the discriminatory policies in the Indian Act. So many things are still in place today, and it's hard to come out of that when they're still there.

Indigenous people are incredibly resilient. Where 20 or 30 years ago they would have just accepted what somebody told them, they're now standing their ground and saying, "Wait a minute; I'm not going to take that from you." We are doing our bit to make sure we're pushing back on those types of behaviours, and I see communities stepping up more and more on that.

• (1150)

Ms. Lori Idlout: Thank you so much. You naturally responded to the follow-up questions I was going to ask on ensuring that the health care system is more trauma-informed about Canada's treatment of indigenous peoples.

Of course, you mentioned residential schools. In the High Arctic, we had the dog slaughters and things like TB. I wonder if you could speak to how the current system is having a negative impact on indigenous women's health with its lack of investments in housing and its lack of investments in infrastructure, and how that impacts the ability of indigenous women to seek breast cancer screening.

Ms. Alethea Kewayosh: One of my colleagues mentioned that most screen-eligible women—50 and up and 40 in Ontario if you talk to a primary care provider—can't get screened. We have women who are not only looking after their grandchildren, but looking after their great-grandchildren. They're trying to put food on the table. They're trying to keep a roof over their heads. Getting screened is the last thing they're thinking about because these are the issues they contend with every day.

We have communities that are struggling to make ends meet. Where does any kind of screening or any type of self-care come into place? We have high rates of diabetes, as one of my colleagues mentioned. We have heart disease. When it comes to health issues, we have them all. It would probably be easier to identify the ones we don't have than the ones we have.

How do you prioritize health care and self-care when you are dealing with these day-to-day struggles of trying to feed your family, look after the grandkids, look after the great-grandkids or deal with a family member who may have taken a path that leads to unhealthy coping mechanisms, such as drug abuse or alcohol abuse? These are the realities in communities.

• (1155)

The Chair: Thank you.

[*Translation*]

Mrs. Vien, you have the floor for five minutes.

Mrs. Dominique Vien (Bellechasse—Les Etchemins—Lévis, CPC): Thank you, Madam Chair.

We are learning today—actually, we already knew—that women's mental load knows no borders. It extends everywhere, all the way into the far north.

Ms. Kewayosh, you talked about the enormous mental burden carried by our grandmothers and our great-grandmothers, and the burden women may carry today.

I thank this wonderful panel of witnesses for being with us today. You are very busy women. You save lives every day, which we don't do. Thank you for taking the time to come and meet with us today.

I am a little upset about the guidelines the Canadian Task Force on Preventive Health Care wants to maintain. In any case, those are the signals we've been getting. Clearly, this working group unanimously rejected the recommendation to allow systematic screening, if women so wish, from the age of 40. What I want to say to them today, and I am certain my colleagues all agree, is that the service should instead be made available to women, and they should be left to make their own decisions. Stop infantilizing women. When women see their doctor and they have a urinary tract infection or severe menopause symptoms, everyone contradicts them. They know their body and, most of the time, they know what is happening to them. It seems to me we should put this service in place and tell women that, because it is their body, it is up to them to decide whether or not they want a mammogram or a screening test.

I cannot believe that today, they're still saying that if women don't get diagnosed and don't access the system for early screening, it is because they are afraid of what they might see or hear, or because they may experience stress or anxiety.

I do not believe that. It is impossible. Some of the women I know, both young and less young, went through that experience. Not a single one of them fails to thank the heavens above for being able to get screened and get a much earlier diagnosis. Furthermore, we know that when breast cancer is detected early, it is easier to treat.

Ms. Daniel, you told us today you think the chair of the working group believes that women don't want to know. I am sorry, but I do not agree. All throughout this study, not a single person said that to us. Not a single member of the committee said it either. I am sure it is not true.

Ms. Kewayosh and Ms. Daniel, if I correctly understood what you are telling us today, breast cancer is a taboo subject among Indigenous people. That is why some women may not want to get a diagnosis. In fact, you said that during our first meeting.

For your part, Ms. Daniel, you told us a kind of curse is associated with this knowledge, as well as a stigma. This is a barrier that could certainly be removed, specifically by using awareness and communication campaigns. Do you not agree?

Also, have you approached the government or other authorities so that we can solve this problem?

Ms. Kewayosh, I invite you to answer first.

[*English*]

Ms. Alethea Kewayosh: Yes, I believe we can improve upon the understanding of what people think of cancer today. We have done that in Ontario for the last 15 years. We launched a massive communication and education campaign to help communities better understand what cancer is and what they can do about it. Fifteen years ago, people wouldn't even talk about cancer, and if they did talk about, all they knew about it was that it was a death sentence. However, to fast-forward to today, we have communities asking us to develop survivorship programs because they are now seeing people surviving cancer in their communities. To me, that is so heartwarming because we are working so hard to get them to that understanding.

Is it across the board? No. We still have a lot of work to do, but for communities to now see themselves surviving cancer is a major development and is the result of a lot of work to help increase the understanding of cancer in communities and take away the fear from that word. We are moving in that direction, so yes, I believe that we can take out the stigma.

• (1200)

The Chair: Thank you.

[*Translation*]

Thank you, Mrs. Vien.

[*English*]

Sonia, you have the floor for five minutes.

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

Thank you to all the witnesses.

We heard in this committee about reliable data and education for cultural safety.

Dr. Caron, last week, the Minister of Health announced funding for research into breast cancer screening, including treatment and outcomes by race and ethnicity. You mentioned the lack of data, specifically on triple-negative breast cancer in indigenous women. How can we bridge this data gap and ensure that women are getting the care and access to breast cancer screening they deserve?

Dr. Nadine Caron: That is a great question, and it's great to hear.

One answer to that is that you can't do something about indigenous women and indigenous people without indigenous people. It can't be done. It will never be done successfully. That's yesteryear. That's a historical response. That's number one.

Second, you're tapping into indigenous scholars, physicians, health care providers and researchers. Given the historical approach to education and the marginalization of indigenous peoples in this country, that is a relatively small pot. We have to acknowledge that and support those who are willing to go into that space.

Third, we have to recognize and not lose sight of the fact that data has been absent—we have a bit of data—and then be patient and wait for it. In saying to be patient and wait for it, I really cannot stress enough that we should not have to prove we need it. The governments and funding bodies of the health systems that would pay, fund and resource the screening mammogram, for example, should have the burden finally fall on them, as the health care system, to prove that indigenous people will not benefit from this.

It's always like the data needs to be there to prove that the resources are warranted. As a first nations physician, a breast cancer surgeon and a breast cancer researcher, I hear it ad nauseam. Why? We don't have the data because we haven't had the resources and don't have the educational background based on residential schools and all that. Patience needs to mean that until we know otherwise, we're going to be very cautious and value indigenous lives in this country.

Finally, what's really emerging now is indigenous data sovereignty. When we generate data, start to get this knowledge and move together as a country in our health care systems and public health systems, we need to recognize that we need to protect the sovereignty of this data, which is owned by indigenous people and should be guarded by indigenous people. Knowing how that data will be used is very important. How do you do that? I'll go back to my original answer: not without indigenous people to help direct it.

I think we're at a place where I can trust, as an indigenous researcher and health care provider, that with the right people in the room, the whole room doesn't need to be indigenous people. I'm hearing all these questions and brilliant responses from elected officials—and you guys sound like you're listening, you sound like you care and you sound like you're hearing us—so you don't need to be indigenous to care or understand, but I think we need to move forward as a country, as a community.

The fact that you asked this question is in itself a step forward.

● (1205)

Ms. Sonia Sidhu: Thank you.

We heard one of the witnesses last time, Jennie Dale, note that women often face a power imbalance with doctors. This makes it difficult to push back when a doctor refuses to refer them for screening. What has the impact of this power imbalance been, particularly on women of colour, indigenous women or racialized women?

Dr. Nadine Caron: Actually, we can take the adjectives off. Women in general tend to have a power imbalance. I feel this as a surgeon when I walk into the room and I'm surrounded by male colleagues. I think it's improving, but it hasn't gone away.

In the power imbalance between a patient and a health care provider, when you add the beliefs of the health care provider, having spent years studying and learning, and those of the patient, who is not really thinking about breast cancer day in and day out if that's not their field, there's a power imbalance of knowledge, and it can be magnified by stereotypes, bias, racism, and gender or sex inequity—power imbalances that way. As Alethea said, I don't think that should be tolerated. There should be significant ramifications for it.

If you're looking at this concept of racism and whether there is data, during the pandemic, the provincial government launched an inquiry into indigenous-specific racism in the health care system. This was not related to COVID. It wasn't related to vaccines. It wasn't related to PPE. It was literally related to everything in our health care system, and in the middle of a pandemic, it became an urgent inquiry into what was going on in our health care system. It's not one story, one patient; it's an entire population in an entire health care system that no doubt mirrors the rest of Canada.

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

Andréanne Larouche, you have the floor for two and a half minutes.

[*Translation*]

Ms. Andréanne Larouche: Thank you very much, Madam Chair.

Once again, I thank all five witnesses for being here this morning.

For my second turn—and likely my last—I will address you, Ms. Daniel.

You talked about biomarkers. We obviously heard about it before, but I am struck by it every time. Correct me if I'm wrong, but you said 40% to 70% of them were present in Western Africa.

Are these, in fact, breast cancer biomarkers? I am not sure, because opening statements sometimes go by quickly. You also said the percentage was 20% to 22% in the United States and 10% in Canada.

Are those the right numbers? Did I understand correctly?

[English]

Prof. Juliet Daniel: The statistics I mentioned are basically on the incidence of triple-negative breast cancer, not the biomarkers. The incidence of triple-negative breast cancer ranges from 40% to 70% in West Africa; 20% to 25% in the Caribbean, which is relatively homogeneously Black; and then, similarly, 20% to 22% in the U.S. However, in white women the incidence of triple-negative breast cancer is only 10%.

Based on the research I'm doing in my lab, we think there are unique genetic mutations or epigenetic marks on our genomes that are predisposing Black women to this aggressive breast cancer subtype compared to white women and other women. However, what I also want to point out, which we didn't get to talk about much today, is that studies in the U.S. have found that racism is a social determinant of health. There are studies and researchers in the U.S. examining this at the molecular and genetic level, and what they have found is that continued perpetual racism can lead to epigenetic changes on our genomes. They are not mutating the genes; you can think of these epigenetic marks as a tag or tattoo that goes on the genome. That slight modification is not changing the DNA sequence, but it's changing the way our genes are then expressed. Some genes could be turned off when they should be on, or they are turned on when they should be off.

That's a booming field of research that's growing, but we do need to identify those biomarkers and epigenetic marks in populations that have been historically traumatized and oppressed by racism, because that would shed significant light on why we, including me as a Black woman, have or may be predisposed to these very aggressive types of cancer.

• (1210)

The Chair: Thank you.

MP Idlout, you have the floor for two and a half minutes.

Ms. Lori Idlout: *Qujannamiik, Iksivautaq.*

I'll be asking my questions of Dr. Letendre.

I want to divert my question a bit away from the importance of distinctions-based research or care. I understand how different that is and I completely agree that we need to make sure that first nations, Inuit and Métis are included in all of this work. However, I want to take the opportunity to ensure that remote communities are being amplified.

I want to ask you very quickly if you have read a study called "Perspectives of Nunavut patients and families on their cancer and end of life care experiences". This study was conducted by Tracey Galloway, Sidney Horlick, Maria Cherba, Dr. Madeleine Cole, Roberta L. Woodgate and Gwen Healey Akearok.

Dr. Angeline Letendre: Yes, I have read that study. I'm the vice-president and research chair for the Canadian Indigenous Nurses Association, and we work with all three distinct groups in the country. We are actually celebrating our 50th year anniversary this year. We are the oldest health care provider organization, both indigenous and non-indigenous, in the country.

We've done some really groundbreaking work with primary health care providers. We worked with the Pauktuutit Inuit Women

of Canada committee quite closely on this, and we were able to support them to do some information and data gathering not only with the Inuit communities they work with, but also with health care providers.

Much of our work—and we're going into phase two of it—is about working with primary health care and national indigenous primary health care organizations. We started out with friendship centres, social workers, physicians and, of course, nurses, and now we're going to expand to try to work with pharmacy, occupational therapy and indigenous dental associations. What we have found from our work is that primary indigenous health care providers are facing multiple challenges in trying to address the cancer and cancer prevention needs of indigenous communities, and certainly Inuit and northern ones.

Thank you for the good question.

The Chair: Thank you.

For the last two members, instead of five and five, we're going to do four and four, just to shave off a few minutes so we have room for the second part of the meeting.

Michelle, you have the floor for four minutes.

Ms. Michelle Ferreri: Thanks, Madam Chair.

Again, thank you to the witnesses. It's valuable expert testimony coming from the years and decades of experience we have from those sitting on this panel.

I have a fairly pointed question, because as I've sat here and thought about how this is playing out, I've felt that a lot of it doesn't make any sense to me. My colleague Ms. Vien was so articulate in what she said about women being able to advocate for themselves and ask for what they need, but unfortunately the problem is that a lot of people don't even have access to doctors in this country. That is one of the big issues, for sure.

I'm curious about what you guys would suggest for this task force and its chair. We have to put together recommendations from this study. Would you ask for the resignation of the chair?

Who wants to start? I'll go with Professor Daniel.

• (1215)

Prof. Juliet Daniel: My recommendation would be to dismantle the task force and have a completely different task force with membership that's representative of the Canadian population they're serving so that there is a diverse membership on the committee. We could have, for example, indigenous and Black breast cancer oncologists and physicians; Black and indigenous cancer researchers and biologists; cancer survivors; and cancer caregivers. I think we don't get the perspective of the caregivers of cancer patients often enough, and that's a valuable perspective to have in these decisions.

I would not necessarily recommend the resignation of the chair, but I think the entire committee should probably be dismantled and a new task force struck that will approach this from the lens we've been discussing for the past hour, plus the hour a couple of weeks ago.

Ms. Michelle Ferreri: Just to push back on that—and I'd like to hear anybody else's answer to this question if we have time—do you think the task force is even efficient? If you have provinces doing this job and overseeing it—provinces already doing their own thing—do you think a task force is just another arm of bureaucracy?

Prof. Juliet Daniel: It definitely is, and I think for many of us, that's probably one of the questions we had. Why do we have a task force when every province seems to be doing its own thing? As a settler immigrant in Canada, that's been one of my challenges. I see how our provinces tend to be responsible for health and education, but the federal government also plays a role in that, and they don't get along. That's a whole different story, but it is a challenge.

For example, when I was diagnosed, I couldn't get my mastectomy and reconstruction at the same time. The only province that was doing that in 2009 was British Columbia. That was when I realized that there were discrepancies in our health care system and that, as a Canadian, I wasn't privileged to be in the right province at the right time when I was diagnosed. To me, as a Canadian, it shouldn't matter where one lives in Canada. We should all have access to the same health care. It should be equitable, regardless of the province we reside in.

Ms. Michelle Ferreri: I only have 20 seconds left. Just quickly, would any of the experts want to see the resignation of the task force chair?

Ms. Alethea Kewayosh: I don't know who he or she is, but they're obviously very out of touch with the topic. I'm sure there was a task force struck at one time that created residential schools, and look at how well that went over.

They need to be more in touch with the topic. They need to have an understanding of what's happening with communities and people. They need to have the pulse of what communities are saying and what people are saying. They're very out of touch.

Ms. Michelle Ferreri: Thank you. I love that answer.

The Chair: Thank you.

Emmanuella, you have the floor for four minutes.

Ms. Emmanuella Lambropoulos (Saint-Laurent, Lib.): Thank you, Madam Chair, and thank you to all of our witnesses for being here with us today to answer some more of our questions.

A few of the witnesses today spoke about the role, perhaps, that intergenerational trauma plays in this, especially with indigenous and Black Canadians. Professor Daniel spoke a bit about epigenetic changes and changes in genes due to stressful situations.

I've known people who had experience with cancer at a young age. They were white but had it very early on and very aggressively because they had very severe trauma in their early lives.

Based on what you've been looking at, Professor Daniel—and anyone else who wants to can chime in—do you have any kind of

recommendation on taking a look at how trauma and epigenetics play a role in this? I think we would probably be tackling different minority communities. We would be tackling indigenous communities and Black communities, but generally all women who may have experienced very significant stressful issues in their life.

Prof. Juliet Daniel: That's a fantastic question. I know we're short on time, so I'm going to say, yes, I would recommend that we have a longitudinal study or a clinical trial—depending on how it's done—that looks at the impact on women of environmental factors, racism, the social determinants of health and trauma. The epigenetics study I referred to in the U.S. was actually based on a longitudinal study looking at women who developed chronic disease in their forties. The only evidence or factor that correlated with the development of a chronic disease in their forties was having a trauma, and that was irrespective of ethnicity.

To your point about younger white women having breast cancer at a young age, it was definitely linked to trauma before the age of 10. If a woman experienced any kind of trauma before the age of 10, whether it was the loss of a family member or parent, being in a car accident or anything incredibly traumatic, it correlated with the epigenetic changes that were seen on their genome and with having a chronic disease in their forties, whether it be diabetes, cardiovascular disease or cancer.

I would therefore recommend that we engage and look at the data coming out of the U.S., where they're doing these studies. We don't have to reinvent the wheel. We can use some of that data in our Canadian context and do it faster and better.

• (1220)

Ms. Emmanuella Lambropoulos: Dr. Caron, would you like to chime in as well? You spoke about intergenerational trauma, and so did Dr. Kewayosh. If you guys want to chime in on that, you can.

Dr. Nadine Caron: Thanks. I know we're very short on time.

First of all, ditto to Dr. Daniel. I agree with everything. The one thing to note is that this will take time. We cannot wait. We've heard it. We believe it. We think it. I've been to hundreds of first nation, Inuit and Métis communities. I hear it repeatedly.

What we need to do is move upstream, fix it and then ultimately prove that we were right, rather than have more lives lost and say we should have started it earlier.

That's what I've noticed over my career in the world of cancer in particular.

Ms. Emmanuella Lambropoulos: Thank you.

The Chair: Thank you. I think that was a fitting wrap-up.

That concludes our panel for today. On behalf of the committee, I would like to thank all of the witnesses for their testimony.

At this point, we will be suspending for approximately five minutes to transition to the in camera portion of today's meeting.

[Proceedings continue in camera]

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